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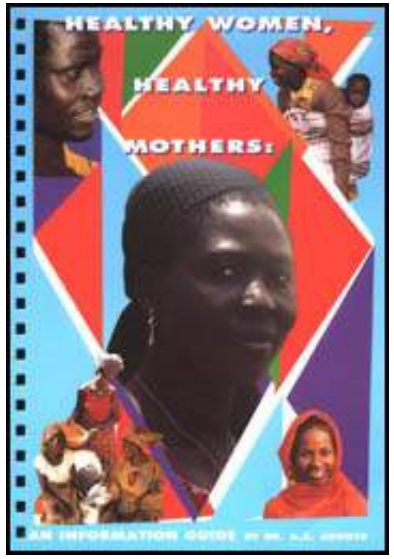

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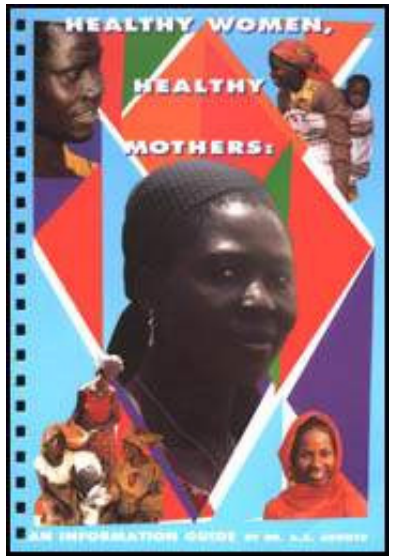

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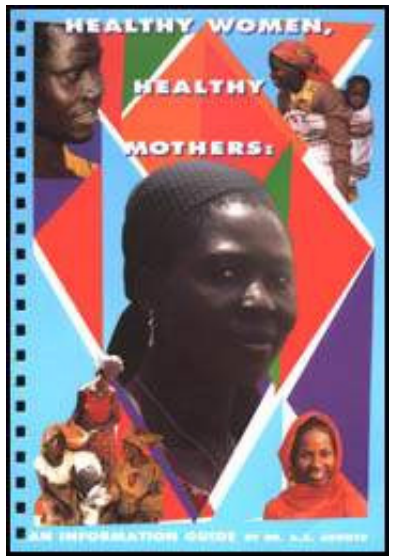

Chapter Eight - MINOR DISCOMFORTS DURING PREGNANCY

Many women experience some discomfort or minor complaints during pregnancy. Although these discomforts are not dangerous, they can be troublesome. It is important for women to learn what is normal and what is dangerous. For problems that are not life-threatening, it is helpful to explain to women what they can do to ease the discomfort on their own, and to listen to them with sympathy and kindness. This helps create trust and understanding between the health worker and the woman, and makes the job of caring for her easier.

MORNING SICKNESS

About one-third to one-half of pregnant women feel nausea (discomfort in the stomach) during the early weeks of pregnancy. Although it is called morning sickness, women may also feel unwell in the early evening or at other times of day. It generally goes away by about the third month of pregnancy. If it usually happens in the morning, it may help the woman to eat a piece of dry biscuit, yam, or banana before getting out of bed. If she feels nausea at other times during the

day, it may help to eat smaller meals more frequently, rather than two or three big meals a day. If the nausea and vomiting are severe or persist after the third month, or if they interfere seriously with eating, the woman should go to a health facility.

HEARTBURN

Heartburn, in spite of the name, has nothing to do with the heart. It is a burning sensation in the throat and chest caused by indigestion. It tends to occur towards the end of pregnancy when the enlarged womb pushes up the stomach. This causes small amounts of stomach acid to pass upwards. Women should try to eat several small meals every day, not eat spicy or oily foods, and avoid lying down immediately after eating.

Box 8.1: ***Common Discomforts and When to Expect Them***

FIRST TRIMESTER

- Morning sickness or nausea and vomiting
- Tiredness or dizziness
- Tenderness in the breasts
- Frequent urination

SECOND TRIMESTER

- Tiredness
- Backache
- Changes in the colour of the skin

- Increased fluid from the vagina
- Increased saliva in the mouth
- Heartburn

THIRD TRIMESTER

- Tiredness
- Backache
- Pressure in the pelvis
- Increased fluid from the vagina
- Contractions in the womb that are irregular and do not cause any pain
- Muscle cramps, especially in the legs
- Frequent urination
- Heartburn and gas
- Constipation
- Increased varicose veins
- Colostrum (yellowish liquid) from the breasts
- Stretch marks on the skin of the abdomen
- Shortness of breath

- Swelling in the ankles and feet

CONSTIPATION (NO BOWEL MOVEMENT)

Constipation during pregnancy is quite common. It occurs because the contractions of the bowel which move digested food through the body are slowed

by the hormones of pregnancy. Eating lots of vegetables and fruits, drinking a lot of water, and exercising regularly can help keep the bowels working normally. Enemas should be avoided unless recommended by a doctor, nurse, or midwife.

VARICOSE (SWOLLEN) VEINS

Varicose veins are caused by the blood collecting in the veins, particularly in the veins of the legs. They may appear for the first time during pregnancy, or become worse. This is because the body produces more blood during pregnancy, and because the weight of the baby makes the blood collect in the legs. Women can make themselves more comfortable by propping up their feet when sitting, and by making sure they do not stand for long periods of time. Regular exercise also improves the circulation of blood in the legs. Varicose veins improve after delivery, but will not disappear altogether.

HAEMORRHOIDS (PILES)

Haemorrhoids are varicose veins around the anal opening. They may cause pain and bleeding during bowel movements and are made worse by constipation (hard stool). Haemorrhoids may be relieved by avoiding long periods of sitting, and by eating foods that promote easy bowel movements (fresh fruits and vegetables in particular). The pain can be relieved by warm baths or suppositories.

VAGINAL DISCHARGE

The normal fluids in the vagina tend to increase during pregnancy. This is nothing to worry about unless the discharge becomes greenish, yellowish, or bubbly, and is accompanied by itching or an unpleasant odour. Changes like these are usually

signs of an infection. If a woman develops these problems, a laboratory test may be necessary to identify the cause and determine the best treatment. If the facilities are not available to do laboratory tests, there are guidelines available that specify which antibiotics to give when signs of a vaginal infection are present (see Chapter 18).

BACKACHE

As the baby grows heavier and a woman's balance changes, her lower back is put under increasing strain. Keeping the back straight when standing and sitting may help relieve or prevent backache. There are also exercises that may help to relieve the strain (see Figures 8.1-8.3).

Ways to Relieve Backache and Avoid Straining the Back

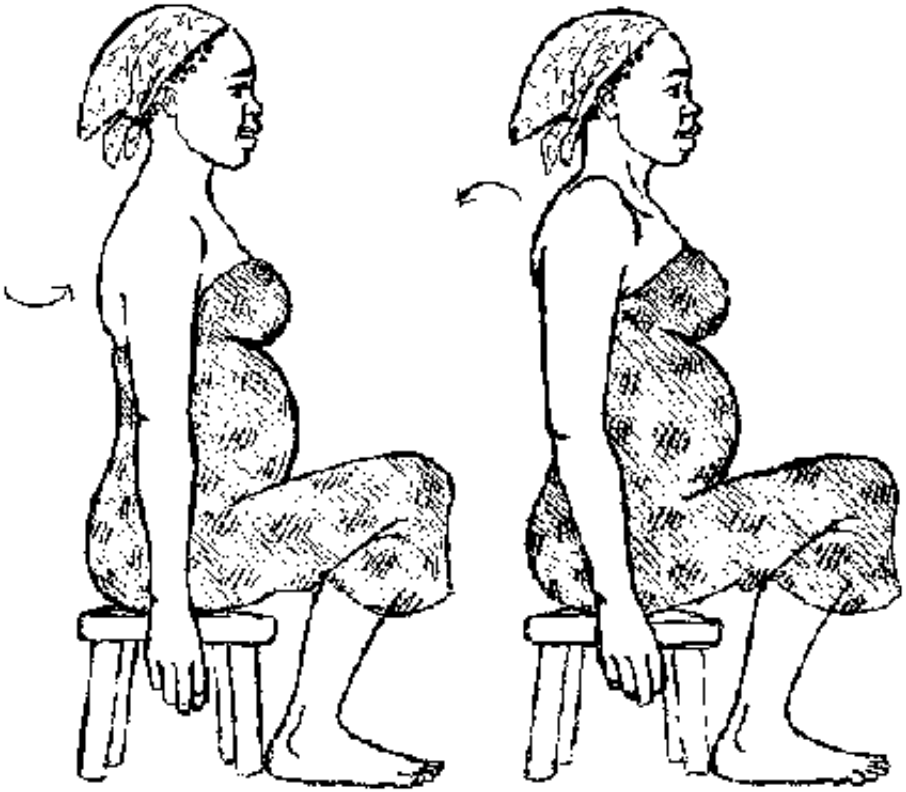

Figure 8.1: Shoulder Circles

1. Sit with arms hanging to the side.
2. Lift shoulders up towards ears.
3. Move shoulders back.
4. Relax shoulders and return to the starting position.

Figure 8.2: How to Lift Something

1. Place one foot forward and bend down on the other knee.

2. Bring the child or object close. Rise slowly with front foot flat on the floor and use back foot to push up and for balance.

Figure 8.3A: How to Reach Things on the Ground

Do not bend over at the waist to reach things on the ground.

Figure 8.3B: How to Reach Things on the Ground

Instead, squat down by bending knees and keeping back straight.

LEG CRAMPS

Cramps in the muscles of the legs, especially the calf, frequently occur towards the end of pregnancy. To relieve the cramp, women can try gradually stretching the leg out straight with the toes pointed back towards the body (see Figure 8.4). Rubbing does not usually help as much as stretching out the muscle.

SWELLING IN ANKLES AND FEET

It is normal to have some swelling in the ankles and feet during pregnancy. Swelling in the wrists or hands is less common. Swelling occurs because the body is keeping more fluid in the tissues than normal. Women should be advised to

avoid tight cuffs, bracelets, shoes, or rings. If the swelling increases too much these may be difficult and painful to remove. If the swelling increases suddenly or causes very rapid weight gain, women should go to a health facility to have their blood pressure and urine checked for pre-eclampsia, which is a life-threatening complication (see Chapter 9).

SHORTNESS OF BREATH AND TIREDNESS

It is not unusual for women to get tired easily, especially during the first three months or so of pregnancy. The body is adjusting to many new changes. Towards the end of pregnancy, the womb takes up so much room that breathing may become difficult. This does not necessarily mean there is anything wrong. The shortness of breath goes away as soon as the baby is born. If, however, a woman becomes very short of breath, has chest pains, has a very high pulse rate, or remains tired even after resting, she may be suffering from heart disease, anaemia, or some other problem. She should go to a health facility for an examination.

ABDOMINAL DISCOMFORT

As pregnancy continues, women may experience occasional cramps or discomfort in the lower part of the abdomen. This is often due to stretching of the abdomen or the baby moving about too much. It may be relieved by sitting or lying down. Drinking plenty of fluids can also help prevent this problem. Toward the end of pregnancy women may notice irregular contractions of the womb. These are quite normal. But if a woman is still a month or more before her due date and the contractions become increasingly strong and regular and do not go away after

resting, she should be advised to go to a health facility.

URINARY DISCOMFORT

During the first and last months of pregnancy, as the uterus and baby are pressing on the bladder, a woman may feel the need to urinate more often than normal. Drinking a lot of water and urinating often may help prevent infections. Signs of infection may include a painful burning sensation when urinating and a constant need to urinate with little or no urine actually passing. If a woman has these signs she should go to a health facility immediately for medicine, since urinary infections can become worse very quickly.

Figure 8.4: How to Stretch Out a Cramp in the Calf of the Leg

Stretch the leg out straight and point the toes back toward the body.

Summary: Minor Discomforts During Pregnancy

There are a number of minor problems that a woman can have during pregnancy. Most of them can be taken care of within the home; none of them are life-threatening. The most common complications, and what to do about them, are:

MORNING SICKNESS: Eat smaller meals more frequently, instead of several big

meals.

HEARTBURN: Avoid spicy foods and eat frequent, small meals. Do not lie down immediately after eating.

CONSTIPATION: Drink water, eat vegetables and fruits.

VARICOSE VEINS: Prop up feet when sitting; avoid standing for long periods of time.

HAEMORRHOIDS: Avoid sitting for long periods; eat fruits and vegetables.

VAGINAL DISCHARGE: If it is green or yellow and has an unpleasant odour, seek treatment at a clinic.

BACKACHE: Keep back straight when sitting and standing; do exercises.

LEG CRAMPS: Stretch the muscle out slowly by straightening the leg and pointing the toe back.

SWELLING IN ANKLES AND FEET: Avoid tight clothing, shoes, and jewelry. If the swelling is sudden, go to a clinic.

SHORTNESS OF BREATH: if prolonged, go to a health facility.

ABDOMINAL PAIN: Drink fluids to prevent the pain. Sit or lie down when the pain strikes. If it is prolonged, go to a clinic.

URINARY DISCOMFORT: Drink lots of water and urinate often. If there is pain, go to a health facility.

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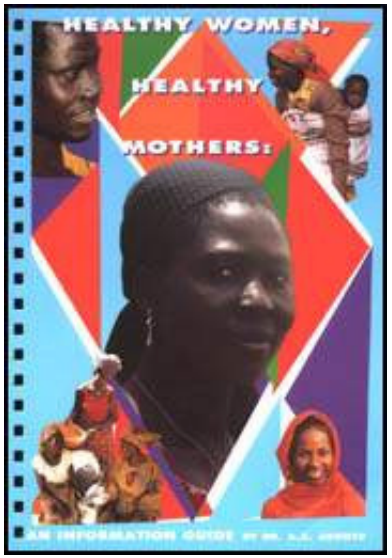

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Chapter Nine - SERIOUS COMPLICATIONS DURING PREGNANCY

During any pregnancy, complications can arise. Some of them are relatively minor, as discussed in the previous chapter. Others, however, can be serious and may require medical attention. These include problems that are caused by pregnancy, as well as conditions that existed before but are made worse by the pregnancy.

Some are life threatening, so it is important for women and their families to know which ones are dangerous and which ones are not. They should also know what to expect, and what to do when a problem occurs. This chapter discusses some of the more serious complications of pregnancy.

Problems Caused by Pregnancy

The problems described in this next section are, for the most part, complications that are caused by pregnancy.

MISCARRIAGE AND ABORTION

Not all pregnancies last the normal nine months (40 weeks) and result in the birth of a baby. In some cases pregnancy ends by itself; this is called a miscarriage or spontaneous abortion. Miscarriages usually occur before the 26th week. In some cases an operation is carried out to end the pregnancy; this is called induced abortion.

MISCARRIAGE OR SPONTANEOUS ABORTION:

Out of every one hundred pregnancies, ten to twenty end in miscarriage. Miscarriage occurs when the pregnancy ends before the baby has any chance of survival. Most miscarriages occur in the first 12 weeks of pregnancy.

What causes a miscarriage? By far the most common reason is that something is wrong with the fertilised egg. When examined under a microscope, 60% of all pregnancies that miscarry show signs of serious problems with the fertilised egg. If the egg had continued to grow and develop, it would have resulted in a baby

with severe abnormalities such as deformed or missing organs. Miscarriage, therefore, can sometimes be nature's way of dealing with such problems.

A miscarriage may also result if a woman has a serious illness such as malaria or syphilis, a severe fall, or a problem with her reproductive organs. Some miscarriages occur because the pregnancy was ectopic. This means the fertilised egg was implanted someplace other than the womb, usually in the fallopian tube. Ectopic pregnancies almost always miscarry and can be very dangerous; they are discussed later in this chapter.

THE SIGNS OF A MISCARRIAGE: There are two main signs of a miscarriage: bleeding from the vagina, and pain in the lower abdomen. The bleeding is usually slight to begin with, but gets heavier and soon big clots appear. Both the bleeding and the pain can be quite similar to those accompanying a heavy menstrual period, especially for an early miscarriage. It may therefore be difficult to tell when a miscarriage happens, especially if pregnancy was never suspected.

"COMPLETE" MISCARRIAGES: A miscarriage is described as "complete" when all the tissues of the developing embryo or foetus and the placenta have passed out through the vagina. With a complete miscarriage, the bleeding will stop after a few days. In this case a woman should rest and avoid any heavy lifting or exercise for 2-3 weeks. Sexual intercourse and tub baths should also be avoided during this time, as they increase a woman's chances of getting an infection. To clean herself, she should use a wet cloth or towel instead. A normal miscarriage should not cause any problems, but a woman should go for a check-up at a health clinic in the first week after the bleeding has stopped, even if she feels fine, to make sure no harm has been done. Furthermore, women with any bleeding that is not a

menstrual period, whether pregnancy is suspected or not, should be encouraged to have a thorough examination.

INCOMPLETE MISCARRIAGES: A miscarriage is incomplete when part of the foetus or placenta remains inside the womb. A miscarriage is more likely to be incomplete if it happens between the tenth and twentieth week of pregnancy. Bleeding continues and there is a good chance that the dead tissues inside the womb will become infected, which usually causes fever and pain in the abdomen (see Figure 9.1). When a miscarriage is incomplete, the womb must be completely emptied as soon as possible by a trained health worker in a hospital or clinic. If an incomplete miscarriage becomes infected, it can lead to fever and pain in the reproductive organs that does not go away. If the infection is not treated it can cause scarring in the fallopian tubes, which can make a woman infertile. If a woman has any signs of infection after a miscarriage, she should go immediately for a check-up.

After a miscarriage, especially an incomplete one, a woman should wait several months before trying to get pregnant again. During this time a family planning method should be used to avoid pregnancy (see Chapter 17).

REPEATED MISCARRIAGES: Some women have miscarriages again and again. Sometimes it is possible to figure out why this happens. For example, there may be a weakness in the neck of the womb which can be corrected by closing it with a stitch during pregnancy. But often, no medical explanation can be found even after lengthy tests and investigations. After one or two miscarriages early in pregnancy, a woman should be reassured not to worry. Even a woman who has had three or more early miscarriages has a 75% chance of carrying the next pregnancy to term.

But after the third or fourth miscarriage, or if a miscarriage occurs late in pregnancy, a woman should be encouraged to have a medical examination to see if any explanation can be found.

INDUCED ABORTION: Miscarriages are also called "spontaneous abortions", which means they start on their own. There are, however, times when a woman ends the pregnancy by an "induced abortion". There are various reasons why a woman might want to end her pregnancy. Some illnesses can make pregnancy dangerous to a woman's health, and an induced abortion may be necessary to preserve her health or even to save her life. In these cases, an abortion can be legally performed by a doctor in most African countries. In some countries, abortion may also be legal if the foetus has a severe abnormality, or if the pregnancy is the result of rape or incest.

A woman may also want to end a pregnancy because she is not married or because her husband has left her. Or, she and her husband may have many children already and feel they cannot afford to take care of any more. If a woman does not want to become pregnant, the best thing for her to do is to use a method of contraception to prevent a pregnancy before it starts. No contraceptive method is perfect, however, and neither are people; so unintended pregnancy does happen. In situations where abortion is legal, the procedure is usually performed early in the pregnancy, during the first three months. The woman is given an injection to reduce the pain, and then a doctor cleans out the womb using instruments that are inserted through the vagina. The operation usually takes about 15 minutes. If it is done by a trained person, with proper equipment and in a clean environment, the operation is not dangerous.

Figure 9.1: Complications of Miscarriage or Abortion

An incomplete miscarriage or unsafe abortion can result in severe bleeding, infection, and fever. If a miscarriage occurs and any of these signs develop, the woman should go immediately to a hospital or clinic.

Where abortion is not legal, women may still try to end their pregnancies - by themselves, with the help of a traditional healer or birth attendant, or in an illegal abortion clinic. Some of the traditional methods used include inserting a twig into the womb; swallowing a special tea, chemical, or fruit; taking a very large dose of a drug like chloroquine; douching (washing out) the vagina with a harsh chemical like bleach; or having someone massage the abdomen very roughly. Most of these

methods are not effective, and many are extremely dangerous to the woman's health. These procedures are often performed in secret and in unclean conditions by untrained people. Even abortions performed by health professionals in medical facilities can be unsafe if they are not done carefully, or if the equipment or the environment is not clean.

If an unsafe method is used to induce an abortion, the woman is likely to have a major infection in her reproductive organs. In some cases, a hole is made in the womb. Both problems are very serious; they can cause death or long-term illness, and are likely to make the woman infertile.

If for some reason a woman has had an induced abortion and she develops any of the signs in Box 9.1 below, she should go to a hospital for treatment immediately. Delay can mean death. The health workers and family members who are helping her should treat her with kindness and sympathy, since she is likely to be frightened and in pain. It is important to gain her trust and reassure her that she will not be punished or blamed. Otherwise she is unlikely to tell the truth about what has happened, which makes it harder to provide the correct medical treatment.

Box 9.1: ***Post-Abortion Danger Signs***

FEVER OR CHILLS
PAIN IN THE ABDOMEN, CRAMPING, OR BACKACHE
BLEEDING FROM THE VAGINA THAT DOES NOT STOP OR IS VERY HEAVY
BAD-SMELLING DISCHARGE FROM THE VAGINA
DELAY (6 WEEKS OR MORE) IN RESUMING NORMAL PERIODS

ANAEMIA

Anaemia is a common complication of pregnancy. In anaemic women, the blood does not have enough iron in it, and is not able to carry enough oxygen to the body. This is often called "weak blood". Even if a woman had a normal amount of iron before pregnancy, more is needed during pregnancy. In fact, two or three times as much is needed to meet the needs of mother and baby. If anaemia existed before pregnancy, the increased need for iron will make the anaemia worse.

Unfortunately, many women start pregnancy with some degree of anaemia. It can be caused by a number of things:

- **A diet that is low in iron-rich foods such as liver, eggs, lean meat, and leafy green vegetables. Foods with vitamin C (oranges, pawpaw, mangoes) also help the body absorb iron from other foods.**
- **A parasite (malaria, hookworm, schistosomiasis) in the blood or body that reduces the amount of iron.**
- **Repeated pregnancies without adequate time in between to recover physically, which uses up iron.**
- **Sickle cell disease or some other blood disorder.**
- **Heavy menstrual periods may lead to anaemia over time, since women lose iron during their periods each month.**

THE SIGNS OF ANAEMIA: A woman who is anaemic usually feels tired and weak

most of the time; she may also feel dizzy and out of breath. Her skin may be unusually pale on the insides of her eyelids (conjunctivae), gums, and tongue, as well as the palms of her hands and the soles of her feet (see Figure 9.2). While these signs can be used as a warning, it is best for her to go to a hospital or clinic that can diagnose the disease through a blood test and find out how serious it is. Blood testing for anaemia may be done more than once during the pregnancy.

WHY IS ANAEMIA SERIOUS? If anaemia is not identified and properly treated early, it will get worse during pregnancy. Very severe anaemia can cause heart failure, miscarriage, or premature labour. Anaemia can also make other problems, like infection or bleeding, even more life-threatening. The blood of an anaemic woman is already weak, and excessive bleeding during an abortion (spontaneous or induced) or following delivery can be very dangerous. Anaemic women also have less ability to fight off infections, especially after an abortion or an operation.

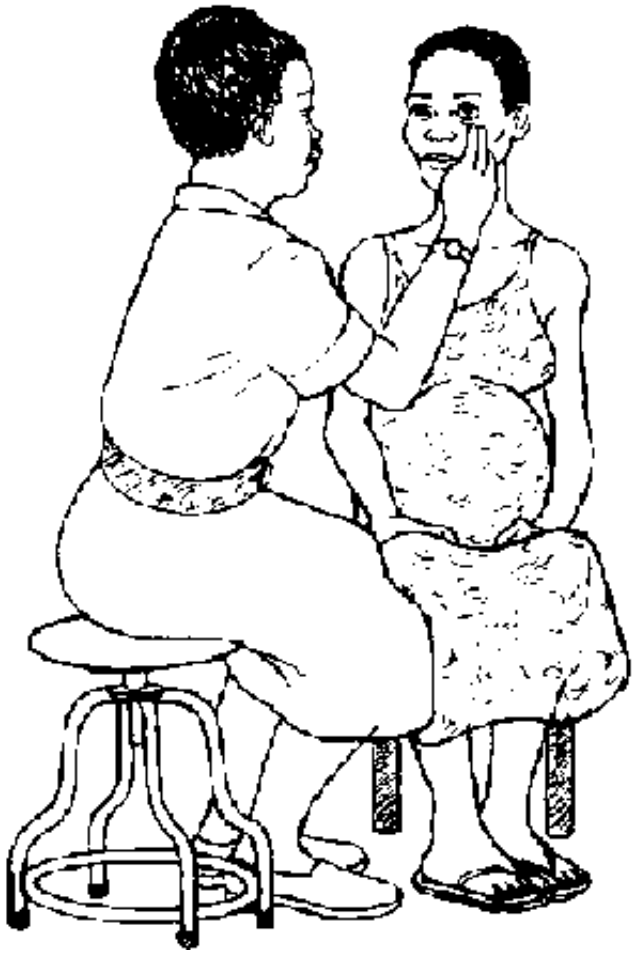


Figure 9.2: Checking for Signs of Anaemia

If a woman is feeling tired, weak, and dizzy, or if the insides of her eyelids or her palms are especially pale, she might have anaemia. She should go to a hospital or clinic for a test.

WAYS TO PREVENT ANAEMIA: The best way for a woman to avoid severe anaemia is to not be anaemic when pregnancy starts. Eating a diet rich in the foods listed above, and allowing plenty of time between pregnancies (two to three years) will

help. Avoiding malaria and other diseases will also help prevent anaemia.

Even if a woman is not anaemic, once she is pregnant she should take iron tablets regularly as prescribed by a trained health worker. Sometimes these tablets will include folic acid or other vitamins. It is best for her to take them with food. Some women find that the tablets make them feel sick, and are therefore reluctant to take them. The benefits of taking the tablets should be carefully and thoroughly explained to them, and they should be advised to take the tablets with food to minimise the discomfort. Iron tablets should not be taken with milk, since milk can prevent the body from using the iron.

TREATMENT OF ANAEMIA: If treatment with iron tablets is started early enough, there is usually time to correct the anaemia before delivery. In severe cases, if there is not enough time for this treatment to work, or if a woman loses a great deal of blood at delivery, it may be necessary to give a blood transfusion. This can be a risky procedure.

PRE-ECLAMPSIA AND ECLAMPSIA

Pre-eclampsia (high blood pressure caused by pregnancy) can occur anytime during pregnancy, but it usually occurs towards the end (after the 28th week). No one knows what causes this serious condition, but it is most common in young women in their first pregnancy. If pre-eclampsia is not treated, it may lead to full-blown eclampsia.

SIGNS OF PRE-ECLAMPSIA: Pre-eclampsia is also known as pregnancy-induced hypertension. It has three major signs:

1. Swelling of the feet, hands and fingers, and face (see Figure 9.3): Some swelling of the ankles during pregnancy is not unusual, especially if a woman has been standing for a while. But if the swelling is present when the woman first wakes up in the morning, or if her shoes are too tight and there is swelling in the face, she should be advised to go to a clinic to see if she has pre-eclampsia. Many women are not aware that such swelling indicates a potentially serious complication. Health education during antenatal care should explain the signs and seriousness of pre-eclampsia in terms that they can understand.

2. A rise in the blood pressure: An increase to 140/90 mmHg or above, or an increase in the blood pressure of 30 mmHg systolic and 15 mmHg diastolic in comparison to earlier measures, is a sign of severe hypertension or high blood pressure. This can only be detected by measuring the blood pressure.

3. Protein in the urine: This too can be found only by a test at the clinic.

EFFECTS OF PRE-ECLAMPSIA ON MOTHER AND BABY: In mild cases, a woman may feel no ill effects apart from swelling of the feet, ankles, hands, and face. But if pre-eclampsia is not treated properly and promptly, it can lead to high blood pressure, kidney damage, and increasing amounts of fluid in the body. The baby may not receive enough oxygen and food, and may be small and weak. A woman may develop severe headaches, blurred vision, spots before her eyes, and vomiting. These are signs that the most serious stage of this complication, called eclampsia, may be developing. Eclampsia, in which a woman has fits or convulsions and loses consciousness, is a life-threatening complication for both

mother and child. It can occur late in pregnancy, during delivery, or shortly after the baby is born (within two days or 48 hours).

WHAT TO DO: If signs of pre-eclampsia exist, a woman should go to a hospital. Local treatments with herbs and other mixtures are generally not effective. The woman may need total bed rest to prevent pre-eclampsia from getting worse. If resting at home does not work, she may need to enter the hospital for rest and treatment under supervision. Sometimes sedatives or medications are needed to reduce the blood pressure. A woman should understand the danger of the situation so that she knows why these measures are necessary. Sometimes women are reluctant to take these measures because they often feel fine, even though their blood pressure may be dangerously high.

Figure 9.3: Oedema

Swelling in the feet, hands and fingers, as well as the face, is a sign of pre-eclampsia. A woman with these signs should go to a clinic to have her blood pressure and urine checked.

In severe cases, when eclampsia is developing, a woman must get immediate, expert treatment in a hospital. If she starts having fits, she should be prevented from hurting herself, but should not be held down forcibly. The handle of a spoon wrapped in a cloth should be put into her mouth to prevent her from biting her

tongue. When the fit is over and she is being taken to the hospital, she should be placed in a lying-down position on her side. It is essential that the baby be delivered as soon as possible; this is necessary to save the lives of both mother and baby. Sometimes an operation is necessary.

SEVERE VOMITING

Morning sickness, sometimes accompanied by vomiting, is a relatively common complaint during the first three months of pregnancy. It is not normal, however, if the vomiting persists or is severe, or if it occurs late in pregnancy or causes weight loss and severe dehydration. A woman should be advised to rest in bed at home or in the hospital for a few days, avoid fatty foods, and not drink too much water at one time. If the vomiting continues in spite of this treatment, she may become very dehydrated. It may be necessary to give fluids and nourishment through a vein in the arm.

TOO MUCH WEIGHT GAIN

During pregnancy, most women put on weight - around 20-30 pounds (10-12 kilos) on average. Most of the weight gain occurs after the fourth month, when women gain roughly four pounds (two kilos) per month. If a woman gains a lot of weight suddenly (more than two pounds or one kilo in a single week) when she has been eating normally, her body may be keeping too much water. This could be a sign of pre-eclampsia; the woman should go to a health facility to have her blood pressure and urine checked, and to be examined by a trained health worker.

NOT ENOUGH WEIGHT GAIN

After the first three months, most women gain weight steadily during the rest of the pregnancy. If the weight gain is less than two pounds (one kilo) per month after the third month, this may be a sign that the baby is not growing as it should. This may be caused by not eating enough or working too hard. It may also be caused by some illnesses, such as tuberculosis or AIDS, or by a placenta that is not carrying enough oxygen and food to the baby. The woman should go see a trained health worker for an examination.

Failure to gain any weight over a number of weeks, or actually losing weight, is an even more serious sign, and needs immediate evaluation by a doctor. Losing weight when eating normally may be a sign that the mother has a serious disease, and may mean that the baby's life is in danger.

BLEEDING EARLY IN PREGNANCY

Slight bleeding from the vagina may occur in early pregnancy (before 26 weeks). A woman who has slight bleeding should lie down and rest for 2-3 days.

Typical causes of this bleeding include implantation bleeding (when the fertilised egg attaches itself to the lining of the womb), an infection in the vagina, irritation caused by herbal douches, and threatened miscarriage. If the bleeding is accompanied by cramps or if it gets worse, the woman should go to a health facility.

BLEEDING LATE IN PREGNANCY

Any bleeding from the vagina during the last four months of pregnancy (after 26 weeks), however slight, must be taken very seriously. A woman should go to a

hospital immediately, as she may need a blood transfusion and possibly an operation. Someone should go with her who can donate blood if a transfusion is needed.

Bleeding from the vagina during late pregnancy is called antepartum haemorrhage. It is a sign of two possible problems:

PLACENTA PRAEVIA: Normally, the placenta is attached to the womb high up and out of the way of the baby. Occasionally (in about one out of every 200 pregnancies), the placenta lies low down in the womb, blocking the way the baby has to pass during delivery. This situation is called placenta praevia and frequently causes bleeding in the latter half of pregnancy. In this type of haemorrhage, there are usually small "warning bleeds" earlier in the pregnancy, and the bleeding is not usually accompanied by pain. It may be necessary to deliver the baby by Caesarean section.

"ACCIDENTAL" HAEMORRHAGE: Bleeding sometimes occurs behind the placenta, even when it is in the normal place, if it separates partially from the womb. The cause of this condition, which is also called abruptio placenta, is not known.

It usually occurs without any "warning bleeds" and is nearly always accompanied by sudden and severe pain in the abdomen and/or back. When the placenta separates, it cuts off food and oxygen to the baby, who may be born dead. Sometimes this separation can happen without any of the blood coming out of the vagina. The only sign in this case may be sudden and severe abdominal pain and tenseness of the womb.

Labour may or may not start soon after an accidental haemorrhage. If the baby is still alive when the mother reaches the hospital, the doctor will try to deliver the baby as soon as possible, sometimes by Caesarean section. A woman who has had this problem runs the risk of postpartum haemorrhage. She should be kept in a hospital and observed for at least 24 hours after delivery.

ECTOPIC OR TUBAL PREGNANCY

Sometimes a fertilised egg does not reach the womb within seven days of being fertilised. It may then attach itself in the tissues surrounding it, often in the fallopian tube. Implantation somewhere other than the inside of the womb is known as ectopic pregnancy. When this happens, the thin walls of the fallopian tube cannot stretch adequately to hold the growing embryo for more than a few weeks. The wall of the tube ruptures or breaks, and severe bleeding occurs inside the body.

SIGNS OF AN ECTOPIC PREGNANCY: At the beginning, an ectopic pregnancy appears similar to a normal pregnancy: menstrual periods stop, and some of the other signs may develop such as the breasts getting bigger. There are two signs that indicate the pregnancy is ectopic rather than normal: bleeding from the vagina, and pain in the abdomen. If a woman has these symptoms, she should go to a doctor immediately for treatment. If the tube ruptures (breaks), she will experience severe, sudden pain and may also vomit or faint. She will need to go to the hospital immediately for surgery, and perhaps a blood transfusion. If possible, someone should go with her who can donate blood for a transfusion in case it is necessary.

PREVENTING ECTOPIC PREGNANCY: Unfortunately, ectopic pregnancies are very common in many areas. Most often they happen because a previous infection of the reproductive organs has damaged the fallopian tube, preventing the egg from reaching the womb. Women who have had a sexually transmitted disease are more likely to have an ectopic pregnancy (see Chapter 18). If a woman has an infection in the reproductive organs, she can reduce her chances of both infertility and ectopic pregnancy by seeking treatment promptly and following instructions carefully.

TWINS (MULTIPLE PREGNANCY)

Having twins is not really a complication. If a woman is carrying twins, however, she is more likely to develop some of the complications described above, such as premature labour, anaemia, or pre-eclampsia. The complications tend to occur earlier than one would expect. Women with twins are also more likely to start labour early. A woman carrying twins should be advised to rest as much as possible during pregnancy in order to avoid or delay the onset of these complications. She should go for antenatal care regularly and often.

Existing Problems that Can Be Made Worse by Pregnancy

A pregnant woman can be affected by an illness just like anyone else. In her case, however, the effects of the illness may be more serious because of the pregnancy. Diseases like malaria and diabetes, for example, become more serious or more difficult to control during pregnancy. Conditions that can be made worse by pregnancy include:

MALARIA

Malaria is a common disease in many parts of Africa that is transmitted through mosquito bites. The symptoms are high fever, severe headaches, and sometimes vomiting. When a pregnant woman suffers an attack of malaria, it can result in miscarriage, premature labour, stillbirth, or an underweight baby. In addition, pregnancy may make women more susceptible to malaria and its complications. Malaria also increases a woman's chances of developing severe anaemia.

It is important, therefore, for pregnant women to take all possible steps to avoid malaria and to get treatment as soon as possible if they do get the disease. Women should be advised to sleep under a mosquito net, stay indoors during the evening, and take anti-malaria tablets if prescribed by a doctor, nurse, or midwife.

DIABETES

Diabetes is a disease marked by the presence of sugar in the urine and blood. It is more difficult to control the disease during pregnancy, and sometimes it is necessary for a pregnant woman with diabetes to be hospitalized. If a woman is diabetic, her infant may be either bigger or smaller than normal, depending on the stage and seriousness of the disease. In both cases the baby can develop problems. Women with diabetes are also more likely to develop complications like pre-eclampsia and urinary tract infections. Some women develop diabetes only during pregnancy, which usually goes away after the baby is born.

A woman with diabetes needs careful supervision throughout pregnancy to check the amount of sugar in her urine and blood. With the correct diet and proper care,

serious complications can be avoided or treated. Sometimes it is necessary to start labour a little early. Women with diabetes must have careful antenatal care and deliver in a health facility.

SICKLE CELL DISEASE

This inherited blood disorder is very common in parts of Africa. Its symptoms include frequent attacks of severe pain in the bones, anaemia, and fever, especially during the cold and rainy season. Jaundice can also be a sign. Women with this disorder should go for antenatal care often to make sure that the pregnancy is going well. They should deliver in a hospital if possible, since they might need a blood transfusion and the baby might need special care as well.

There is no known treatment for sickle cell disease. Since attacks are often brought on by fever, infections like malaria should be avoided as much as possible. Women with sickle cell disease should report immediately to a health facility as soon as an attack begins.

Sickle-cell carriers can be diagnosed easily by a simple and reliable laboratory test. Every African woman should have her blood tested for this disorder, ideally before pregnancy. Since sickle cell disease is inherited from both parents (see Chapter 5), it is important that both parents be tested to determine if the baby is likely to be affected. This is especially true if one of them has the disease.

HEART DISEASE

A pregnant woman with heart disease needs careful supervision. Pregnancy requires a lot of extra work for the heart, because the body produces more blood.

If a woman has a long and exhausting labour she risks going into heart failure. She should have trained help with delivery, ideally in a hospital. Under proper care and supervision, most women with known heart problems have normal, safe pregnancies and labours.

JAUNDICE

Jaundice is a yellow discolouration of the whites of the eyes, and is a common sign of liver disease. The most common type of liver disease is due to an infection called hepatitis A. The main signs of this disease are fever and chills; nausea and vomiting; abdominal pain; and especially yellowness of the eyes and passing dark urine. It is usually a mild disease which has no serious effects on the mother or the baby. In rare cases, especially when there is high fever and vomiting, it may lead to miscarriage or an early start to labour.

There is no special treatment for infectious hepatitis A. Women should be advised to rest in bed and drink as much liquid as possible. The illness usually clears up in about three to four weeks. Because hepatitis A is easily passed from one person to another through contact with stool or contaminated food or water, women should be counselled on careful hygiene. They should also avoid close contact with anyone who has the disease.

Hepatitis B, a viral infection of the liver, is a chronic, untreatable infection. Often people with this infection will remain in a healthy "carrier" state in which they do not feel sick but may infect others. In some cases, however, it may lead to severe liver damage and death. There is no known cure for the infection, although adults and infants may be protected from the disease by a series of vaccinations. Unlike

hepatitis A, hepatitis B is transmitted through contact with blood and body fluids.

TUBERCULOSIS

Tuberculosis is a disease of the lungs, marked by a deep, persistent cough. Women with tuberculosis are more likely to suffer from miscarriage or premature labour, so they need special care during pregnancy. During labour, it is important that a woman with tuberculosis does not become exhausted. She should deliver in a hospital or health facility, and may need to have an assisted delivery (see Chapter 12).

OBESITY

Women who are very overweight may be at higher risk of some complications, especially obstructed labour and high blood pressure (pre-eclampsia). They should go for antenatal care often during pregnancy, and deliver in a health facility if possible.

Summary: Serious Complications During Pregnancy

Some serious complications can be caused by pregnancy. In other cases a woman may have had a condition or disease which is made worse by pregnancy. It is important for women and their families to know the signs of serious complications, and to know what to do.

If a woman develops any of the following signs, she should go to a hospital or health centre IMMEDIATELY:

High fever

Severe pain in the abdomen

Bleeding from the vagina

Very bad headaches, blurred vision, spots before the eyes, or fits

Fluid from the vagina that smells bad, is greenish in colour, or looks like foam

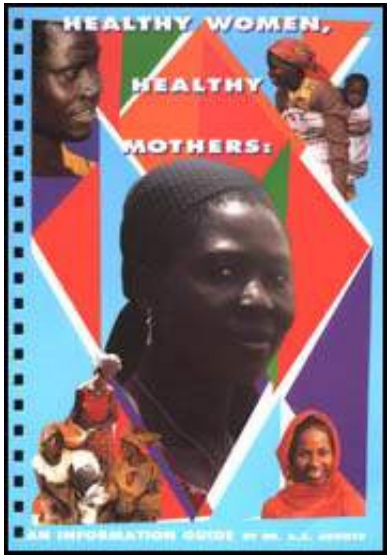
Contractions or rupture of the membranes that occur three weeks or more before the due date (before the 37th week of pregnancy)

Severe jaundice (yellow discolouration of the eyes)

If a woman develops any of the following signs, she should visit a health centre as soon as possible because a serious complication may be developing:

Pale eyelids, tongue, gums, or palms; always feeling tired and short of breath (anaemia)
Swollen hands, ankles, and especially face (pre-eclampsia)
Severe vomiting or vomiting that does not stop
Too much weight gain

Not enough weight gain

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Chapter Ten - LABOUR

Labour is the process by which a woman delivers her baby into the world. Normally labour lasts about 5-18 hours, but this varies a lot. Labour requires great effort from the woman; it is often accompanied by pain, anxiety, and physical exhaustion. Despite the hard work of labour, however, most women also feel a deep sense of satisfaction in their accomplishment and love for their new child.

Planning for the Delivery

Plans for delivery should be made before labour begins. As described in Chapter 7,

a decision should be made about where the baby will be delivered and who will help the mother during delivery. These decisions should be based on how healthy the woman is and whether there were any signs that she was likely to have a complicated delivery. Wherever the delivery takes place, essential supplies should be gathered, and transportation should be arranged in case a complication develops. The requirements for a safe delivery are listed in Box 10.1.

How Does Labour Start?

Nobody knows the full answer to this question. Labour appears to be caused by changes in the levels of hormones and other chemicals in the blood, but no one knows for sure. There are three signs that may indicate labour is starting: regular contractions of the womb, the "show", and a gush of water from the vagina. These three signs of labour do not necessarily occur in any particular order, and some women may never see any show or break their water. Usually, however, when these signs occur labour is beginning and preparations should be made for delivery.

Box 10.1: ***Basic Requirements for Proper Care During Delivery***

Whether the delivery takes place at home, in a clinic, or at the hospital, certain basic requirements should be met. These include:

1. The delivery room should be clean, have fresh air, and offer some privacy.

2. Any instruments that will be used - razor blades, scissors, needles, thread, etc. - must be clean and sterile (scissors or a razor blade can be sterilised by leaving

them in boiling water for 20 minutes). Unclean instruments can cause infection. Soap and water should be available for the birth attendant to wash her or his hands thoroughly, and if possible the attendant should wear surgical gloves. Clean towels, cloths, and cotton wool must also be available.

3. The birth attendant, whether a relative, neighbour, or midwife, should be experienced enough to recognise the warning signs of trouble which may arise suddenly. The attendant should also know what action to take (see Chapters 9 and 11).

4. If the delivery is taking place at home or in a local clinic, arrangements should be made to have transport available. That way, if a serious complication develops, valuable time is not wasted while the family searches for a vehicle and petrol, or for some other means to get to the hospital (see Chapter 11 for signs of serious complications during delivery).

Box 10.2: ***True vs. False Labour***

TRUE LABOUR

- Contractions get stronger, longer, and closer together
- Contractions come in a regular pattern
- Walking or changing position makes them stronger
- The cervix gets thinner and opens (this can only be felt if a vaginal examination is done)

FALSE LABOUR

- Contractions remain the same strength, length, and time apart
- Contractions are usually irregular
- Walking or changing position does not affect the contractions

- The cervix does not change

CONTRACTIONS

During the last four weeks of pregnancy, a woman may notice occasional painful contractions of the womb. They may be regular, but do not last very long. These are called "false labour pains". True labour pains are caused by regular, rhythmic contractions of the womb. They are usually felt in the lower back first, then spread to the front. At the beginning, they occur every 10-15 minutes and last only a few seconds. As labour progresses, the contractions occur more and more frequently, last longer, and become stronger. These contractions are the most reliable sign that labour has actually started.

THE "SHOW"

During pregnancy, the neck of the womb or cervix is plugged by thick mucus. When labour starts, this mucus plug often comes out, together with a little bit of blood, as the cervix begins to open. This spotting of blood and mucus is called the show; it is not a flow like a heavy menstrual period. If there is a lot of blood or if the bleeding continues, the woman should go to a health facility immediately. This can be a sign of a serious complication.

GUSHING OF WATER

During labour, the bag of water surrounding the baby in the womb often tears, and the water escapes through the vagina in a "gush". Usually several cupfuls of fluid come out, although it may seem like more. This process is called rupture of membranes. It is usually caused by the contractions of the womb. It does not always happen, however, and some babies are born inside their unbroken bags of water.

The Stages of Labour

The process of labour has been divided into three stages.

THE FIRST STAGE

The first stage of labour is the period during which the cervix opens or dilates from a fraction of an inch (a few millimetres) to about four inches (ten centimetres). At the end of the first stage, the opening is large enough to allow the baby's head to pass through. This stage is marked by regular, painful contractions of the womb and can be the longest and most tiring of the three stages. Contractions gradually occur more often and last longer, until they come every 2-3 minutes and last about 40-50 seconds. This can be a very anxious as well as difficult time for the woman in labour because it requires great physical effort. In hospitals, some women may receive an injection to help reduce the pain. Usually this is not given if it is very early in labour or very near delivery (because it may make it harder for the baby to breathe after being born).

It is important for women to understand that with each set of contractions, the

neck of the womb is gradually opening and the baby is being pushed towards the outside. At this early stage, while the neck of the womb is opening, the woman should be discouraged from pushing or "bearing down". Pushing too early can cause the neck of the womb to become swollen or damaged.

Probably the most trying period during the first stage is the period towards the end called "transition". By this time, the contractions seem to come very quickly without much rest in between. Often women begin to feel a strong urge to bear down or push as the baby's head descends into the birth canal.

For women having their first baby this stage of labour usually lasts between 8 and 18 hours. With later pregnancies this stage is usually shorter. A woman who is in hard labour (strong, regular contractions) for more than 12 hours should be taken to a hospital.

COMFORT AND SUPPORT IN LABOUR: Labour is a physically and emotionally demanding experience. A woman in labour must focus all of her attention and energy on completing the process of bringing new life into the world. For this reason it is important that she is given support during labour and birth, and made to feel as comfortable as possible.

When labour starts and the pain or discomfort is still mild, women usually appreciate doing something that distracts them: talking, walking around, eating a light meal, and drinking fluids. As labour progresses, the discomfort may prevent them from doing these things. Breathing deeply and relaxing between contractions can help relieve the intensity of labour. A massage, shower, or bath can be helpful. Women should also be encouraged to pass urine frequently, as a full bladder can

contribute to problems during labour. Most women feel comforted by having someone with them, such as their mother, sister, friend, or husband. This can help them relax and may make the labour and delivery easier. A woman in labour should not be left alone.

If there are no complications and labour is progressing normally, women should be encouraged to be out of bed and walking around. Toward the end of labour, they should be allowed to find the position that is most comfortable for them. Figures 10.1-10.4 show some possible positions for delivery, both at home and in the hospital or health centre.

Positions for Delivery

A woman should be as comfortable as possible during delivery. The positions shown are good because they make it easier for the baby to pass through the birth canal. Whatever position makes it easiest for the woman to breathe and push is best.

Figure 10.1: Squatting

The woman should be supported from behind.

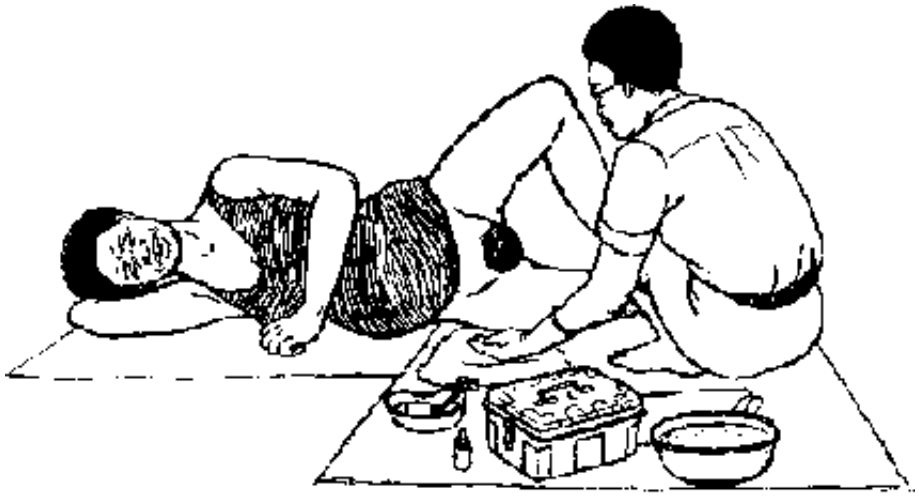


Figure 10.2: Lying on Side

This position may be more comfortable for some women.

Figure 10.3: On All Fours

This position is sometimes used in home deliveries. Care needs to be taken

to make sure that the baby is fully supported as it comes out of the vagina.

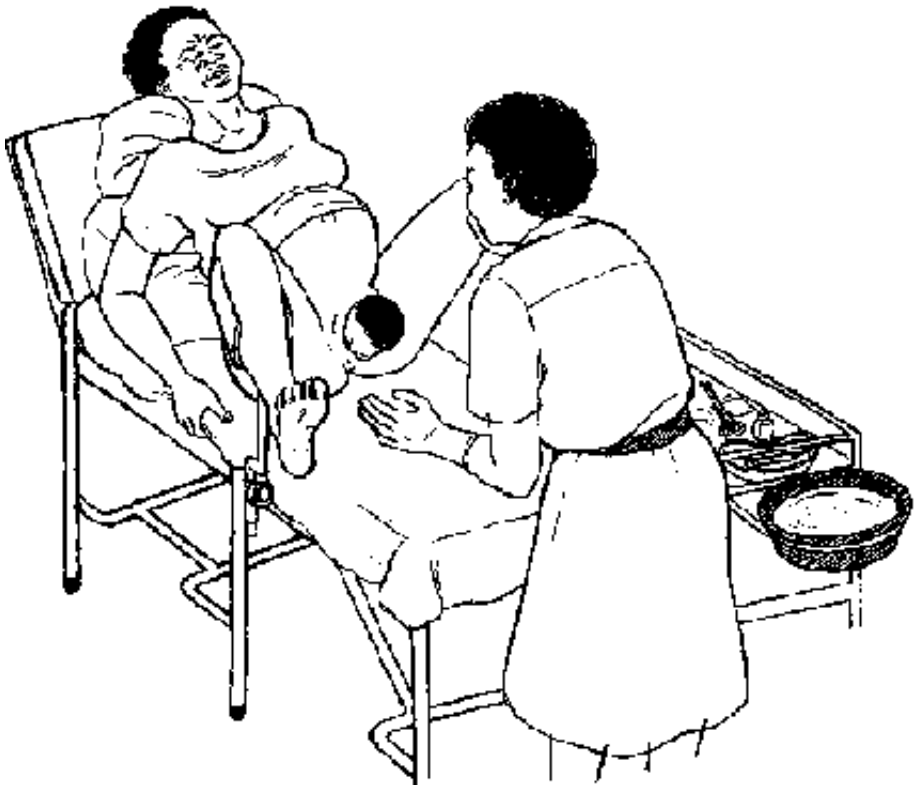


Figure 10.4: Hospital Delivery (sitting semi-upright)

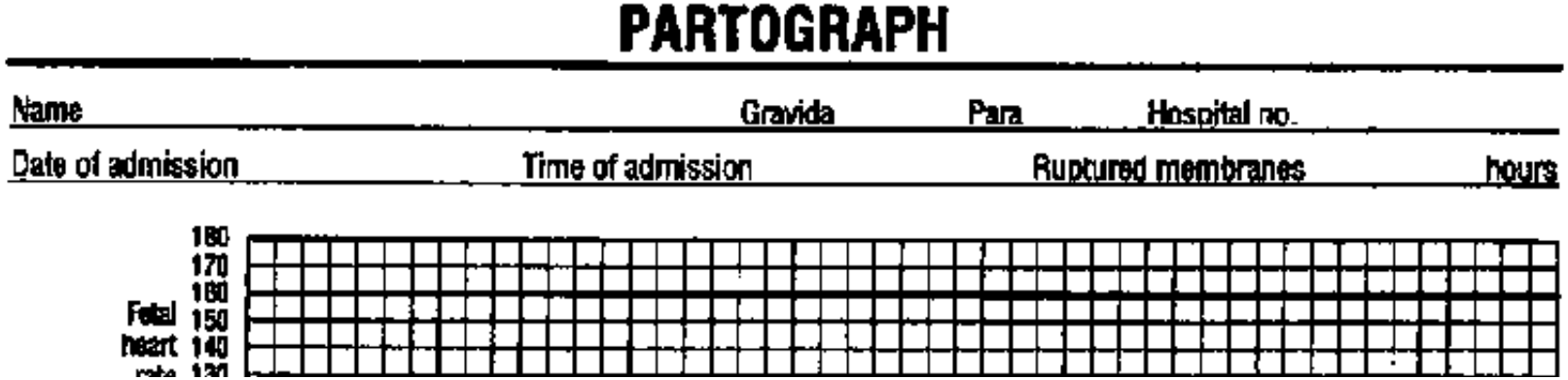
Most hospitals and health centres have delivery beds; the woman sits with her back supported and her knees apart.

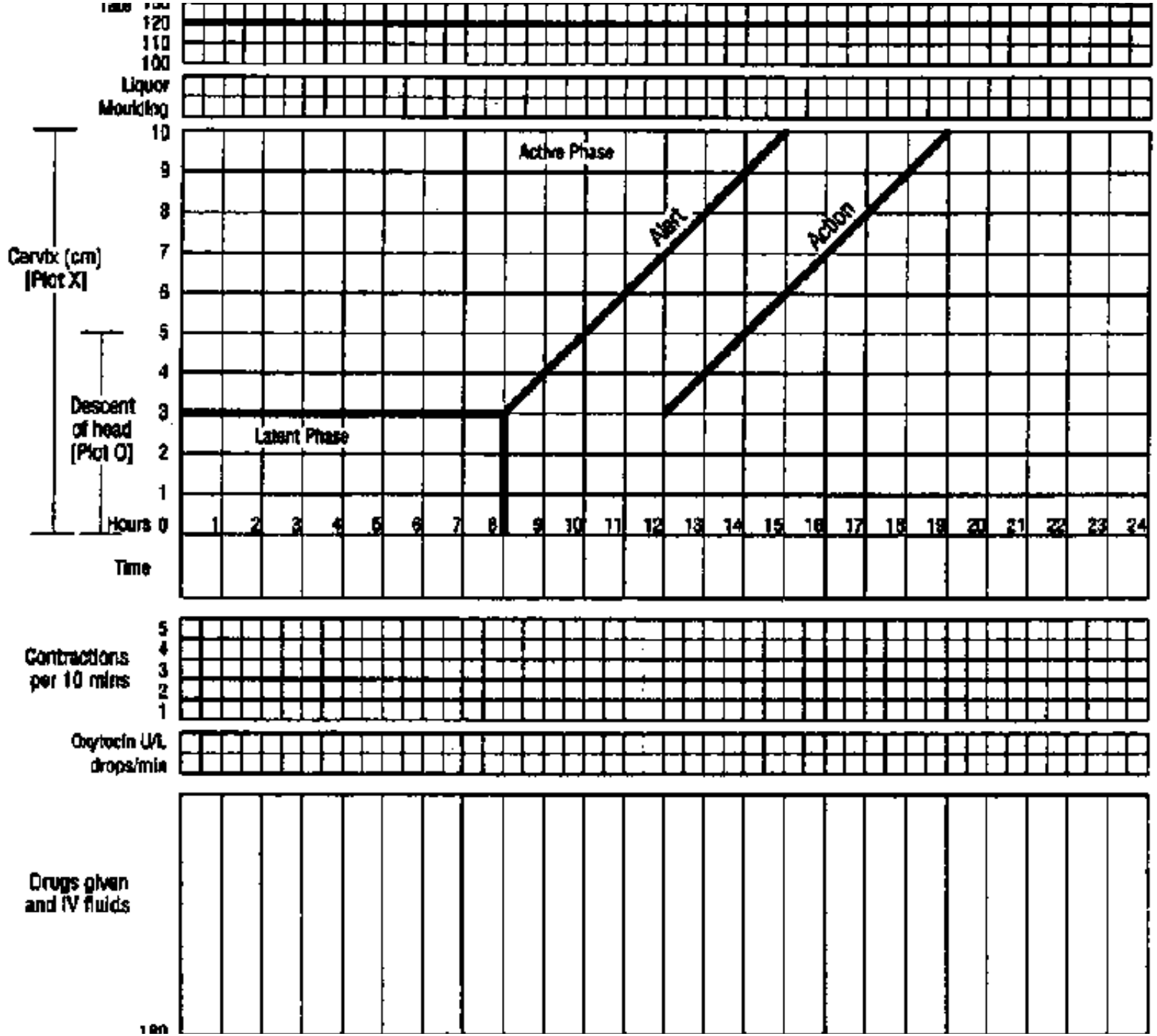
USE OF THE PARTOGRAPH: In many hospitals and health centres, a partograph is used to measure the progress of labour during the first stage (see Figure 10.5). To use a partograph, a trained midwife measures the dilatation (opening) of the neck of the womb every four hours. These measurements are recorded on the partograph form, along with measurements of the woman's blood pressure, pulse,

the frequency of the contractions, and the heart rate of the baby. If labour is not progressing rapidly enough, this can be seen easily by looking at the partograph, and appropriate action can be taken. Many midwives and doctors have been trained to use a partograph. Its use is a standard procedure in most hospitals and health centres today.

THE SECOND STAGE

This is the stage when the baby is actually delivered into the world. The neck of the womb is now fully open (about 4 inches or 10 centimetres) and the baby can be pushed out. Women often feel a strong urge to push or bear down with each contraction. They should be encouraged to push with each contraction and relax in between. This encouragement and reassurance is especially important if this is their first baby. Women generally feel better overall during the second stage: they know they are almost finished and they are actively pushing to bring their babies into the world. For a woman's first delivery, the second stage generally lasts around one hour. For women who have had babies before, this stage usually lasts around 15 minutes but may last as long as one hour. If a woman is in this stage for more than one hour, she needs to be taken to a hospital.

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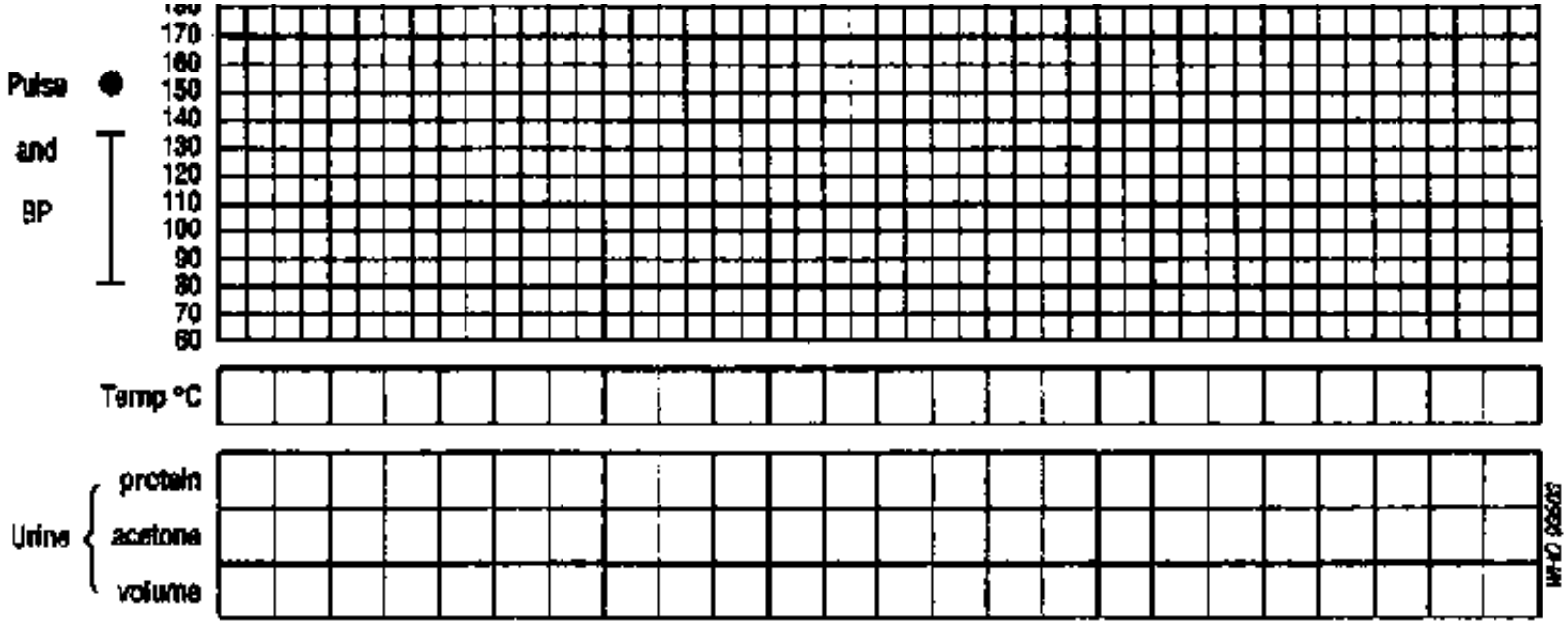

Figure 10.5: Using a Partograph to Measure the Progress of Labour

The partograph is a chart used to record information on the progress of labour (contractions, dilatation, blood pressure, pulse, and foetal heart rate). If labour is not progressing correctly, the partograph provides an early warning (the "alert line"), and shows when referral or other action may be necessary (the "action line").

THE THIRD STAGE

Labour is almost over after the baby comes out, but not quite. The placenta or afterbirth has yet to be delivered. The time between the birth of the baby and the delivery of the placenta is called the third stage (see Figure 10.6). It is usually a brief period lasting only 5-15 minutes, but it still carries some potential danger to the mother. Immediately after the birth of the baby, the contractions of the womb

cause the placenta to separate from the wall of the womb. The next few contractions push the placenta into the vagina. It is then gently delivered by a birth assistant while the woman bears down just as she did with the birth of the baby. This stage is always accompanied by some bleeding. The birth attendant should not pull on the umbilical cord or push on the abdomen to make the placenta come out. This can cause severe bleeding, and can be very dangerous.

The baby may be put to the breast immediately while waiting for the placenta to come out (see Figure 10.7). Not only does this get the baby off to a good start, but it will also cause contractions which help the placenta separate and control bleeding. In most places, a procedure called "active management of the third stage" is used to ensure that the placenta comes out. In this procedure, as soon as the baby is delivered, the midwife or doctor first makes sure that it is not a twin delivery. Then the woman is given an injection with a drug called an oxytocin that helps promote contractions of the womb. This drug helps the womb push the placenta out quickly, and reduces the chances that there will be a lot of bleeding.

If the bleeding does not stop after the placenta is delivered, or if the bleeding is excessive, immediate assistance should be sought (see the next chapter on complications during labour).

Figure 10.6: Waiting for Delivery of the Placenta

After the baby has been delivered, the womb will continue to contract to push the placenta (afterbirth) out.

Figure 10.7: Delivery of the Placenta and Care of the Newborn

The baby should be put to the breast immediately following delivery. The baby's sucking causes the womb to contract, which helps push out the placenta and stop bleeding.

Summary: Labour

Labour is the process by which a baby is delivered into the world. It normally lasts 5-18 hours, but can be much shorter in a woman who has had a baby before.

THERE ARE THREE SIGNS THAT LABOUR IS BEGINNING:

Regular, painful contractions of the womb.
The "show": a small amount of blood mixed with mucus that comes out of the

vagina.
A gush of water that comes out of the vagina when the bag or water around the baby breaks.

LABOUR IS DIVIDED INTO THREE STAGES:

FIRST STAGE: The neck of the womb begins to open and the contractions become more frequent. The baby begins to push down the birth canal. This stage generally lasts between 5 and 18 hours.

SECOND STAGE: The neck of the womb (cervix) has opened fully and the baby is born. This stage usually lasts about one hour.

THIRD STAGE: From the birth of the baby to the delivery of the placenta. This stage generally lasts 5-30 minutes.

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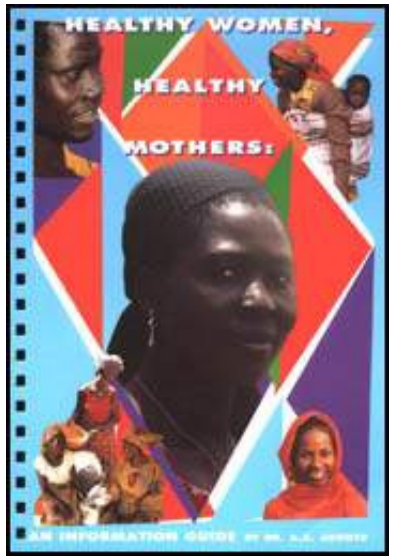
Chapter Eleven - COMPLICATIONS ARISING DURING LABOUR

(introduction...)

Premature Rupture of the Membranes



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Chapter Eleven - COMPLICATIONS ARISING DURING LABOUR

The majority of women experience no problems or complications once labour has started. Sometimes, however, problems do arise that require skilled management and care. Women and their families, as well as others in the community, need to know about these problems, and what to do if they develop.

Premature Rupture of the Membranes

Premature rupture of the membranes is the sudden gush of water from the vagina several days or even weeks before labour actually begins. By itself, it is not necessarily dangerous. The problem is that once the bag of water is ruptured, the woman can get an infection which can endanger her life and especially the life of

the baby. Therefore, a woman whose membranes rupture early needs to be taken to a health facility for special care.

There is little that can be done to prevent premature rupture of the membranes. If the membranes rupture when the pregnancy is near term (36 weeks or later), but labour does not start within 24 hours, artificial means may be used to start labour at a hospital. The woman may also wait in the hospital for labour to start on its own. During this time she should be observed carefully and treated if any signs of infection develop.

If the membranes rupture before 36 weeks, the baby may be too small to live, so labour is usually not started artificially. In such cases, everything possible must be done to prevent infection, delay labour, and give the baby time to mature. The woman should be advised to stay in bed. She should also be advised to avoid getting an infection by not taking tub baths (she should take a shower or sponge bath instead), not having sexual intercourse, and not having vaginal examinations except with a sterile instrument. She may be given antibiotics to prevent an infection. It is best for her to stay in a hospital that can care properly for the baby if it is born early.

Box 11.1: ***Complications and Care During Labour***

When complications develop during labour and delivery, it is often necessary for the *midwife,* nurse, or doctor to intervene. It may be necessary to refer the woman to a hospital where the complication can be managed. She may feel frightened and out of control. By remembering a few basic principles, the health worker can help her relax and feel proud of the difficult experience she has had.

- No woman "fails" when she is having a baby. Whatever the complication - whether delivering by Caesarean section, or in extreme cases delivering a baby that has died in the womb - women should be praised and supported throughout the experience. If a traditional birth attendant or relative has accompanied the woman to the hospital, she should also be praised and encouraged for recognising the problem and bringing the woman.

- All women should be encouraged to ask questions and receive answers about their care. When emergencies occur, it is sometimes necessary to take action without providing an explanation. Although quick action is necessary at times, women and their families have the right to know what is being done and why, and to ask questions.

Abnormal Lie or Presentation

Towards the end of pregnancy, about 95% of babies come to lie in the womb with their heads pointing downwards, so that the head is delivered first (see Figure 11.1). In 4-5% of cases, the baby lies with the feet or buttocks pointing down; these cases are called breech presentations (see Figure 11.2). Rarely, the baby may lie diagonally with the shoulder ready to come out first; this is called transverse lie (see Figure 11.3). All cases where the baby's head does not come out first are abnormal; childbirth may be more difficult and can result in injury or death of the baby or the mother. Transverse lie is especially dangerous, and should always be referred to a hospital. Abnormal lie is most common in women who have had many babies before, or those carrying twins (see Figure 11.4). It is usually possible for a trained person to tell whether the baby is lying in an abnormal position towards the end of the pregnancy. A trained and skillful person

must assist in such deliveries. In some cases a Caesarean section (see next chapter) may be necessary.

Positions of the Baby

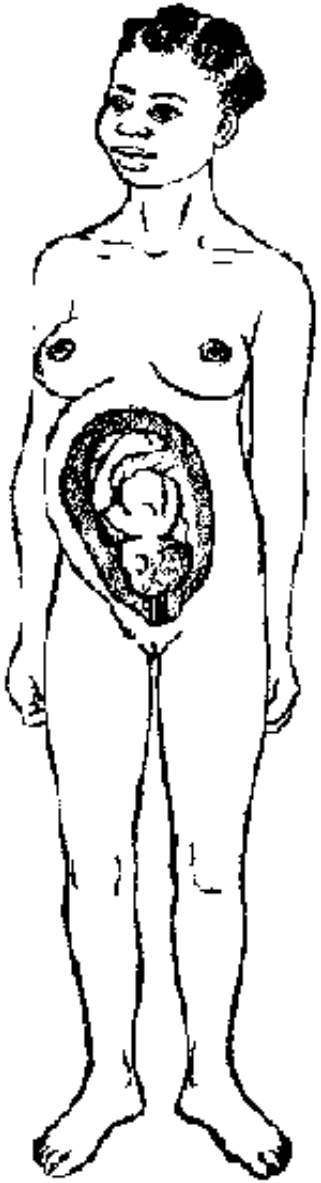

Figure 11.1: Normal Presentation (head down)

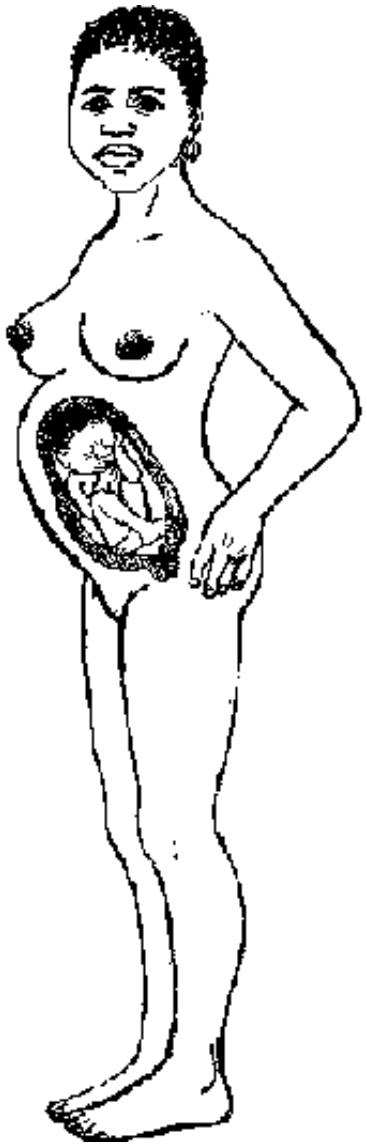

Figure 11.2: Breech Presentation (feet or buttocks first)

A breech presentation should be referred to a health facility if possible.

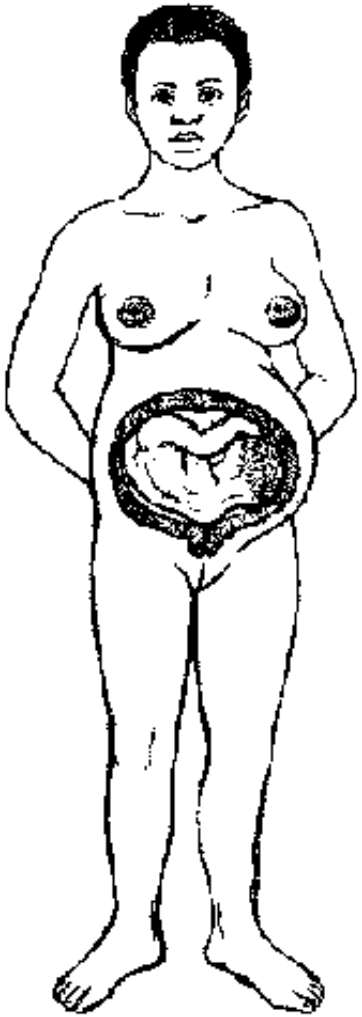

Figure 11.3: Transverse Lie (shoulder or arm first)

A transverse lie should always be delivered in a health facility; an operation may be necessary.

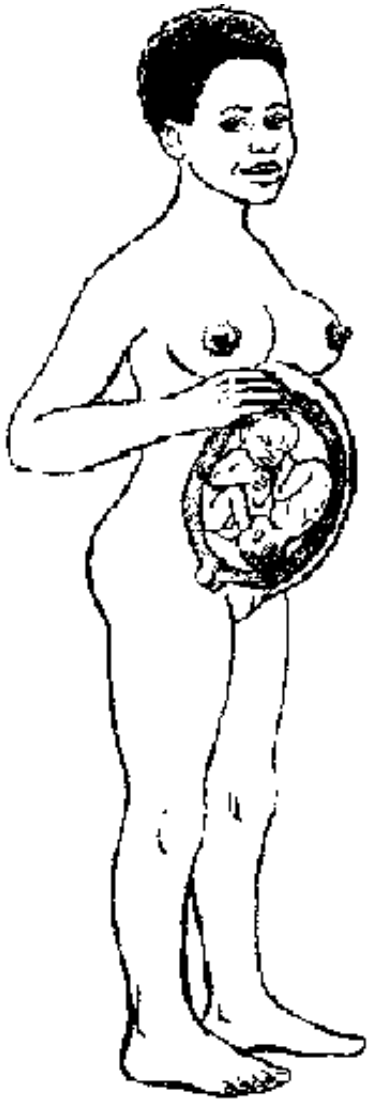

Figure 11.4: Twins

Women bearing twins are more likely to have complications such as obstructed or prolonged labour. There is also a higher risk of abnormal presentation such as breech or transverse. For this reason twins should he delivered in a health facility if possible.

Obstructed Labour

This is the most common complication of labour in Africa, and one of the most dangerous. Labour is obstructed if the baby cannot be delivered normally through the birth canal without serious damage or injury to the mother or baby. Obstructed labour can sometimes be predicted during antenatal care, long before labour starts. Usually, however, the problem is only recognised after the woman has been in labour for many hours without making any progress.

CAUSES OF OBSTRUCTED LABOUR: Labour is obstructed when the baby is too big to pass through the mother's birth canal. Women in the following categories are more likely to have obstructed labour:

- **Women who are less than 5 feet tall (150 centimetres). These women may have difficulties during childbirth because their pelvises may be smaller than normal. That is why height is measured during antenatal visits.**

- **Girls in their early teens, even if they are taller than 5 feet (see Chapter 21). This is because the pelvis grows more slowly than the rest of a girl's body, so the pelvis can be quite narrow in a girl under the age of 15 or 16 even if she is tall.**

- **Women with certain abnormalities of the spine or lower limbs. These affect the size or shape of the pelvis, and can therefore cause obstructed labour. Women with such abnormalities need careful attention during the antenatal period, and special supervision during labour.**

- **Women who have undergone female genital mutilation. These women often have scars in the vaginal area that may cause obstructed labour. Any woman who has had this operation should deliver in a hospital if possible.**

- **Women with babies that are unusually big. The average baby weighs around 6-7 pounds (about 3 kilos) at birth; babies much larger than this may be difficult to deliver normally. Babies of older women and of women suffering from diabetes tend to be heavier and bigger than average. A larger-than-average baby can sometimes be detected during antenatal care, and it may be recommended that the delivery take place in a hospital.**

- **Women with babies who are lying abnormally in the womb. Any abnormal presentation, such as breech, can also lead to obstructed labour. This is true even if the mother's pelvis is normal and the baby is of normal size.**

In some parts of Africa, people believe that obstructed labour means the woman was unfaithful to her husband or misbehaved in some other way. Often, they believe that the baby will not be born until the woman has confessed what she did wrong. The families of pregnant women should understand that obstructed labour has nothing to do with a woman's past behaviour. It is a life-threatening condition for both the mother and baby. A woman with obstructed labour is in desperate need of medical attention, and needs to be taken to a hospital immediately so she can receive trained assistance.

Figure 11.5: Obstructed Labour

Obstructed labour is very dangerous for the woman and baby. If a woman has been in labour for 12 hours or more she should be taken to a hospital; she may need special help or an operation to deliver.

WHY IS OBSTRUCTED LABOUR DANGEROUS?

First, if labour continues for too long (over 12 hours) both mother and baby may become exhausted (see Figure 11.5). The mother may become very dry (dehydrated) because after many hours in labour she has perspired a lot and lost a

great deal of body water. Second, the mother may catch an infection during the long hours in labour. The infection can spread upwards into the womb and affect the baby too. Third, if something is not done quickly to relieve the obstruction, the womb will continue to contract powerfully to try to push the baby out, and may tear or rupture. Severe bleeding may occur inside the abdomen. This will soon lead to shock in a mother already exhausted and dehydrated from prolonged labour.

If a woman is in labour for more than 12 hours without being able to deliver the baby, she should be taken to a hospital where she can be properly examined. Sometimes it is necessary to perform an operation to deliver the baby.

FISTULAE: During obstructed labour, the baby's head presses hard on the soft tissues of the mother's pelvic organs such as the bladder (the organ that holds urine) or the rectum (the organ leading from the bowel to the outside). After many hours or sometimes days of this pressure, the tissues pressed between the baby's head and the mother's bones die. After a few days they fall away, leaving a hole between the vagina and the urinary bladder or the rectum. If the bladder is torn, urine leaks uncontrollably through the vagina. If the rectum is torn, faeces pass out through the vagina without control. The constant flow of urine or faeces and the smell are extremely unpleasant for the woman. As a result, sometimes she is rejected by her husband, her neighbours, and even her family.

These holes between the vagina and the bladder or the rectum are called fistulae. Unfortunately, they are quite common in many parts of Africa. They develop especially often in young girls of 12, 13, or 14 years who become pregnant before their birth canals are big enough. These young girls, just starting their adult lives,

are condemned to being social outcasts unless they can undergo an operation to repair the hole. This operation can be quite expensive and is not always successful.

Prolonged Labour

Labour is "prolonged" when it continues for many hours without making any real progress towards delivery of the baby. The most common cause of prolonged labour is obstructed labour, as discussed in the previous section. Labour can also be prolonged for other reasons as well. Sometimes the womb is not contracting as it should, or the contractions even stop altogether. This is especially common in a woman having her first child. Other times the neck of the womb is not opening up enough to allow the baby to come out.

Normal labour can last anywhere from 5-18 hours. It can be longer in a woman having her first baby. It can be difficult for someone who is not a midwife or doctor to tell when labour is prolonged. In health facilities, partographs are often used to detect when labour is "too long", or when no progress is being made and action is therefore necessary (see Chapter 10). If a partograph is not being used (for example, if delivery is taking place at home), it is usually recommended that a woman who has been in labour for 12 hours without any signs that the baby is coming out should be taken to a hospital or health centre. This is especially true if the trip will be a long one.

Sometimes when the bag of water has broken, the liquid that comes out is coloured green or brown. This is called meconium and is a sign that the baby has passed his or her first stool (bowel movement). It may also be a sign that the

baby is having a problem. If this happens, the birth attendant should check for other signs of distress, for example by listening to the baby's heartbeat. If this sign is noted, the mother should be taken to a hospital quickly.

Pre-Eclampsia And Eclampsia

These conditions often occur in the late stages of pregnancy (see details in Chapter 9). If they are not properly controlled during pregnancy, they can become worse during labour. Sometimes they appear for the first time during or after labour. Eclampsia causes fits or convulsions and loss of consciousness or coma (see Figure 11.6). It is especially likely to start suddenly during labour or even soon after the birth of the baby. Severe pre-eclampsia or eclampsia during labour may make it necessary to deliver the baby by Caesarean section. A woman who starts having fits before, during, or after labour should be taken immediately to a hospital for medical care, because her life is in danger.

Haemorrhage (Heavy Bleeding) During Labour

Haemorrhage, or heavy bleeding, during labour, can be caused by obstructed labour or by problems with the placenta. The placenta may be lying below the baby, which can cause bleeding when the neck of the womb begins to open (see Chapter 9). An accidental haemorrhage can occur if the placenta separates from the womb too early. Haemorrhage can also be caused if the womb ruptures or is torn during labour. Whatever the cause, blood loss of more than two cups during labour requires skilled care in a hospital, because loss of a lot of blood endangers the mother and baby.

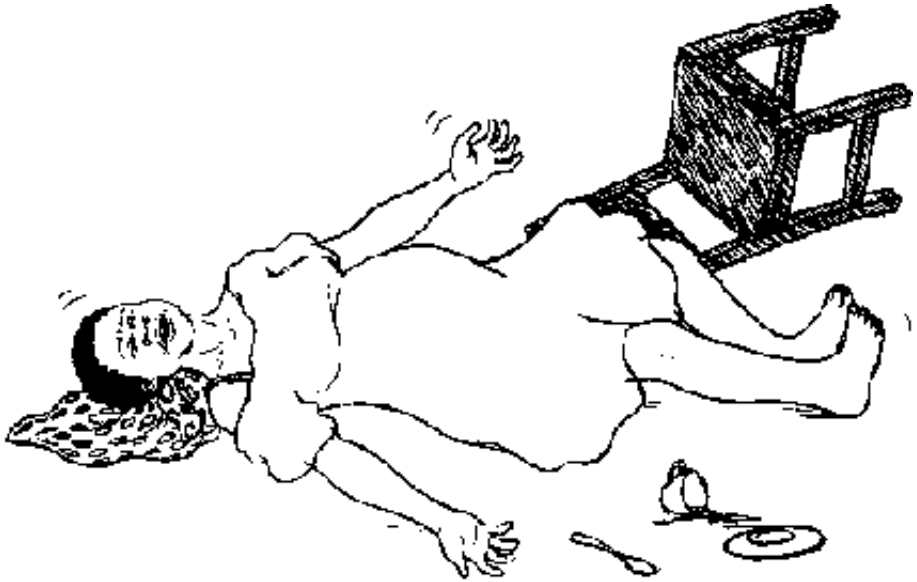

Figure 11.6: Eclampsia

Eclampsia causes fits or convulsions, and may cause a woman to faint. If a woman begins to have fits before, during, or after delivery, she should be taken to a hospital as soon as the fit stops.

Postpartum Haemorrhage

Haemorrhage after the birth of the baby (postpartum) is always a serious problem. If bleeding has not stopped half an hour after the placenta has come out, or if it is severe (more than two cupfuls), the woman should be taken to a hospital as quickly as possible since she needs urgent attention (see Figure 11.7). Normal postpartum flow is similar to that of a heavy menstrual period. Postpartum haemorrhage can be due to a number of causes:

RETAINED PLACENTA: Sometimes the placenta does not separate completely from

the wall of the womb after the baby is born. The womb cannot contract properly, and bleeding from the womb where the placenta is attached may occur. If the placenta has not come out and the woman is bleeding heavily, she should be taken to a health facility immediately. If the bleeding is minimal but the placenta has not come out within 30 minutes of the baby's birth, it is usually necessary to remove it. This is especially true if a drug called an oxytocin has been given to make the womb contract (see Chapter 10). If the placenta is not removed, the mother is likely to bleed again or go into shock. The procedure for removing the placenta is called manual removal of the placenta and should be done at a health facility; it is described in the next chapter. If trained help is not available, loss of blood may lead to shock or death in a woman already exhausted from the hard work of labour. Women who develop this complication are quite likely to do so again in later deliveries.

Figure 11.7: Postpartum Haemorrhage (heavy bleeding)

Postpartum haemorrhage after the birth of the baby is extremely dangerous. If the bleeding is severe (more than two cups) or prolonged (continues more than half an hour after the delivery of the placenta), the woman should be taken to the hospital as soon as possible.

WEAK UTERUS: In some cases the uterus may be weak or stretched out, and bleeding does not stop after delivery. This can happen because of prolonged labour, or because the woman has had too many pregnancies. It may be necessary to give her drugs to help the uterus contract. The drugs can be given either through an injection or an intravenous line. Breast-feeding, vigorous massage of the uterus, and emptying the bladder may also help with this problem. Sometimes bleeding occurs because the abdomen was massaged too hard or squeezed during the third stage of labour. This practice is dangerous and should be avoided.

RUPTURE OF THE UTERUS: If labour is obstructed and the baby cannot come out, the womb may tear or "rupture". Sometimes, if the woman is delivering at home, she may be given herbs to take during labour that cause contractions; these herbs can be very dangerous and may cause the womb to tear. This can also happen if the woman had a Caesarean section with a previous delivery and is trying to have a vaginal delivery this time. Whatever the cause, rupture of the uterus is a very serious, life-threatening complication. It must be dealt with in a hospital where an operation can be carried out to save the woman's life.

TORN VAGINA OR CERVIX: Sometimes the lips of the vagina or the cervix (neck of the womb) are torn during delivery. This can happen if the baby is very large, or if the presentation was abnormal (for example, breech or transverse). It can also happen if the woman was subject to female genital mutilation, which can leave

heavy scars in the vaginal area which are then torn during delivery (see Chapter 2). A torn cervix or vagina will usually continue to bleed until it is stitched up. This should be done by a trained midwife or doctor in a properly equipped facility.

Summary: Complications Arising During Labour

Most women go through labour and delivery with no complications. Sometimes, however, complications can arise. This can happen even if there were no warning signs during pregnancy. Women with the following signs should be taken to a hospital or well-equipped health centre for proper care:

Strong labour (contractions) that lasts for 1 2 hours without the baby being delivered

The baby is not coming out head first; for example, an arm or foot can be seen coming out of the birth canal

The woman loses more than two cupfuls of blood from the vagina

The placenta (afterbirth) does not come out of the vagina within 30 minutes of the birth of the baby

The woman has fits or loses consciousness (faints)

The bag of water breaks but labour does not start within 12 hours

Meconium, a green or brown fluid, is seen after the bag of water breaks

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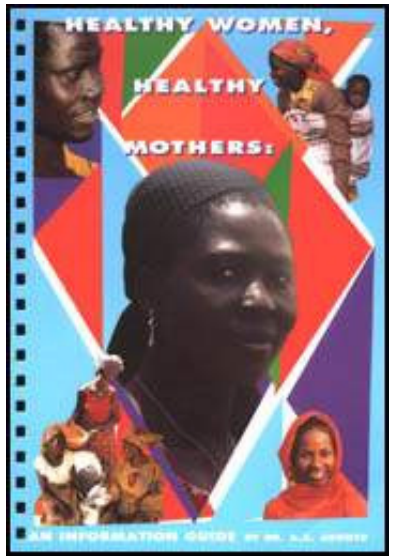

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Chapter Twelve - SOME OBSTETRIC OPERATIONS AND PROCEDURES

This chapter describes procedures that may be performed during labour or delivery in a hospital or other properly equipped health facility. It also explains why these procedures may become necessary. Only trained medical or midwifery personnel in a well-equipped facility should perform these procedures.

Induction of Labour (Starting Labour Artificially)

Labour normally starts by itself about the 40th week of pregnancy. About 30 of every 100 babies are born before their due dates. About ten of every 100 babies are born more than ten days after their due dates. If labour has not started by itself after the 42nd week, however, it may be necessary to start labour artificially. If there are signs that the baby is not doing well (for example, the mother has not felt the baby move for 24 hours or more), it is definitely time for the mother to be taken to a hospital for evaluation. The baby's life may be at risk. Other possible reasons for starting labour artificially include pregnancy complications such as pre-eclampsia, diabetes, premature rupture of the membranes, or a previous pregnancy that has resulted in the birth of a dead baby around term.

Labour can be induced by giving the woman an enema which irritates the bowel and can cause the womb to start contracting. Sometimes a special drug called an oxytocin is given to cause the womb to contract. This drug is given in the form of a slow drip through a vein in the arm. It may take quite a long time for labour to start when these methods are used.

Labour can also be induced by artificial rupture of the membranes. With this procedure the bag of water surrounding the baby is punctured and the fluid is allowed to drain away. The effect is the same as when the membranes rupture by themselves; labour usually starts within a few hours. This procedure is usually no more uncomfortable than a vaginal exam.

Inducing labour may not be effective unless the cervix is "ripe" or ready for labour to start. Inducing labour works best if the cervix is already open a little bit, and the baby's head is low. If an attempt to start labour is unsuccessful, a Caesarean section may be necessary.

Episiotomy

An episiotomy is a deliberate, clean cut made at the outside entrance of the vagina (see Figure 12.1). It is sometimes done when it appears that the delivery of the baby's head is likely to cause a tear in the opening of the vagina. It may also be done to speed the delivery of a distressed baby. Usually a pain-killing injection is given to the area before the cut is made. After the baby is born the cut is stitched up. The stitches may have to be removed after a few days. In many cases, when catgut is used, they dissolve by themselves and do not need to be removed. Women often feel very sore for a while around the episiotomy, but this usually disappears within a few weeks. Good hygiene is necessary to prevent an infection.

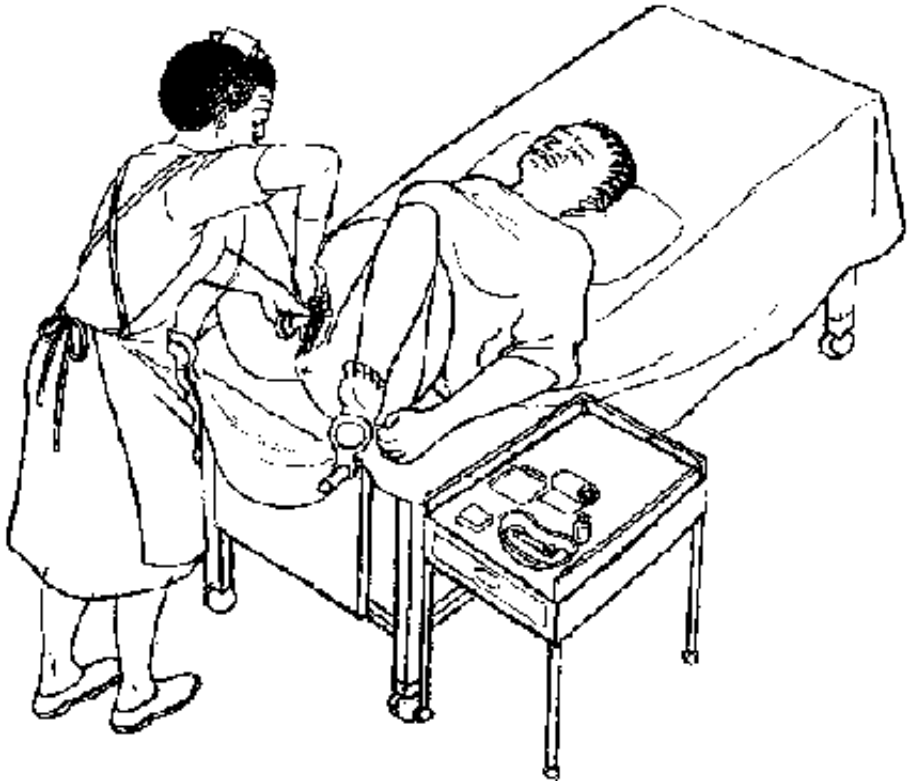

Figure 12.1: Episiotomy

An episiotomy is an incision or cut made at the entrance of the vagina during labour.

In women who have undergone female genital mutilation (female circumcision), the entrance to the vagina may be tightly closed and the surrounding tissues hardened by scarring. Normal delivery is impossible without further severe damage. A large episiotomy is often necessary to permit delivery through the vagina.

Forceps or Vacuum Delivery

An obstetric forceps is an instrument that is specially designed to help pull the baby out of the vagina or birth canal. There are usually two reasons for forceps delivery. If the first stage of labour is very long, a woman may be too exhausted to make the final effort to push the baby out. Also, if the baby shows signs of distress it may become necessary to shorten the second stage of labour. A forceps delivery can be quite uncomfortable or painful. A local anaesthetic is usually injected into the nerves around the birth canal in order to lessen the pain. Occasionally, a general anaesthetic may be required.

Another procedure to pull the baby out is vacuum extraction. With this procedure a metal or plastic cup is applied to the baby's head and attached by means of a vacuum. By pulling on the cup, the baby is gradually pulled out of the birth canal.

After a forceps delivery or vacuum extraction, there may be marks made by the instrument on the face or head of the baby for a few days. These are nothing to

worry about; they will soon disappear.

Manual Removal of the Placenta

If the placenta fails to separate from the womb at the end of the second stage of labour, it may be necessary to remove it manually. A trained health worker can do this. The procedure involves using a catheter, then putting a sterile, gloved hand into the womb and gently separating the placenta from the womb. The placenta should then be checked to make sure it is complete, and that no pieces were left in the womb. An oxytocic drug is given to help make the womb contract. Antibiotics are also given to prevent an infection. The woman should be given iron tablets to prevent anaemia.

The procedure can be rather uncomfortable after the strain of childbirth. To avoid discomfort, an anaesthetic may be given, but it is not always necessary. If the placenta was retained in a past delivery it may happen again. Women who have had retained placenta before should have future deliveries in a clinic or hospital where a trained person can remove the placenta manually if necessary.

Delivery by an Operation

For the health and safety of both mother and baby, it is sometimes necessary to deliver the baby by an operation. There are two types of operations most commonly performed: Caesarean section and symphysiotomy.

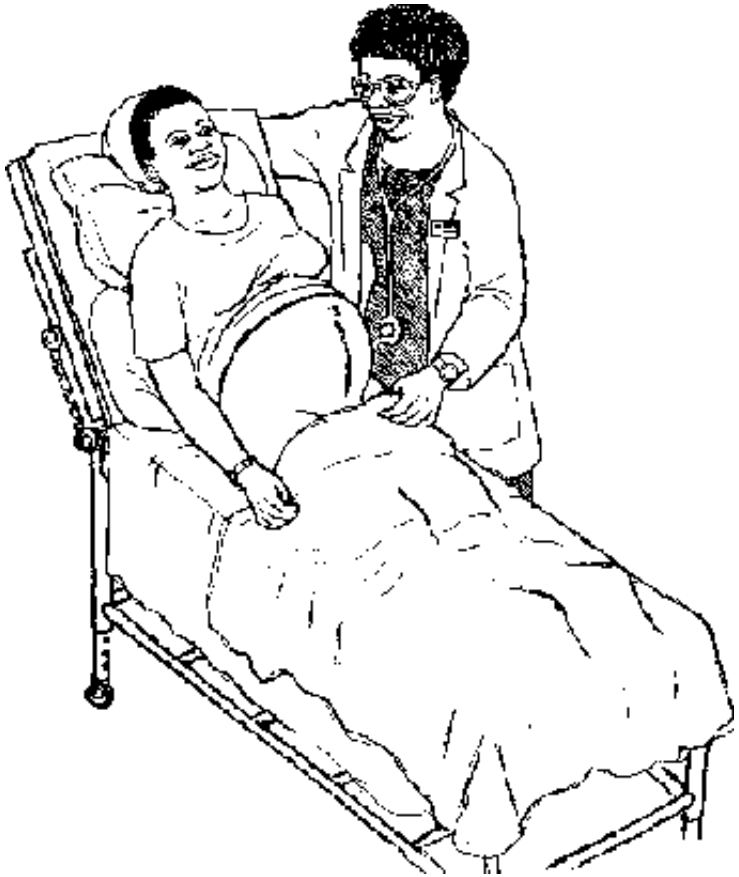

Figure 12.2: Caesarean Section

A Caesarean section is an operation in which the abdomen and womb are cut open and the baby and placenta are removed. The womb and abdomen are stitched up and left to heal.

"Classical" or Vertical Incision

If a previous Caesarean section was done with a vertical cut in the uterus, the woman should have a Caesarean section with all future deliveries.

Transverse Incision

If a previous Caesarean section was done with a transverse or horizontal cut in the lower part of the uterus, it may be possible for the woman to deliver normally. However, she should deliver in a hospital in case an operation is necessary.

CAESAREAN SECTION: A Caesarean section is a major operation in which the abdomen and womb are cut open and the baby and placenta are removed. The womb is not removed; it is stitched up and left to heal (see Figure 12.2). The operation has to be performed under general or local anaesthesia to make sure the

woman does not feel anything. Such an operation should be performed only in a fully equipped hospital and by someone who has been well trained to perform the procedure. There are several reasons why a Caesarean section might become necessary:

- **Prolonged labour - that is, labour that has lasted more than 12-18 hours without any sign that the baby is going to come out safely. This could be due to several reasons, but the most frequent cause of prolonged labour is when there is an obstruction (see Chapter 11).**

- **Abnormal presentation (see Chapter 11).**

- **Heavy bleeding before delivery (see Chapter 9) or, occasionally, heavy bleeding during labour (see Chapter 11).**

- **Severe hypertension, pre-eclampsia, or full eclampsia (see Chapters 9 and 11).**

- **Signs that the baby is in distress, such as a slow or irregular heartbeat.**

- **A previous Caesarean section. Depending on the type of Caesarean section that was done and the reason it was done, it may be necessary to repeat the Caesarean section. It may be possible for the woman to have a normal delivery through the vagina if the baby is a normal size and is lying head-down, if the woman had only one previous Caesarean section, and if the scar was in the lower part of the womb. Even if a normal delivery is being attempted, it should take place in a hospital in case another Caesarean section becomes necessary.**

- **Previous pregnancies that have ended in a stillbirth, or diabetes or severe heart disease in the woman.**

The risk of dying from a Caesarean section is higher than for a normal delivery, largely because of an increased risk of infection. A Caesarean section should be carried out only if it is really necessary.

SYMPHYSIOTOMY: When labour is obstructed, a symphysiotomy is sometimes performed. In this operation, a small cut is made at the top of the pubic bone so that the bones around the birth canal can be opened a little more to allow the baby to pass through. The operation is performed with anaesthesia.

Summary: Some Obstetric Operations and Procedures

Sometimes during labour it is necessary to perform procedures which will facilitate delivery. These should only be performed by properly trained personnel using appropriate equipment.

CIRCUMSTANCES	**PROCEDURE**
No labour after 42 weeks Slow heartbeat in the baby, or other signs that the baby might be in trouble Pre-eclampsia or	**INDUCTION OF LABOUR**: Methods include: giving an enema giving certain drugs (oxytocin) artificial rupture of membranes

diabetes Early rupture of membranes when the baby is near term	
Scar tissue in the vagina due to genital mutilation Signs of distress in the baby	**EPISIOTOMY**: A cut is made at the entrance to the vagina to enlarge the opening for delivery. It is sewn up after delivery. Drugs are used to stop the pain.
Exhaustion on the part of the mother Signs of distress in the baby	**FORCEPS OR VACUUM EXTRACTION:** The baby is pulled out of the birth canal using forceps or a vacuum.
Failure of the placenta to separate from the womb after the baby is born	**MANUAL REMOVAL OF PLACENTA:** A doctor or trained midwife uses his or her hand to separate the placenta from the womb.
Prolonged labour Obstructed labour Heavy bleeding Hypertension/pre-	**CAESAREAN SECTION:** The abdomen and womb are cut open and the baby is removed. The abdomen and womb are then stitched closed. Sometimes when labour is obstructed, a symphisiotomy is performed.

eclampsia/eclampsia Previous Caesarean section (depending on the type of scar) Transverse lie near the due date Fistula during a previous delivery	

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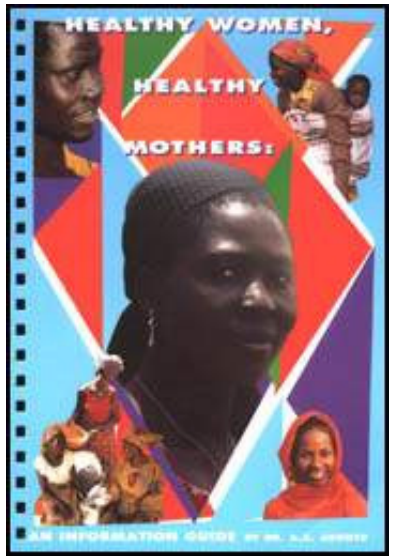

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Chapter Thirteen - THE POSTPARTUM PERIOD (SIX WEEKS FOLLOWING DELIVERY)

A woman's body goes through remarkable changes during pregnancy, ending in the physical effort of the birth itself. After the birth she needs a period of recovery so that she can return to feeling strong and healthy. This is especially important since the woman must also care for her newborn during this time. This period of rest and recovery is called the postpartum period. It covers about six weeks during which the body returns to the normal state and the woman adjusts to life with her child. The husband and other family members can help during this time by assuming responsibility for household tasks (see Figure 13.1).

Figure 13.1: Rest During the Postpartum Period

After giving birth the woman needs time (about six weeks) to return to feeling healthy and strong, and to care for her newborn. Family members can help by taking on household tasks.

The first few days immediately after delivery are often called the lying-in period. In many countries, there is a tradition that women rest for anywhere from one week to six months after delivery. This tradition recognises the hard work they have done - and the work they still have ahead. Many women may enjoy and appreciate this time of rest. However, they should also feel free to return to their

normal activities when they feel ready.

Changes After Delivery

EMOTIONAL CHANGES

Childbirth is a deeply emotional experience that often affects a woman's mood and behaviour. Many women have extreme mood changes after their babies are born. They may feel happy and relaxed one minute, and anxious, depressed, or tearful the next. The responsibility of caring for a new baby can feel confining or demanding. Relationships with other loved ones seem to change. For most women, these feelings fade and go away as time passes. What women need most at this time is support, understanding, and help from their friends and families. If a woman is feeling anxious and depressed and these feelings do not go away, she may need special help at a health facility that can provide psychiatric counselling or therapy. This is especially important if she talks seriously of hurting either herself or her baby, or makes an attempt to do so.

PHYSICAL CHANGES

Chapter 6 discussed the physical changes a woman's body goes through during pregnancy. These changes are reversed during the first six weeks or so after the baby is born. The first noticeable change, of course, is the loss of weight when the baby and the placenta, plus the bag of water, are delivered. The changes continue until most organs - womb, heart, etc. - have returned to the way they were before the pregnancy.

Immediately after delivery, the womb weighs about two pounds (one kilo). It

soon begins to get smaller; by the end of the fourth week it has returned almost to its original size and position in the pelvis. The overstretched soft tissues of the birth canal also return to normal. Breastfeeding helps this process by stimulating the womb to contract. This also helps reduce the amount of fluid (lochia) that comes from the womb during the first couple of weeks after delivery.

Immediately after delivery the lochia is bright red because it contains mostly blood. A clean cloth or cotton pad can be used to absorb the blood. The area can be washed gently to help prevent an infection. Women should be told to avoid tampons, douching, and intercourse at this time as they may increase the risk of infection. Over the next several weeks, the lochia changes to a dark brown colour, then to pale cream. The amount of the discharge becomes smaller over time and then completely stops, usually by the end of the fourth week. At first, it has a heavy smell which is not unpleasant. If the amount of the lochia increases, or has a bad smell, the woman may have an infection. If so, she should go to a clinic for a check-up and treatment immediately. Other signs of infection may include fever; chills; abdominal pain; a red, swollen, painful area in one of the breasts or in the leg; or very painful urination.

RETURN OF MENSTRUATION: If a woman breastfeeds without giving the baby any other milk or formula, her periods may not return for six or more months after delivery. If she is not breastfeeding, menstruation usually begins 4-6 weeks after delivery. Exactly when menstrual periods return may vary from one pregnancy to another. Women should know, however, that it is possible to get pregnant even before menstruation starts again if no family planning method is used.

RESUMPTION OF ACTIVITIES AFTER AN UNCOMPLICATED DELIVERY: Women

recover from labour and feel ready for their usual activities at different times. It depends on many things, such as how many other children she has, how much family support is provided, and how the new baby is adapting. There are no firm rules about this, and women should be encouraged to let their own feelings be their guide.

RESUMPTION OF ACTIVITIES AFTER A CAESAREAN SECTION OR SYMPHYSIOTOMY: A woman who has undergone a Caesarean section or symphysiotomy will take longer to recover from the delivery than a woman who did not have any complications. She will need to stay longer in the hospital. After she returns home, she will also need extra help and rest. If any drainage, redness, increased pain, or swelling appears at the site of the incision, she should go immediately to a clinic for evaluation. A woman who has had a symphysiotomy may need to wear a tight band around her abdomen and hips to support her pelvis as it heals.

CARE OF HAEMORRHOIDS: Many women develop haemorrhoids or enlarged blood vessels around the anus late in pregnancy or after delivery. These usually shrink after delivery, but they can cause a lot of discomfort. Eating lots of fresh fruit and vegetables and drinking plenty of liquids will help reduce constipation, which makes the haemorrhoids worse. Medicated creams and suppositories may also be used.

POSTPARTUM EXERCISES: Postpartum exercises can help a woman regain her energy, muscle tone, and feeling of well-being. These exercises may be started when a woman is thoroughly recovered from the delivery, and should be done for about 15-20 minutes a day. The exercises are not difficult and should not be tiring

(see Figures 13.2-13.4).

Postpartum Exercises

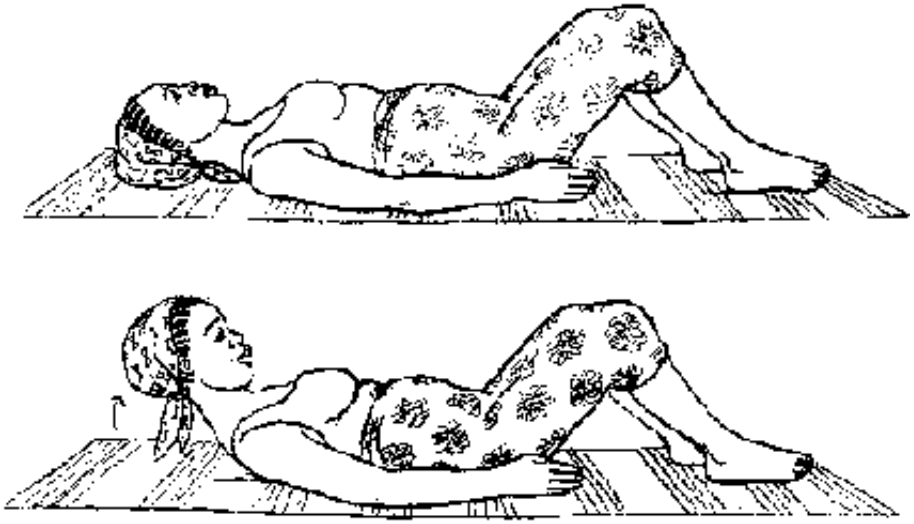

Figure 13.2: Head Lifts

1. Lie on back with arms at sides. Bend knees with feet flat on floor.
2. Raise head a little, breathing out. Then lower head slowly, breathing in.
3. Repeat the exercises 5-10 times.

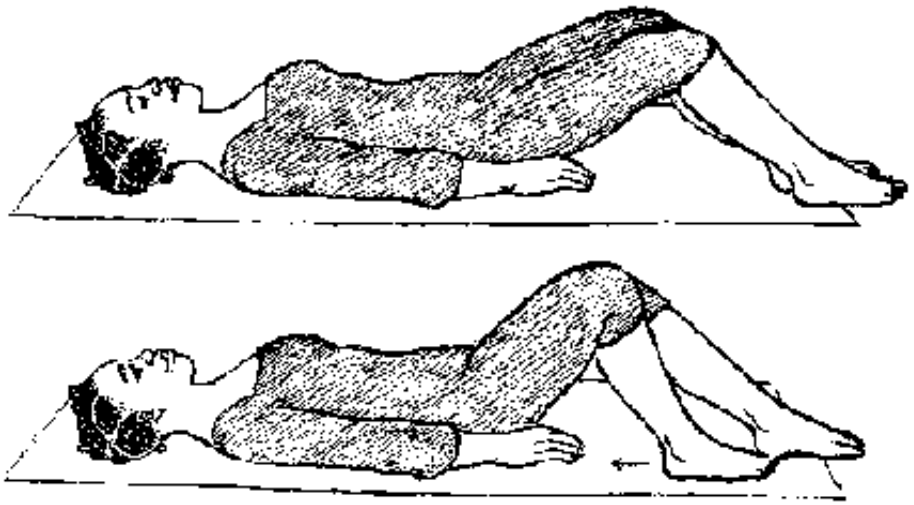

Figure 13.3: Leg Slides

1. Lie on back with arms at sides. Bend knees a little, with feet flat on floor.

2. Slide foot back toward buttocks, keeping right foot flat on floor and bending knee. Slide leg back down.

3. Repeat 10-15 times for each leg.

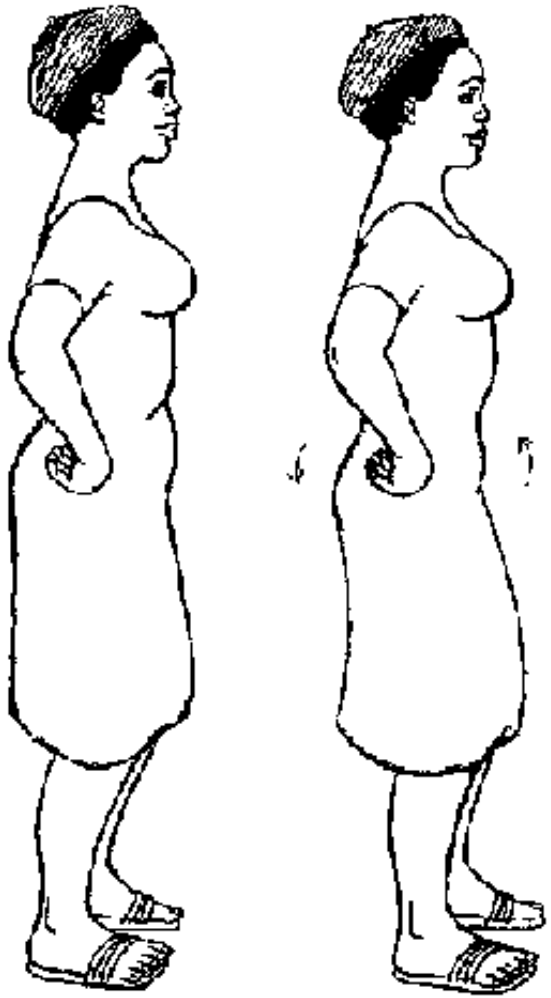

Figure 13.4: Pelvic Tilts

1. Stand with feet shoulder-width apart and knees slightly bent.

2. Push hips forward a little, tightening stomach muscles. Hold for a count of 5-10, then repeat 5 times.

Possible Complications

There are three serious complications that can develop in the period after delivery: eclampsia (within the first two days or 48 hours after delivery), infection, and haemorrhage (heavy bleeding). Eclampsia, fits caused by high blood pressure, is discussed in Chapter 9. Infection is most often caused by prolonged labour or early rupture of the membranes. It can also be due to poor hygiene during a delivery (for example, if the birth attendant's hands or instruments were not clean), or it can happen after a Caesarean section. The signs of a severe infection are fever, headaches, pain in the lower abdomen, bad-smelling vaginal discharge, and vomiting or diarrhoea (see Figure 13.5). These are dangerous signs, and a woman should go to a clinic or hospital immediately if she has them.

Haemorrhage can happen as late as ten days or more after delivery. If the placenta did not come out completely after delivery, bleeding may continue and become heavy. If the lochia is still bright red two weeks after delivery, she should go to a health facility.

Other complications that can develop after delivery are anaemia and fistulae. Anaemia is discussed in Chapter 9. Fistulae, which are holes that can develop between the vagina and the urinary tract or rectum, are discussed in Chapter 11.

Figure 13.5: Sepsis or Infection in the Postpartum Period

Signs of postpartum sepsis include fever, headaches, pain in the lower abdomen, foul-smelling vaginal discharge, and vomiting or diarrhoea. A woman with these signs should be taken to a clinic or hospital.

Box 13.1: ***Postpartum Danger Signs***

If a woman has any of the following danger signs after she has delivered her baby, she should seek care immediately:

- fainting, fits, or convulsions
- bleeding that increases rather than decreases, or has many large clots or pieces of tissue

- fever
- severe pain in the abdomen, or pain that keeps increasing
- vomiting and diarrhoea
- bleeding or fluid from the vagina that has a bad smell
- severe pain in the chest, or shortness of breath
- pain, swelling, and/or redness in the leg or breast
- pain, swelling, redness, and/or discharge at the site of an incision (if the woman had an episiotomy or a Caesarean section)
- urine or faeces (stool from a bowel movement) leaking out of the vagina
- pain when urinating

- paleness in the gums, eyelids, tongue, or palms

Postpartum Clinic Visit

Ideally, a new mother should visit a health facility for her first postpartum visit, or be visited by a health worker at home, within 7-10 days of delivery (see Figure 13.6). This is especially true if she delivered at home. This first visit is important to make sure that the woman and the infant are recovering from the labour and

delivery. If all is well, the next visit should be about six weeks after the birth of the baby. Both the mother and infant should have a thorough physical examination, and the infant should be immunised. In addition, this is an excellent opportunity to answer any questions the woman may have about breastfeeding, sexual relations, family planning, immunisations for the baby, sleep, or other topics.

Figure 13.6: Postpartum Care

A mother should visit a health facility, or be visited at home, within 7-10 days after delivery for a postpartum check-up.

Resumption of Sexual Relations and Contraception

There are no firm rules about when to resume sexual intercourse after delivery. In general, sexual intercourse during the first six weeks after delivery should be avoided due to the risk of infection. At the very least, sexual relations should be delayed until all bleeding has stopped. After that, women should resume intercourse as they feel comfortable and interested. Whenever sexual relations are resumed, it is important to use an effective family planning method so that the woman does not become pregnant while the baby is still only a few months old. There are several types of contraceptives suitable for women who are breastfeeding (see Box 13.2).

Box 13.2: ***Family Planning Methods for Breastfeeding Mothers***

Women who are breastfeeding should not use contraceptive methods that contain oestrogen (such as combined oral contraceptives), because oestrogen reduces the amount of breast milk that is produced. Other methods that are appropriate for breastfeeding mothers, which are described in Chapter 17, include:

- lactational amenorrhoea method (LAM)
- progestogen-only pills (mini-pills)
- injectables
- implants (Norplant)

- barrier methods (condoms, spermicide, or the diaphragm)

Diet

After childbirth, women need to eat well in order to regain their strength and recover from the labour and delivery. They should continue to take iron tablets to prevent anaemia, especially since they lost blood during delivery. If a woman is breastfeeding, her diet should include extra food and drink (see Chapter 6). Breastfeeding mothers need to eat even more than they did while pregnant, as breastfeeding places great demands on nutritional reserves. They should also be certain to drink plenty of liquids. If a woman is not breastfeeding, she can eat as she normally would. As during pregnancy, it is perfectly safe for a woman to eat almost anything she eats when she is not pregnant. The only things she should avoid are alcoholic drinks.

Summary: The Postpartum Period

During the six weeks after delivery, the mother experiences a number of physical and emotional changes:

she may feel sad or tearful after the stress of pregnancy and labour

her internal organs, especially the womb, return to normal size

the blood and other fluids from the womb gradually change from red to pale cream in colour, and stop altogether about four weeks after delivery

menstruation returns after 4-6 weeks if she is not breast-feeding, or several more months if she is breastfeeding

Serious complications can still develop after a woman has given birth. She should be taken to a clinic immediately if she has any of the following signs:

eclampsia, shown by fits or convulsions

infection, shown by high fever and pain in the abdomen; other signs include headaches, vaginal discharge with a bad smell, and vomiting or diarrhoea

haemorrhage (heavy bleeding)

fistulae, shown by urine or faeces leaking from the vagina

During the postpartum period, women should watch their bodies carefully, eat well, and resume normal physical activities when they feel able. They can also do exercises to help regain their strength. They should go for a postpartum check-up within one week of delivery if possible, or be visited at home by a health worker. They should have another checkup about six weeks after delivery, which should include information and counselling on family planning.


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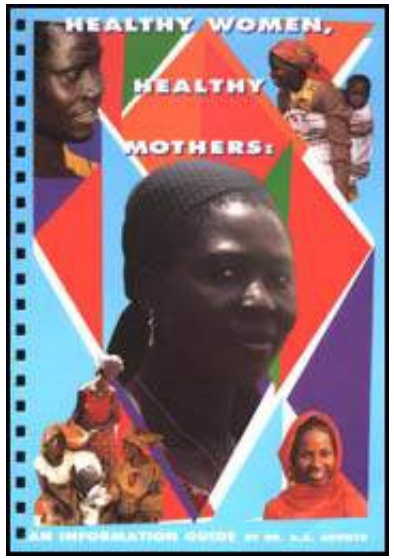

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Chapter Fourteen - HOW TO CARE FOR THE NEWBORN BABY

Newborn babies need a lot of care and help. If both mother and baby are healthy, there are a few simple steps that will help the baby get a good start. If the baby has a problem and the mother is not already in a hospital or health facility, she may need to go to a health facility in order to get the problem treated.

First Steps in Caring for the Baby

As soon as the baby is born, there are a few steps that must be taken right away. These are:

KEEPING THE BABY WARM

The very first step is to wipe the mucus from the baby's mouth and nose so that the baby can start breathing. It is important to have a trained attendant who knows how to help the baby start breathing if necessary.

Next, the rest of the baby's body should be dried with a soft, clean cloth or towel, and then wrapped in a warm cloth and given to the mother to hold close to her body. Newborn babies get cold much more easily than adults or older children, so babies must be kept warm and dry. The room where the baby is being delivered should be kept warm if possible. Since most heat loss occurs through the head, the baby should wear a hat or be wrapped in a blanket so the top of the head is covered.

The baby should lie on his or her side with the head slightly lower than the body. This will help drain mucus and fluids from the newborn's mouth and nose.

CUTTING AND CARE OF THE CORD

Right after the infant is born, the umbilical cord is still providing oxygen. It should be left alone until it is no longer pulsing (this can be felt by holding the cord between the thumb and forefinger). Then, it should be clamped or tied shut in two places: one tie or clamp should be about two finger widths from the baby's belly, and the other tie about two finger widths closer to the mother (see Figure 14.1). The cord should be cut between the two ties, using clean, sterilised scissors or a new razor blade. The instrument used to cut the cord must be sterile. If it is not, the baby may get tetanus, a very dangerous disease.

Figure 14.1: Proper Cutting of Umbilical Cord

The umbilical cord should be tied or clamped as shown, then cut between the two ties using sterilised scissors or a new razor blade.

Figure 14.2: Putting the Newborn Baby to the Breast

The baby should be breastfed immediately following delivery. The liquid that comes from the breast at this time, called colostrum, is very good for the baby and protects against illness.

The stump of the cord on the baby's belly should be kept clean and open to the air to dry. By no means should things like mud, cow's dung, herbs, or other substances be put on it, as these are likely to cause infection. If the cord stump gets moist it should be left more open to the air. If it begins to bleed or have a bad smell, it could be infected, and should be looked at by a trained health worker.

PUTTING THE BABY TO THE BREAST

The baby should be put to the breast immediately after delivery (see Figure 14.2). Contact with the mother's body helps give the baby warmth and comfort. Breastfeeding should be started right away, as long as the baby is alert and interested. The milk that comes from the breasts right after delivery, called colostrum, is very good for the baby and protects against sickness (see Chapter 15). Breastfeeding immediately also tells the mother's body that the baby has been delivered, and helps the placenta come out and the womb begin to return to its normal size right away. Sugar water or formula should never be given to a newborn baby. This can make the baby reluctant to take the breast, and can cause serious illness if the water is not clean, or if the cup or bottle is unclean. The sooner and more frequently the baby breastfeeds, the sooner the mother's milk will start coming and the more there will be.

EXAMINATION OF THE BABY

If the delivery occurs in a health facility, or if a trained health worker attends the delivery, the baby should be checked soon after birth. A midwife, nurse, or doctor should check the baby's pulse and heartbeat, make sure the baby is breathing well, and check to make sure the baby's colour is good and that the body is normal. The baby should also be weighed, and the weight should be recorded (see Figure 14.3).

Figure 14.3: Examination and Weighing of Newborn Baby

Soon after birth the baby should be weighed, and the information should be recorded on a growth monitoring chart.

Infants Requiring Special Care

Infants who may require special care from a trained health worker include those who are born too early, who are underweight (less than 2,500 grams or 51/2 pounds), who were delivered by Caesarean section, or who are twins. These infants may need assistance to help them breathe, keep them warm, and possibly to treat complications they may have. If the mother had a complication or illness during her pregnancy, such as high blood pressure, diabetes, or bleeding from the

vagina, the infant is also more likely to need special care. This is another reason why a woman should deliver in a hospital or health facility if she has a complication or illness during pregnancy: that way both mother and baby can be cared for properly.

Box 14.1: ***Normal Physical Characteristics of a Newborn***

The baby's hands and feet may be slightly blue immediately after birth.

The eyes may be uncoordinated and appear slightly crossed for the first several days or weeks.

The stump of the umbilical cord is very moist at the beginning; it dries slowly until it falls off in a week to ten days.

The baby's genitals may appear swollen for the first few days.

The breasts of some babies are slightly swollen. This is an effect of the hormones from the mother, and will gradually disappear.

Some baby girls bleed a little from their vaginas. This is like a small period caused by the mother's hormones.

The baby will have two small soft spots on the top of the head that will slowly close during the first year. The size of these soft spots, called fontanelles, varies from baby to baby.

Some babies are covered with fine hair that falls off during the first few months.

Some babies, especially those that are born early, are covered with a creamy white substance called vernix. This can be wiped off after birth, and is not a sign of any problem.

Many babies have small pimples covering their faces and bodies. These slowly go away during the first few days or weeks.

Later Care of the Infant

There are many important steps to making sure the baby is healthy and happy. These include proper breastfeeding and weaning, protecting the baby from infections, knowing the signs of illness such as jaundice or anaemia, and what to do if the baby gets diarrhoea or starts vomiting. If the mother did not deliver in a health facility, she should go to one within 7-10 days to have the baby checked, and to have an examination herself. She should also receive guidance on how best to care for the baby, and what to do if the baby gets sick.

IMMUNISATION

Infants need to be protected against the diseases that are the most common causes of infant and child death. These include measles, whooping cough, and tetanus. Polio also disables one out of every 200 children who has not been protected by immunisation. All children should be fully immunised by the time they are one year old. The proper times to immunise a child are presented in Box 14.2 below.

Box 14.2: ***Immunisation Schedule for Infants****

AGE	ANTIGEN	DISEASE TO BE IMMUNISED AGAINST

At birth	BCG (and polio)	Tuberculosis (and polio in some countries)
6 weeks	DPT and polio (first dose)	Diphtheria, whooping cough (pertussis), tetanus, polio
10 weeks	DPT and polio (second dose)	Diphtheria, whooping cough, tetanus, polio
14 weeks	DPT and polio (third dose)	Diphtheria, whooping cough, tetanus, polio
9 months	Measles	Measles
* Immunisation schedules may vary slightly in different countries.		

Parents should be aware that a child may cry or develop a fever, rash, or small sore after an injection. These are normal after-effects and should not be a cause for worry. The child should be given plenty of food and liquids, preferably breast milk. If the problem seems serious or lasts more than three days, the child should be taken to a health centre.

Summary: How to Care for the Newborn Baby

Infants need care as soon as they are born. The first steps in caring for the newborn baby include:

Cleaning the baby's mouth and nose, and drying the rest of the baby's body
Putting the baby to the mother's breast immediately
Keeping the baby warm and dry

Cutting the umbilical cord with **sterile** instruments, and keeping it dry and clean
Examining the baby for any defects or immediate health problems

Later care of the infant includes proper breastfeeding and diet, treatment of common illnesses like diarrhoea, and immunisation to protect the baby against the major diseases of childhood.

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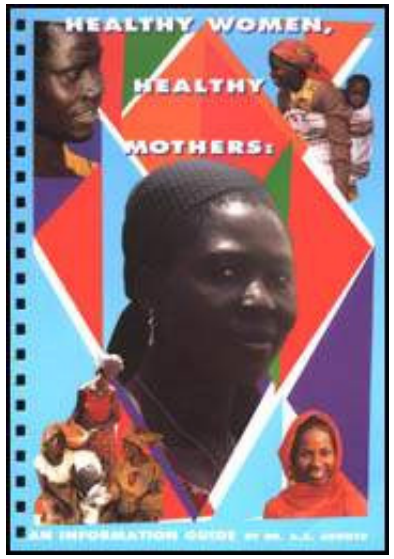

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Chapter Fifteen - BREASTFEEDING

Every child should be breastfed, and should receive only breast milk for the first four months of life. Infants who are not breastfed are twice as likely to die as those who are. The breasts have undergone many changes during pregnancy so that the mother's milk will also be ready when the baby is born. The more a baby is fed at the breasts, the more milk the breasts produce. Artificial milk should only be used when absolutely necessary.

Advantages of Breastfeeding

There are many reasons why breast-feeding is better than bottle feeding. They include:

- **Breast milk is the most natural food for a baby, and is the easiest food to digest. Cow's milk, on the other hand, does not have the right combination of vitamins, nutrients, and fats, and sometimes a human baby cannot even digest it. If infant formulas are not mixed correctly, they can be too weak and will not nourish the baby properly. Also, the breast milk changes as the baby matures to meet the baby's complete nutritional needs at that time.**

- **As long as the mother's nipples are clean, breast milk is always clean and free from germs that cause infection, and is always at the right temperature. Even if the mother is sick, her breast milk is safe for the baby. But if formula is mixed with contaminated water or in a dirty bottle, it can give the baby diarrhoea.**

- **Breast milk contains substances called antibodies which protect the baby from many types of infections and other illnesses, especially during the**

first six months. Formulas and the milk of animals do not contain these antibodies. That is why babies who get only breast milk are healthier and have fewer attacks of diarrhoea than babies who are fed with artificial milk.

- **Touching and looking at the baby during breastfeeding makes both mother and baby feel close and secure.**

- **Having the baby suck the breast immediately after birth helps the womb contract and push out the placenta. During the first few days after the baby is born, the baby's sucking helps the womb return to its normal size.**

- **If a woman gives only breast milk to her baby and breastfeeds on demand (whenever the infant wants to eat), ovulation and menstruation are delayed for about six months. The mother is therefore protected from getting pregnant again (see description of Lactational Amenorrhoea Method in Chapter 17).**

- **Breast milk is free, and it is always available. Artificial milk is expensive and is not always available. It takes time to prepare artificial milk to bottle feed the baby, and few homes can afford the equipment and fuel to sterilise the feeding bottles properly.**

The Process of Breastfeeding

WHEN TO START

Breastfeeding should start as soon as the baby is born. Immediately after delivery, the mother should be given her baby to hold and put to her breast. The baby's

sucking has two advantages. First, it stimulates the womb to contract and therefore helps stop bleeding. Second, it stimulates the milk to begin to flow from the breast.

For the first couple of days, the breasts will produce only the thick yellowish fluid called colostrum. In many cultures, people believe that colostrum is useless or even harmful to the baby, so women don't breastfeed during this time. In fact, colostrum is very good for babies; it is rich in antibodies, protein, minerals, and important vitamins. Women often say they have no milk during this period, but they should be encouraged not to worry. The baby does not need much food or other liquids during the first two or three days. Early sucking also helps prepare the nipples for when the baby gets hungry and begins to suck hard. Usually, by the end of the second or third day, milk begins to flow from the breasts. The more often and the harder it sucks the baby sucks, the more the milk flows.

During the first few days, breast-feeding may cause some painful cramping of the womb and short flows of blood from the vagina. Although it is uncomfortable, this actually helps the womb return to its normal size and reduces overall blood loss. This discomfort soon stops (see Box 15.1).

Box 15.1: ***Comfort Measures for Breastfeeding Mothers***

During the first few days, breastfeeding may be uncomfortable for the mother. She should be reassured that this discomfort soon passes. The following measures can also help:

- Breastfeed as soon as possible after delivery, or as soon as the baby is alert and

interested

- Make sure the area around the nipple (the areola), as well as the nipple itself, is in the baby's mouth
- Breastfeed from both breasts every time the baby nurses
- If the baby started breastfeeding from the right breast last time, start with the left breast the next time (and vice versa)
- Breastfeed the baby "on demand" - whenever the baby seems hungry

- Hold the baby in different positions while breastfeeding

HOW OFTEN TO BREASTFEED

How often the baby is fed will depend on both the mother and the baby. There are no firm rules. It is more natural to feed the baby when he or she is hungry, rather than according to a certain time schedule. In the beginning, the baby may want to feed as often as 10-12 times a day, including at least three or four times during the night. This is demanding, but small frequent feedings are better for the baby. Also, the more often the baby breastfeeds, the more milk the mother produces.

HOW LONG TO BREASTFEED

Breastfeeding can continue for as long as the mother feels comfortable doing it. In many countries, babies breastfeed for a year or more. For the first four months, the baby needs only breast milk. There is no need for any other food or liquid, not

even water; breast milk contains everything the baby needs. After that time, the baby will need other foods in addition to breast milk. Breastfeeding should continue for another 12-18 months while the child gets more and more solid foods. New foods must be introduced gradually.

Reasons Given for Not Breastfeeding and How to Respond

Mothers give many reasons why they do not think they can breastfeed. Some of them include:

- ***"My breasts are too small and cannot produce enough milk to satisfy the baby".*** **The amount of milk produced by the breasts does not depend on their size.**

  Rather, it depends on how often and for how long the baby breastfeeds, and how soon after birth breastfeeding begins.

- ***"Breastfeeding ties me down too much".*** **Certainly, for working mothers, breastfeeding poses some challenges. But even if the mother breastfeeds only a few times a day after starting back to work, the baby continues to receive the benefits of breastfeeding and is usually healthier. Pumping milk from the breasts can help ensure that they continue to produce enough milk. If facilities are available, breast milk can be refrigerated or frozen and given to the infant later.**

- ***"Breastfeeding can be tiring".*** **That's true, and breastfeeding may seem like a burden, especially when a woman is already tired after a day's work. But preparing an artificial formula properly before giving it to the baby can**

be just as tiring. Also, many women find the process of breastfeeding relaxing; it gives them time to be close to the baby.

- ***"I'm sick and have to stop".*** **If a woman gets sick, breastfeeding should continue for as long as possible. The baby probably will not catch the mother's illness. In fact, the baby receives protection from the mother because of the antibodies passed on through the breast milk. A sick baby may eat less, but breast milk is still the best food and the one the baby can digest most easily.**

- ***"My baby must be weaned because I'm pregnant again".*** **Instead, if the mother's diet is adequate and she gets plenty of rest, she can continue to breastfeed for as long as she produces milk and feels able to do so.**

Possible Problems During Breastfeeding

Even with the most willing mother and contented baby, problems may arise during breastfeeding. It is useful to know what might happen and how to prevent or cope with problems.

CRACKED OR SORE NIPPLES: This problem is usually the result of having the baby in a poor position for breastfeeding. For example, it may happen when the baby does not have the area around the nipple (the areola) as well as the nipple itself in the mouth. It can also happen when the baby sucks for a very long time in the same position, when the breasts are too full, when there is friction against tight and ill-fitting brassieres, or if the mother uses irritating soaps or other substances on the nipples. If a woman has cracked and sore nipples, she should be given the

following advice:

1. Start feeding on the less painful breast.

2. If the baby has already breastfed for a long time and is only sucking for comfort, stop breastfeeding and comfort the baby some other way.

3. Always check to make sure that the areola, as well as the entire nipple, is in the baby's mouth.

4. Air dry the nipples carefully before covering them up.

5. Apply breast milk to the dry nipple. Breast milk has natural antibodies that will help prevent infection. Again, the breast should be thoroughly air dried before being covered up again.

6. Change positions during breastfeeding so that the baby latches on to different areas of the areola (see Figure 15.1).

Figure 15.1: Positions for Breastfeeding

Holding the baby in different positions while breastfeeding can help make the process more comfortable, and prevent problems like cracked or sore nipples. It is also important to make sure the dark area around the nipple, as well as the nipple itself, is in the baby's mouth.

Figure 15.1.A: Positions for Breastfeeding

Figure 15.1.B: Positions for Breastfeeding

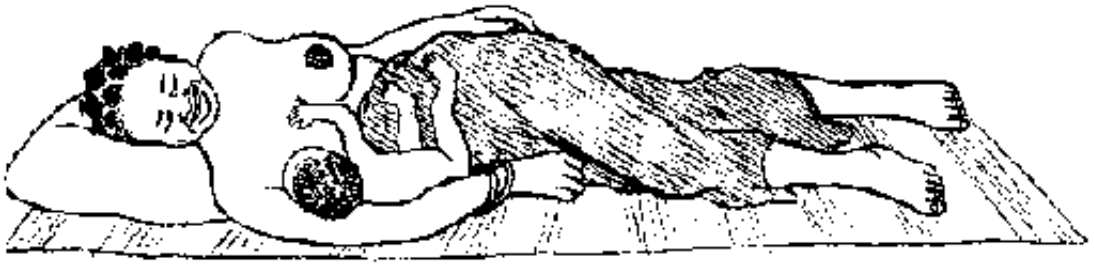

Figure 15.1.C: Positions for Breastfeeding

Figure 15.1.D: Positions for Breastfeeding

BREAST ENGORGEMENT: The breasts can get too full if the baby does not feed often enough or does not thoroughly empty all parts of the breasts. Engorged breasts can be quite painful and cause fever. To prevent breast engorgement, the woman should breastfeed the baby often and be sure that at each feeding, both breasts are emptied. Changing positions during breastfeeding will also help empty the breasts. If necessary, the breast milk can be pumped from the breast to relieve engorgement.

If the baby has trouble attaching to the nipple because the breasts are engorged and the nipple has flattened, warm soaks or a warm shower and gentle rubbing of the nipple will help the milk begin to flow to relieve engorgement. Then the nipple and areola will be softer so that the baby will be able to suck more easily.

INFECTED BREASTS: Sometimes breasts become infected and cause fever and pain. Infection usually follows breast engorgement or cracked nipples. The woman may need medical treatment. Most importantly, she should continue to breastfeed on both breasts. The baby cannot catch the infection and breast-feeding will help relieve the problem.

BREAST ABSCESS: An abscess is an infection that forms a collection of white pus.

Breast abscesses are rare but serious, and will need treatment in a clinic where the abscess can be cut open and drained. During this time the woman should stop feeding the baby from that breast for a while. If the pain allows, milk may be gently squeezed from the breast at regular intervals. The baby may be fed from the healthy breast until the infected one is healed.

FLAT OR INVERTED NIPPLES: If a woman has nipples that turn inward or remain flat rather than standing up, she should be reassured that she will also be able to breastfeed. The sucking of the baby will pull the nipple out. It may take longer for the baby to suck at first, but usually the problem does not last.

Summary: Breastfeeding

Every child should be breastfed. Breastfeeding should start immediately after birth, and the baby should receive only breastmilk for the first four months. Infants who are not breastfed are more likely to become ill and die than those who are. Some advantages of breastfeeding are:

Breast milk is natural and easy to digest.

Breast milk contains nutrients and antibodies that are good for the baby.

Breastfeeding promotes closeness between the mother and child.

In the days after delivery, breastfeeding helps the mother's body recover.

Breast milk is free.

Sometimes complications can arise; for the most part, they are not serious enough to stop breastfeeding altogether. They include:

Cracked or sore nipples: Make sure the entire nipple as well as the dark area around it is in the baby's mouth; change the baby's position frequently.

Breast engorgement: Feed the baby more often and change the position of the baby frequently.

Infected breasts: The woman may need treatment, but the baby will not catch the infection and can continue to breastfeed.

Breast abscess: Treat the infected breast. Feed the baby from the healthy breast.


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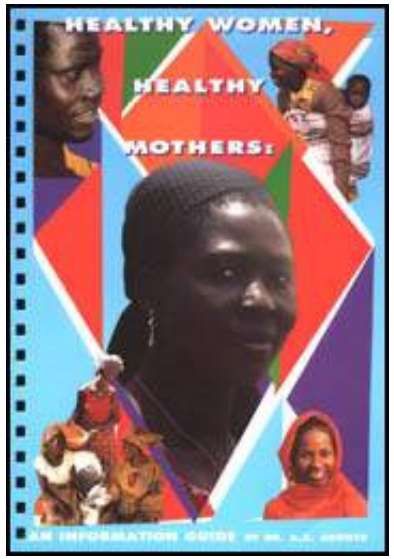
Chapter Sixteen - THE ROLE OF MEN AND OTHER FAMILY MEMBERS

(introduction...)

During Pregnancy and Childbirth

After Delivery

In Family Planning



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Chapter Sixteen - THE ROLE OF MEN AND OTHER FAMILY MEMBERS

Chapters 3 and 4 describe the man's biological role in reproduction. Chapter 5 shows that it is the man's contribution (the sperm) that determines the sex of the baby. Beyond this biological role, a man has an extremely important and useful part to play during pregnancy, and afterwards when he becomes a father. Other family members, such as the baby's grandparents and "aunties", can also help and give advice.

During Pregnancy and Childbirth

Although pregnancy is not an illness, it makes great physical and emotional demands on the mother. Her husband or partner, as well as other members of the

family, need to understand and appreciate the discomfort, anxieties, and tiredness that pregnancy may cause in a woman. Whenever possible, the man or some other family member should take over physically tiring tasks like working in the fields, lifting or carrying heavy loads, washing, and scrubbing floors (see Figure 16.1). Others can assist by taking care of the children. The man can also help by providing encouragement and emotional support, by trying not to make demands on her, and by not criticising her.

The man can learn about the pregnancy along with the mother. This will enable him to help her more effectively, and understand what she is going through. It will also help him feel more involved. If he is interested, he should be encouraged to accompany the woman when she goes to the health centre for antenatal care and health education. He can learn about what happens during pregnancy and what needs to be done to help the woman stay in good health. He can also learn about the danger signs during pregnancy and delivery, so that if a complication develops he knows when the woman needs to go to a hospital or health centre. Men should understand that good nutrition and medical care during pregnancy and childbirth are important. The man can also help in very practical ways by making sure the woman eats well, and by providing whatever money is necessary to pay for transport, fees, or medicines (Figure 16.2). As the time for delivery approaches, the man or other family members should arrange to have transport ready in case an emergency develops.

Figure 16.1: How the Man Can Help During Pregnancy

Husbands and other family members can help by taking over physically demanding tasks like carrying heavy loads.

If this is the family's first baby, the man may have doubts about his ability to be a good father, just as a woman may have doubts about her ability to be a good mother. It will help to talk about these feelings, as well as any other concerns about how having a baby will affect the family.

During labour and childbirth, the man cannot share the physical effort. Men, however, should be encouraged to stay with their wives during the labour and

delivery to provide comfort and support. This will help the man feel a closer attachment to the new baby and have a greater appreciation and sense of responsibility towards the mother.

After Delivery

The first six weeks after the birth of the baby can be an especially trying time for the whole family. The woman has just been through an exhausting and profound experience, physically and emotionally. Both mother and father have to adapt to a new person in their lives and meet the baby's increasing demands and needs, including breastfeeding. Sometimes these responsibilities may seem overwhelming, and parents may doubt their ability to cope. During this time, the father can play a vital role in giving the mother and baby understanding, support, affection, and help with day-to-day tasks (see Figure 16.3). Other family members often provide very valuable help during this period, giving the mother time to recover and adjust.

After the child is born, the man can contribute to having a healthy and happy family by ensuring that the mother is well fed, and that both the mother and baby receive medical care. He should be aware of danger signs that might indicate that the mother or baby is unwell and needs to go to a health facility.

Figure 16.2: Ensuring that the Woman Receives Medical Care

One important role for husbands during and after pregnancy is to make sure that the woman receives proper medical care, and to provide money to pay for clinic fees.

Figure 16.3: How Families Can Help After the Delivery

After the baby is born, the father and other family members can help with day-to-day tasks like caring for the older children while the mother adjusts to her new responsibilities.

In Family Planning

On average, it takes two or more years before a woman has fully recovered from the demands of pregnancy and birth. The first two years are also critical in the growth and development of the child. Many child deaths happen because the mother becomes pregnant again too soon and has to stop breastfeeding her child when she stops producing breast milk.

One very important way a man can help the new mother is to protect her from becoming pregnant for at least two years after the birth of their last child. He can

seek advice from a doctor or family planning clinic about methods of contraception, either alone or, even better, with the woman. He can go with her to a family planning clinic to help select an effective and appropriate method of contraception (see Figure 16.4). After choosing a method, he should be supportive and cooperate in using whatever method was selected (see Chapter 17).

During Child-Rearing

In many societies the man is still seen as the one who provides for and protects the family. But he can and should help with raising the children in other ways as well. The parents should make decisions together about caring for the children - for example, when to take them to a health facility and when they should start school. He can also help counsel and advise them as teenagers, discussing issues like when to get married and what career or job they should train for. The man and other family members can share the task of watching the children and should help teach the children how to cope with responsibilities as they grow up. In particular, a father can and should ensure that his daughters are given the same opportunities as his sons in terms of education, health care, and other benefits.

Figure 16.4: Couple Discussing Family Planning at Clinic

A family planning counsellor can explain the various contraceptive methods that are available. The couple can then discuss the methods and decide together which one is most appropriate for them.

Box 16.1: ***Methods of Family Planning for the Man***

Most methods of family planning are used by the woman. There are several methods, however, where the man takes the lead. These methods are (see Chapter 1 7 for more information on family planning):

- **WITHDRAWAL:** With this method, the man withdraws his penis from the woman's vagina just before he ejaculates or "comes". It requires a great deal of self-control from the man, and is not very reliable.

- **CONDOMS:** The condom is a tube made of rubber and closed at one end. It is put on the man's penis when it is hard, just before sexual intercourse begins. When the man ejaculates or "comes", the condom catches the semen and prevents it from entering the vagina of the woman.

- **VASECTOMY:** Vasectomy, or male sterilisation, is a minor operation in which the doctor makes a small cut in the man's scrotum, then cuts and ties the tubes that carry sperm. After the operation, the man can have sexual relations just as before, but he can no longer make a woman pregnant. The method is permanent.

Communication

At all times during a couple's life together it is important that they find ways to communicate openly and honestly with each other. Men and women can play an equal role in finding ways to talk about and solve problems. Sometimes, problems exist because couples do not communicate. For example, a woman may think that her husband does not approve of family planning, but when the topic is actually discussed she may find out that he does approve. She may also be afraid of asking for money to pay for medicines or medical care, even though the man may be supportive if he understands why they are important. Health workers can help this communication by encouraging both men and women to become actively involved in pregnancy, birth, child-rearing, and family planning decisions. They can also encourage couples to discuss problems such as sexually transmitted diseases, as well as all the day-to-day events that affect the health and well-being of the family.

Summary: The Role of Men and Other Family Members

Other family members, including the baby's grandparents, "aunties", and especially the father, can help the woman in many ways before, during, and after pregnancy. Some of the ways to help include:

Learning about pregnancy and what should be done to help the woman stay healthy, such as proper diet and rest. They can also learn about the danger signs of pregnancy.

Making sure the woman gets the medical care she needs, and gets enough food and rest.

Helping with work in the home and in the fields, especially work that is physically demanding or tiring.

Providing money to pay for medical fees, transport, etc.

When the time of delivery is near, making arrangements to have transport ready in case the woman needs to be taken to a hospital.

Providing emotional support and understanding, and working together to talk about and solve any problems.

Learning about family planning methods, discussing them with the woman, and cooperating in using whatever method is chosen, if any.

Helping to care for and raise the children.

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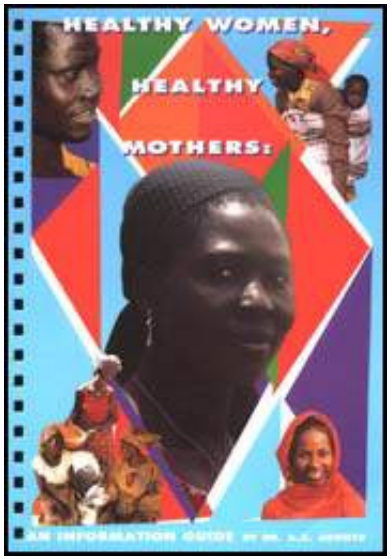

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Chapter Seventeen - FAMILY PLANNING AND CHILD SPACING

Family planning refers to the actions couples take to have the desired number of children, when they are wanted. Using a method of family planning means allowing choice, not chance, to determine the number and spacing of children. Planning the family helps protect the woman's and the children's health, and preserves the well-being of the whole family. Decisions about family planning

should be made by a woman and man together, since most family planning methods require cooperation to make them work.

The Benefits of Family Planning

Family planning is not a new idea in Africa. For generations, couples have found ways to avoid getting pregnant until they are ready to have a child, or to limit the number of children they have. Most African cultures have always known, for example, that having another baby when the elder child is still too young would be bad for that older child. The Ghanaian word "kwashiorkor" describes the malnourishment of a child weaned too early because his or her mother became pregnant again too quickly. Traditions such as breastfeeding for a long time and avoiding sexual relations for months or even years after the birth of a child (for example, until the child can walk) ensured that a woman could recover fully from one pregnancy before becoming pregnant again. These traditions also ensured that each child could have the mother's full attention during the important early years.

Family planning improves the health of children and mothers. Children are more likely to fall ill and die if they are born too close together (less than two years apart), or born after the mother has already had many children (five, six, or more). Having too many children too quickly also increases the mother's risk of having complications during pregnancy and delivery. As discussed in Chapter 7, if a woman becomes pregnant when she is too young (under 16 or 17 years) or too old (over 40 years), her chances of having a complication are increased.

Finally, family planning helps the entire family - father, older children, and even

grandparents. Raising children requires a lot of time, energy, and money, especially if children are given the food, clothing, education, and other opportunities they need to have a good chance in life. By helping parents have the number of children they can raise properly, family planning helps ensure that there are more resources available for every person in the family.

Methods of Contraception

Contraception means preventing pregnancy; a contraceptive is a drug or device used to prevent pregnancy. There are many different contraceptive methods. Most are reversible; that is, a woman will be able to become pregnant again after she has stopped using the method. Some methods, such as surgical sterilisation, are permanent, meaning a woman cannot become pregnant ever again. All methods are designed to work in one of two ways: either they prevent the man's sperm and the woman's egg from coming together, or they prevent the fertilised egg from implanting in the womb.

The effectiveness of a contraceptive method can be described in terms of its "failure rate". If a method has a failure rate of 10%, for example, it means that if 100 couples relied on this method to prevent pregnancy, ten of the women would become pregnant during a year. If 100 couples were not using any method of contraception at all, about 80 of them would become pregnant within the year.

Many factors can influence a couple's decision about whether to use contraception, and which method to use. These factors include:

- **Whether the couple wants to stop having children or just delay the next**

birth by a certain period,

- **How old they are,**
- **The number of children in the family, and their ages,**
- **Whether the mother is currently breastfeeding,**
- **Whether the mother or father have any health problems,**
- **What kind of lifestyle the family has,**
- **The side-effects, advantages, and disadvantages of the different methods.**

Their decision will also depend on what methods of contraception are available. Not all those described here may be found at local clinics. Couples should discuss the various methods with a counsellor or health worker at a family planning clinic before deciding which one to use. This chapter only gives basic information about each type of family planning. It does not give all the instructions necessary for use.

BARRIER METHODS OF CONTRACEPTION

Barrier methods prevent the sperm and the egg from uniting, thus preventing fertilisation. Two of these methods - male and female condoms made from latex rubber - are also the only family planning methods that have been proven to offer protection against sexually transmitted diseases (STDs), including AIDS (see Chapter 18). Therefore, women who are at risk of STD or HIV infection (that is,

women who have more than one sexual partner, or whose partner has other partners) should be encouraged to use condoms. If they are using another family planning method, they should be urged to use condoms as well.

Barrier methods are largely free of side-effects. They do, however, require the couple to make certain preparations before having sexual intercourse.

CONDOM OR SHEATH

Description: The condom is a soft tube made of latex rubber and closed at one end. It is put on the man's erect penis before sexual intercourse (see Figure 17.1). When the man ejaculates, the semen containing the sperm is collected in the tip of the condom. There is a small chance that the condom may tear during sexual inter-course, especially if it is not worn correctly or if it was not stored in a cool place before it was used. It is also important that the man be careful to withdraw his erect penis from the vagina, with the condom still on, so the semen does not spill into the vagina.

Condoms are supplied in different sizes, shapes, and colours; they may come with or without lubrication or spermicide. They should be used only once; they are likely to tear if used a second time.

Effectiveness: Condoms have an average failure rate of around 12%. However, this rate reflects not a failure of condoms but a failure to use them properly. If they are always used correctly and consistently, condoms can be much more effective. If a condom is used with a spermicide (see below), the combined effectiveness is similar to that of oral contraceptives (a failure rate of around 3%).

SPERMICIDES

Description: Spermicides are chemical contraceptives that prevent pregnancy by destroying sperm. They are available in a variety of forms: creams, jellies, foaming tablets, aerosol cans, and suppositories. They are put into the vagina 5-10 minutes before sexual intercourse. Sometimes they are used in combination with other barrier methods (condoms, diaphragms, etc.), which provides greater protection against pregnancy. Spermicides are available at chemists' shops and have no known side-effects apart from occasionally causing skin irritation in some women and men. They also provide some protection against some types of sexually transmitted diseases.

Effectiveness: By themselves, Spermicides are only moderately effective as contraceptives (with a failure rate of 21%). When used with other barrier methods, such as the condom or diaphragm, they are much more effective.

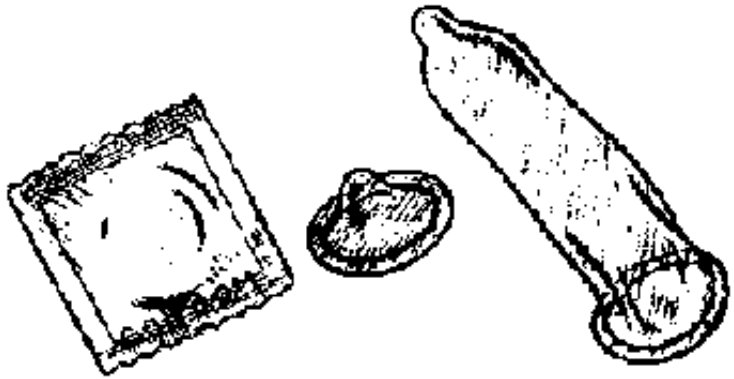


Figure 17.1: Condom or Sheath

A tube made of thin rubber that is placed over the man's penis before sexual intercourse (see next page).

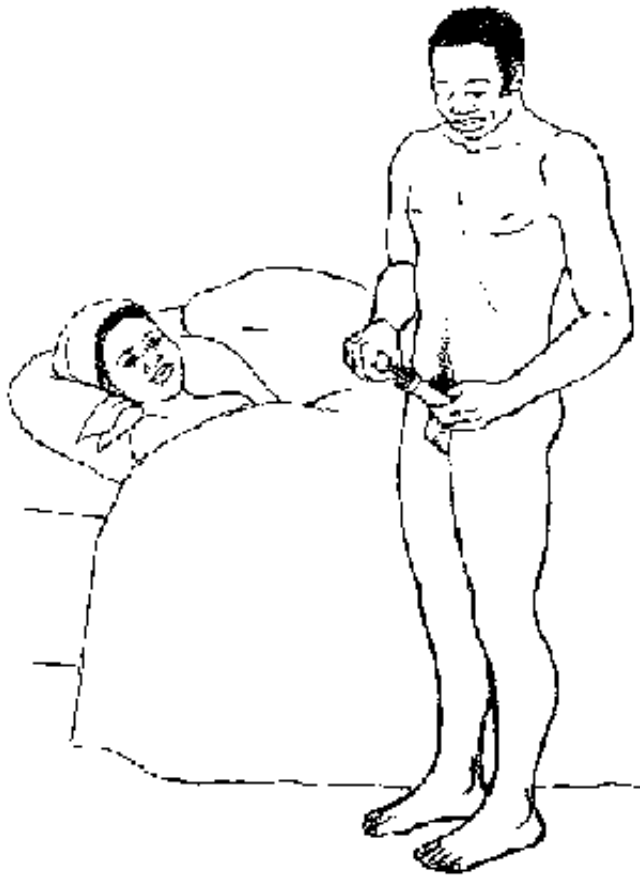
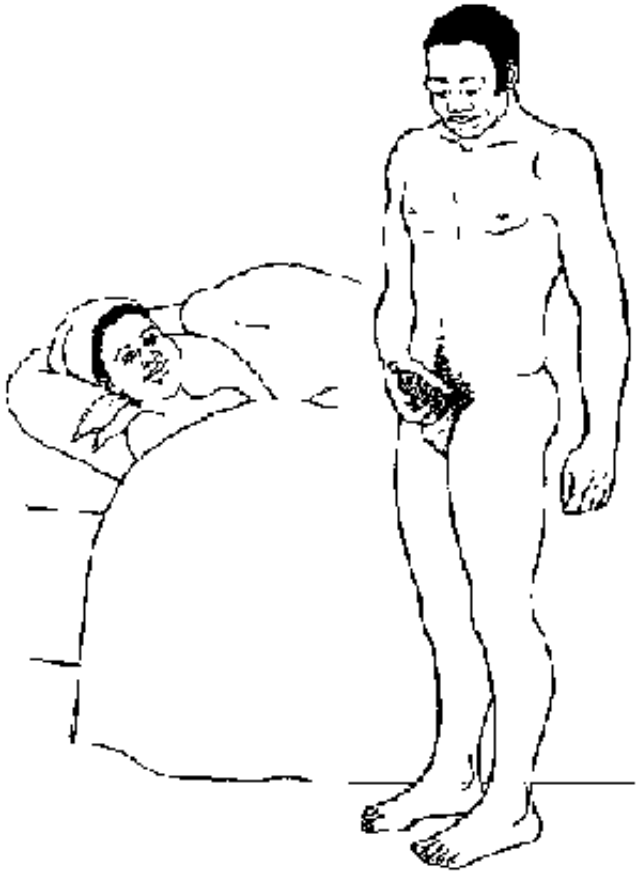


Figure 17.1: Condom or Sheath (cont.)

The steps in proper use of a condom include:

1. Place the condom over the erect penis, holding or pinching the tip of the condom so that there is some space;



Figure

2. Unroll the condom down the erect penis;

3. Hold the base of the condom when withdrawing from the vagina so that the condom is not left inside and so that none of the semen spills.

FEMALE CONDOM

Description: The female condom is a relatively new form of contraception which is still not available in many areas. It is a thin rubber sheath with two flexible rings,

one attached to each end (see Figure 17.2). One ring, at the closed end of the sheath, is placed inside the woman's vagina similar to the way a diaphragm would be inserted, and serves as an anchor. The other ring at the open end of the sheath stays outside the vagina and partially covers the lips of the vagina. It is used once and then thrown away. It also offers some protection against sexually transmitted diseases.

Effectiveness: The typical failure rate among users of the female condom is 21%.

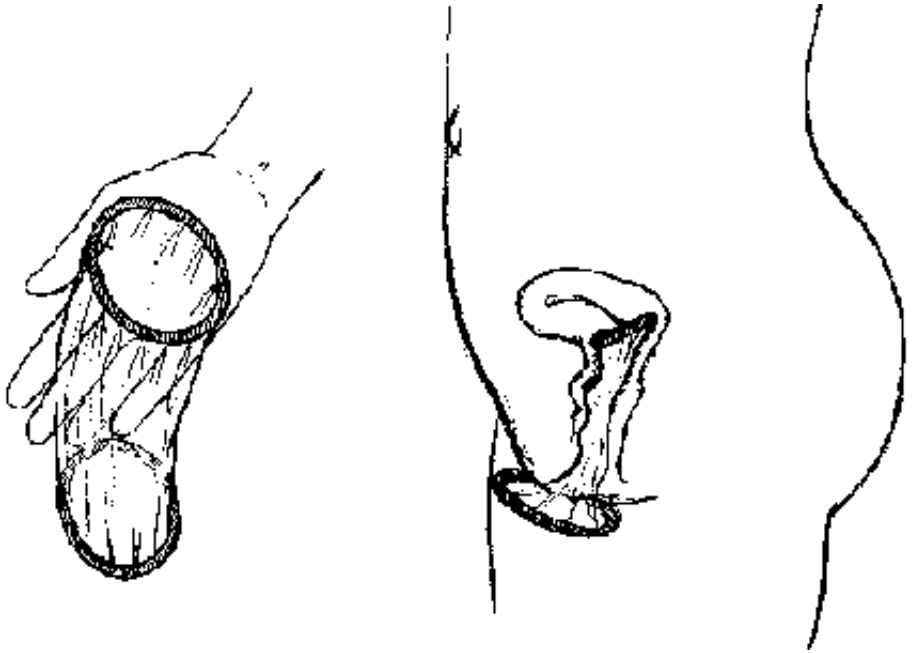


Figure 17.2: Female Condom

A thin rubber tube with rings at each end. It is inserted into the vagina before intercourse. This new method is not yet available in many areas.

DIAPHRAGM

Description: The diaphragm is a shallow rubber cup with a flexible rim. The woman puts spermicide inside the cup, then inserts it into the vagina before intercourse (see Figure 17.3). When correctly fitted and in its proper position, the diaphragm covers the opening of the womb and prevents semen from entering. Diaphragms come in different sizes; a woman must have a vaginal exam by a trained health worker to find out what size is right for her. A woman must also be taught the correct way to insert the diaphragm, and to check that it is in the correct position before sexual intercourse.

The diaphragm must remain in place for at least six hours and not more than 24 hours after intercourse. If the woman has intercourse again while she is still wearing the diaphragm, she should insert more spermicide into her vagina without removing the diaphragm. After it has been used, it needs to be gently washed with soap and water, air dried, and stored in a cool place. The diaphragm can be used again and again, although it should be checked periodically to make sure no holes have developed.

Effectiveness: The typical failure rate of the diaphragm is about 18%.

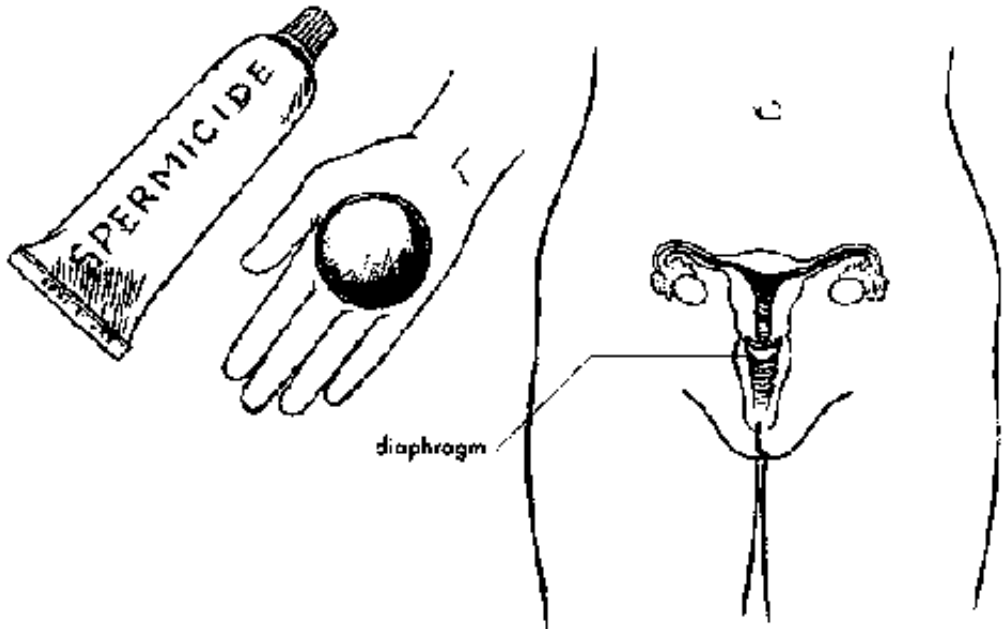


Figure 17.3: Diaphragm with Spermicide

A shallow rubber cup that is filled with spermicide, then placed inside the vagina before intercourse so that it covers the cervix.

CERVICAL AND VAULT CAPS

Description: These devices, also made of soft rubber, are an alternative to the diaphragm for some women (see Figure 17.4). They act in a similar way to the diaphragm but are smaller and cover only the cervix. After being inserted into the vagina, they work by preventing semen from entering the womb. They also come in different sizes and are used together with a spermicide. They can be left in longer than a diaphragm (up to 48 hours).

Effectiveness: The failure rate of cervical caps varies from around 18% for women who have had no children to 36% for those who have, because of differences in

the cervix and vagina.

CONTRACEPTIVE SPONGE

Description: The contraceptive sponge is a small round sponge containing spermicide. It is moistened with water, then placed inside the vagina before sexual intercourse. Each sponge is used only once, and should be thrown away after use. As long as it is left in, it will provide contraceptive protection for up to 24 hours no matter how many times intercourse occurs. It should be taken out six hours after intercourse.

Effectiveness: Failure rates are 36% for women who have had children before and 18% for those who have not.

ORAL CONTRACEPTIVES

These tablets, often referred to as "the pill", contain artificial forms of hormones (chemicals) produced by the body. The most common type of pill is called the combined oral contraceptive, or COC for short. The other type is called the progestogen-only pill (POP), or the "mini-pill". To use either one of these pills, a woman swallows one tablet at the same time every day, whether or not she and her partner have sexual intercourse (see Figure 17.5). Pills should not be shared with anyone else.

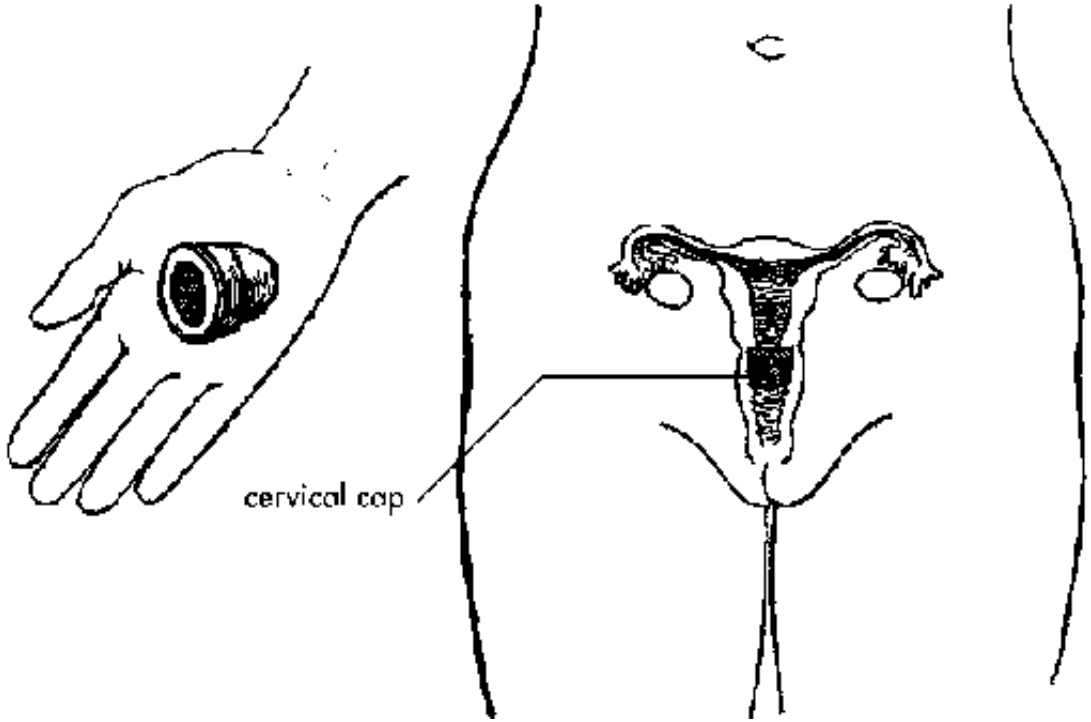


Figure 17.4: Cervical Cap

Similar to the diaphragm, except it is smaller. It is also used with spermicide.

If a woman misses taking the pill for even a few days, it is possible for her to get pregnant. If a woman misses a pill for three or more days in a row, she should use a condom or other barrier method to protect against the risk of pregnancy. Most women do remember to take the pill regularly. Others may have difficulty remembering to take their pills every day. If a woman has problems remembering to take the pills, she should seek advice from a family planning clinic about other contraceptive options or how to restart the pills.

Women on oral contraceptives should see a health worker at least once a year to

be checked. Some women believe they should only use the pill for a year or two, and then stop. This is not necessary; the method can be used for many years, provided the woman has regular check-ups.

COMBINED ORAL CONTRACEPTIVES (COCs)

Description: COCs contain a small amount of both types of hormones normally produced by a woman's body: oestrogen and progestogen. COCs prevent pregnancy by preventing ovulation.

Oral contraceptives may cause side-effects in some women. Usually these side-effects go away after the first three months. They may include: feeling sick in the stomach, weight gain, headaches, depression, breast tenderness, and irregular menstrual bleeding. If these side-effects do not go away, the woman may want to switch to a different kind of pill, or to another method.

Usually oral contraceptives reduce the amount of blood lost during menstruation.

Figure 17.5: Oral Contraceptives

Tablets that contain hormones; the woman swallows one tablet each day.

Box 17.1: ***Who Should Not Use Combined Oral Contraceptives***

A woman should not use oral contraceptives if there is any chance she may be pregnant, or if she:

- Smokes cigarettes and is over the age of 35
- Has any of the following conditions:

  High blood pressure

Blood clots
Heart disease
Cancer of the breast or cervix
Any unusual bleeding from the vagina

If she has any of these conditions and uses COCs, the condition may worsen or may require more careful monitoring.

Although some women are concerned by this, they can be reassured that it is not because the blood is staying inside. It happens because the lining of the womb builds up less when a woman is taking oral contraceptives. COCs also offer protection against some infections of the reproductive organs. When a woman stops taking the pill she is usually able to get pregnant again quite soon.

The most serious, and rarest, side-effect of the pill is that some women develop blood clots. If she falls into one of the categories listed in Box 17.1, a woman is more likely to develop complications from using the pill and should therefore use another method. For healthy women who do not have one of these risk factors, taking the pill is less dangerous than having a baby.

Effectiveness: Oral contraceptives are highly effective; their typical failure rate is around 3%.

PROGESTOGEN-ONLY PILL (MINI-PILL)

Description: POPs contain only progestogen, and no oestrogen. They work in three ways: they make the mucus (liquid) produced by the cervix too thick for the sperm

to go through, they change the lining of the womb so that it is difficult for a fertilised egg to attach itself, and they decrease ovulation. POPs can cause small amounts of bleeding from the vagina between menstrual periods; this may be inconvenient, but is not dangerous. They are ideal contraceptives for women who are breastfeeding a baby under six months of age. Since POPs do not contain oestrogen, they are relatively free of the more serious side-effects of COCs. Because POPs are a lower dose pill, it is important that they are taken at the same time every day. Women who miss one day are at much greater risk of becoming pregnant than those taking COCs.

Effectiveness: POPs are almost as effective as COCs in preventing pregnancy; their failure rate is also around 3%.

LONG-ACTING CONTRACEPTIVES

Long-acting contraceptives were designed to be easier to use. They need no special preparations before sexual intercourse, as condoms and foam do. And the woman does not have to remember to do something every day, as she must with the pill. Three types of long-acting contraceptives are injectables, implants, and intrauterine devices (IUDs).

INJECTABLES

Description: Injectable contraceptives contain progestogen. An injection is given every two or three months, depending on the type, either in the woman's arm or buttocks (see Figure 17.6). The hormones in injectables prevent pregnancy by causing changes in a woman's body similar to those caused by progestogen-only

pills (see above). Injectables can be used while breastfeeding the baby, since they do not decrease breast milk. They do have certain side-effects, however. These include:

- **Menstrual periods may become irregular or infrequent, or even stop altogether. This side-effect may be inconvenient but is not dangerous.**

- **Once a woman stops using the injectable, she may not begin ovulating and become fertile again for some time, occasionally for as long as 12-14 months.**

Effectiveness: Injectables are extremely effective; their failure rate is 0.3%.

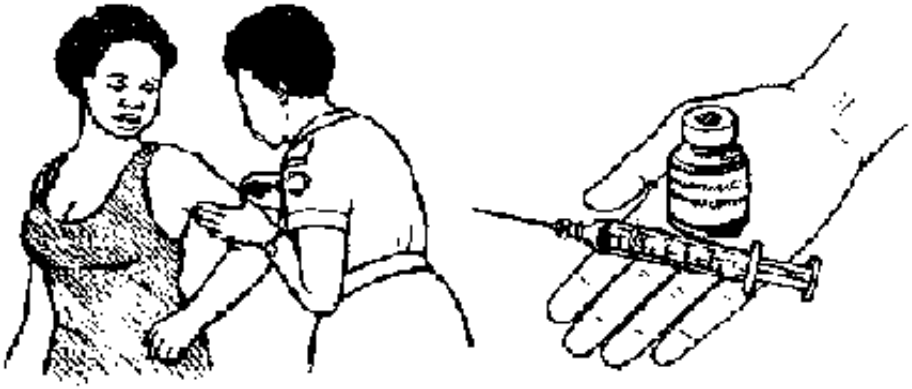


Figure 17.6: Injectable Contraceptive

An injection that is given to the woman every two or three months, depending on the type of injectable; the injection may be given in the arm or in the buttocks.

IMPLANTS (NORPLANT)

Description: Norplant consists of a set of six small, thin plastic tubes containing progestogen. They are placed under the skin of the upper arm through a small cut, during a minor operation (see Figure 17.7). Norplant must be inserted by a trained health worker, who will also remove it later. Once implanted the tubes cannot be seen easily, although they may be felt if the skin in that area is squeezed. Norplant prevents pregnancy by slowly releasing a little of the hormone into the body every day.

Norplant contains a smaller dose of progestogen than the pill or the injectable. It therefore has some of the same side-effects as other hormonal methods, especially the effects on menstruation, but these side-effects are usually minimal. During the first several months, bleeding may be irregular. There may be spotting in between periods, or the periods may be longer or more frequent. Usually menstrual periods will resume their normal pattern within 9-12 months. Once Norplant is removed, fertility returns quickly.

Effectiveness: Norplant is highly effective, with a failure rate of 0.09%. It remains effective for up to five years. It is slightly less effective in women who weigh more than 154 pounds (70 kilos).

INTRAUTERINE DEVICES (IUDs) Description: IUDs are plastic devices inserted into the womb through the vagina by a trained person. They are left in place for a period of time to prevent pregnancy (see Figure 17.8). Some are coated with copper, and some contain small amounts of the female hormone progestogen. Most IUDs have a short "tail" or string that the woman can feel by putting her fingers into her vagina. Generally the string is not felt during sexual intercourse by either partner.

Figure 17.7: Implants (Norplant)

Six small plastic tubes that are placed underneath the skin in the woman's upper arm through a small cut. The operation must be performed by a trained health worker.

Although IUDs need to be put in by a trained person, very little supervision or follow-up is necessary afterwards. A visit to a doctor or nurse once a year is required to check the position of the device.

IUDs are not suitable for all women, however, because they increase the risk of infection in the reproductive organs. A woman should not use the IUD if she has recently had a sexually transmitted disease or had a serious infection of the reproductive organs in the past. She should also avoid the IUD if she has many

sexual partners or her partner has other sexual partners. If she bleeds very heavily during menstruation, or has a disease of the womb such as fibroids, she should not use an IUD.

Side-effects of the IUD may include:

- **Bleeding from the womb and pain in the abdomen or back sometimes occur for a few days after an IUD is inserted. Spotting between periods and heavier bleeding during a period may also occur. Both of these symptoms should stop about three months after the IUD is inserted.**

- **The IUD may come out of the womb by itself, especially during a period, although this is not common. A woman should be taught to make sure the IUD is in place after each menstrual period. She can do this by feeling for the "tail" which lies within reach in the vagina.**

Effectiveness: Once correctly inserted, an IUD can be left in place and remains effective for several years. IUDs have a low failure rate: from 0.1% to 2%, depending on the type used.

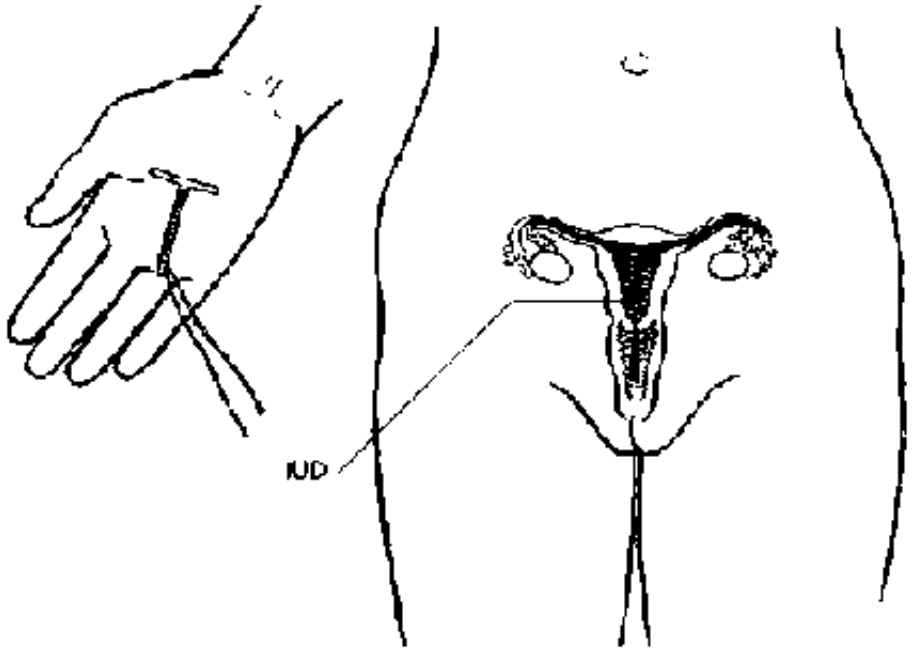


Figure 17.8: Intrauterine Device (IUD)

A device that is inserted into the womb through the vagina by a trained health worker.

MALE AND FEMALE STERILISATION

Sterilisation is the most effective and safest form of long-term contraception available. It is also permanent. Therefore, a couple should be very sure they do not want any more children before choosing this method. Sterilisation may also be a good choice if pregnancy would seriously endanger a woman's health. Although it has been possible in a few cases to reverse the operation, success is very rare. Both men and women sometimes fear that sterilisation will make them "cold" or change their sex life, self-image, or energy level. They should be counselled and reassured that the operation will not affect their ability to perform sexually, or

their capacity to enjoy sex.

MALE STERILISATION OR VASECTOMY

Description: Vasectomy, or male sterilisation, is a simple and minor operation. It can be performed by a trained person who need not be a doctor. First, an injection is made to numb or deaden the skin of the scrotum so that the man will feel no pain. A small incision (cut) is then made in the skin, and the vas deferens tube, which carries the sperm from the testes to the penis, is cut. The two ends are tied separately. The same procedure is carried out on the tube on the other side (see Figure 17.9).

If performed by a trained person in accordance with proper medical procedures, the incision heals quickly, leaving only a tiny scar. There may be slight infection or a small swelling at the incision, which will soon disappear. A new "no scalpel" method is also becoming more widely available. With this method a special instrument is used to make a small puncture in the skin instead of a scalpel incision. Because there is no cut, this method appears to have an even lower complication rate.

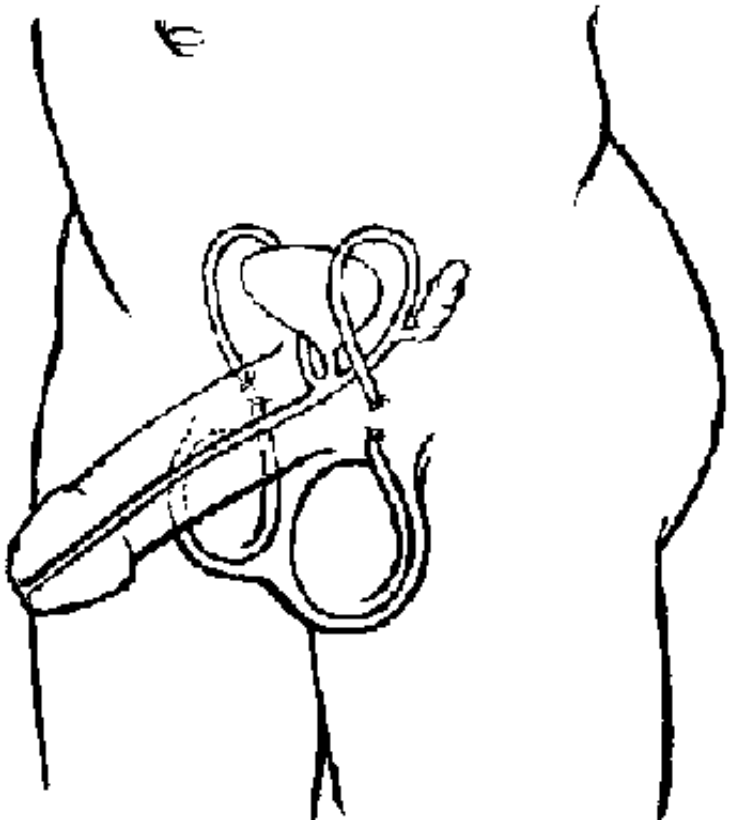


Figure 17.9: Male Sterilisation

A minor operation during which the tubes that carry sperm are cut and closed. The operation must be performed by a trained health worker.

After the man has the operation, he can still have sexual intercourse and ejaculate semen (liquid). However, the semen will not contain any sperm to fertilise the egg. Immediately after the operation is performed, sperm may still be passing with the semen. An additional form of contraception should be used for the first 15 ejaculations until all the sperm has been cleared.

Effectiveness: Male sterilisation has a failure rate of 0.15%.

FEMALE STERILISATION OR TUBAL LIGATION

Description: Sterilisation in the female involves cutting each fallopian tube in two and tying or burning the two ends separately (see Figure 17.10). To reach the fallopian tubes, the doctor gives the woman a pain-killing injection so that she will not feel anything, then cuts the skin of the abdomen. The most common procedure currently used is called the mini-laparotomy. With this procedure, the cut is made just above the pubic hair. The actual procedure is relatively simple, and the risk of complications is low if performed by a trained person in a good clinical setting. The risks of female sterilisation are higher, however, than for male sterilisation. This is because the operation is more serious. The most common complication is infection at the site of the cut. Other possible complications, which occur very rarely, are injury to the womb, bladder, or intestine. After this operation, a woman will continue to have periods as she did before.

Effectiveness: Female sterilisation has a failure rate of 0.4%.

NATURAL METHODS OF FAMILY PLANNING

Description: Natural methods of family planning include all methods that do not involve taking any drugs or using a device to prevent pregnancy. Most of these methods involve finding out when during the menstrual cycle ovulation occurs. The woman then needs to cooperate with her partner to avoid sexual relations during the days when she is likely to get pregnant. Sometimes couples combine natural family planning with the use of barrier methods. This means they use natural methods to determine when the woman is likely to get pregnant, and use a condom, diaphragm, or other barrier method during those days.

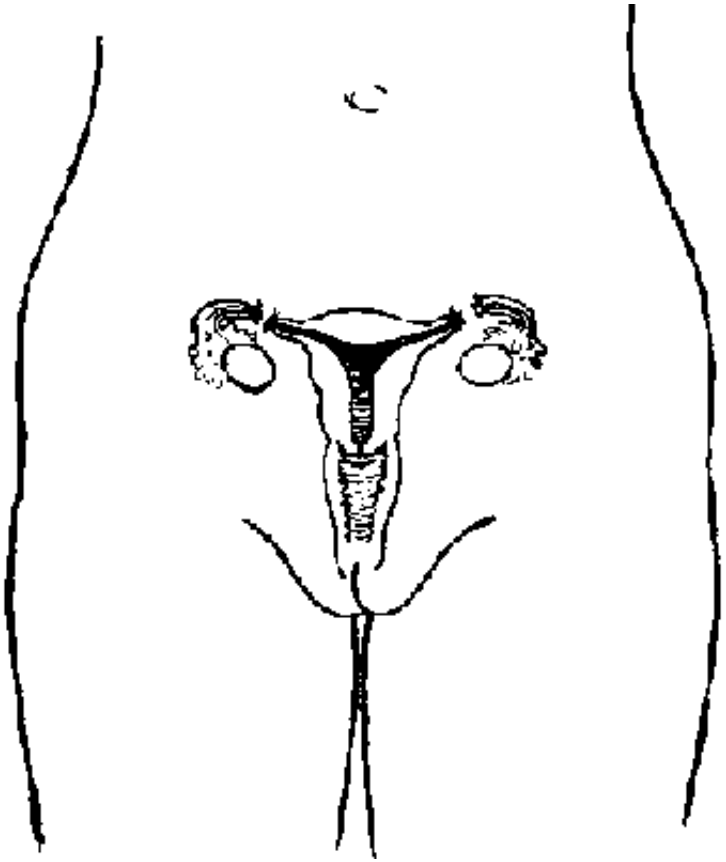


Figure 17.10: Female Sterilisation

An operation in which the tubes that carry the eggs to the womb are cut and sealed. The operation must be performed by a trained health worker.

Menstruation and ovulation are described in Chapter 4. That chapter describes the process by which a woman's body releases a mature egg, ready to be fertilised by the man's sperm. A woman can become pregnant if she has sexual intercourse one, two, or three days before ovulating, the day of ovulation, or one day after. This period is known as the fertile phase. The rest of the menstrual cycle, when there is no egg to be fertilised, is the infertile phase or the "safe period". To use

the natural method of family planning, couples have to avoid sexual intercourse during the fertile phase. Since it can be difficult to tell exactly when ovulation takes place, the best way is to avoid intercourse for about ten days out of every month around the time of the fertile phase.

There are several ways to find out when ovulation occurs. These methods are described only briefly here. If a couple is interested in using one of these methods, they should ask a trained health care provider for more details. These methods can also be used when a woman is trying to become pregnant to help her identify her fertile time.

CALENDAR METHOD: It is possible to use a calendar to estimate the fertile period. If a woman has a very regular cycle (that is, menstruation occurs every 28 days or very close to that), this method is fairly easy to use. Since ovulation occurs about 14 days before the next period is due, a woman should count backward 14 days from when her next period is expected to calculate the day she will ovulate. She should avoid sex from about seven days before that day until about two days after. If a woman's menstrual periods are not very regular, this method can still be used, but it is much more difficult and complicated. A record must be kept for about eight months, and then calculations made to determine the approximate fertile phase.

TEMPERATURE METHOD: A woman's body temperature rises slightly (½ degree centigrade) immediately before ovulation and remains high for several days. To identify her fertile period, a woman must record her body temperature (taken before getting out of bed in the morning) for several months. This indicates when in her menstrual cycle ovulation is taking place. This method may be difficult or

impossible to use if her temperature rises because of malaria or other diseases. It can also be difficult to obtain a thermometer, and for people to read and record the temperature properly.

CERVICAL MUCUS TEST: The cervix, or the neck of the womb, produces a fluid called mucus which has a different thickness on different days of the menstrual cycle. Around the time of ovulation, there is a lot of mucus and it feels watery, thin, and slimy. Intercourse should be avoided at this time. During the rest of the cycle, there is not as much mucus and it feels thicker and drier. In order to test the mucus, a woman can put her finger into her vagina and feel the texture of the secretions. During ovulation the mucus makes a long string between the fingers when separated.

There are other methods of family planning that are considered "natural" because they do not involve using any devices or medicines. These methods differ from the ones described above because they do not depend on calculating when ovulation occurs.

WITHDRAWAL: This method of avoiding pregnancy requires the man to withdraw his penis from the vagina before he ejaculates or "comes". It is undoubtedly the most widely used form of family planning since Biblical times. The main problems are that it requires great self-control on the part of the man, and is not very reliable.

LACTATIONAL AMENORRHOEA METHOD (LAM):

In most women, breastfeeding delays ovulation and the return of menstruation. In

fact, a woman is protected against pregnancy as much as 98% of the time for the first six months after having a baby, if the following conditions are met: she has not started her menstrual periods, and she is fully breastfeeding (giving the baby only breast milk, and feeding on demand). If her menstrual period starts or if she begins giving the baby food supplements, she must immediately start using another family planning method to avoid pregnancy. The preferred methods during this time are barrier methods or methods that rely on the hormone progestogen (mini-pills, injectables, or implants). Methods that include the hormone oestrogen reduce the mother's supply of breast milk.

The natural family planning methods described above are the only types of family planning approved by the Catholic Church. There are no physical side-effects as there may be from drugs or devices. For some women, however, it can be very difficult to determine exactly when ovulation occurs, which is why these methods have a relatively high failure rate.

Effectiveness: The overall failure rate of natural methods of family planning is about 20%. This may be greatly improved depending on the motivation and willingness of the couple, and if two or more methods are combined.

TRADITIONAL METHODS

Most cultures have a variety of traditional methods that are believed to prevent pregnancy. These include using charms or spells, such as tying a string around the waist, drinking teas made from certain leaves or roots, or eating certain foods. There is no scientific evidence that these methods work; in fact, there is quite a bit of evidence that they do not. Some people also believe that jumping up and down

or exercising in other ways just after sexual intercourse will prevent pregnancy. Sometimes women try douching, or washing the semen out of the vagina, immediately after intercourse. These methods do not work because sperm reach the womb and the fallopian tubes very quickly. Less than a minute after the man has ejaculated in the vagina, sperm have already reached the fallopian tubes. If an egg is available, a sperm may have already fertilised it.

As long as a traditional method does no harm, there is no reason to discourage people from practising it; but they should be strongly advised to use another method as well, such as one of the methods described earlier in this chapter.

Summary: Family Planning and Child Spacing	
FAMILY PLANNING METHODS VARY WIDELY, AND CAN BE DIVIDED INTO SEVERAL CATEGORIES:	**FAILURE RATE:**
BARRIER METHODS: These prevent the sperm from fertilising the egg. CONDOM: A latex rubber tube which is closed at one end. It is placed on the man's penis before sexual intercourse.	12%
FEMALE CONDOM: A thin rubber sheath which is placed inside the vagina before sexual intercourse.	21%
SPERMICIDES: Chemical contraceptives placed inside the vagina before intercourse. Often used together with other barrier methods.	21%
DIAPHRAGM: A rubber cup with a flexible rim. It is inserted into the vagina before intercourse and placed so that it covers the opening of the womb.	18%
CERVICAL CAP: A small rubber cup similar to the diaphragm.	18-36%
SPONGE: A sponge with spermicide. It is placed inside the vagina before	18-36%

intercourse.	
ORAL CONTRACEPTIVES ("THE PILL"). Tablets containing hormones. The woman has to swallow a tablet every day.	
COMBINED ORAL CONTRACEPTIVES (COCs): Contain oestrogen and progestogen.	3%
PROGESTOGEN-ONLY PILLS (POPs, OR "MINI-PILLS"): Contain only progestogen.	3%
LONG-ACTING CONTRACEPTIVES INJECTABLES: An injection containing hormones that prevents ovulation. Given to the woman every 2-3 months.	0.3%
IMPLANTS: Several small, thin plastic tubes that are placed in the upper arm of the woman through a minor operation. The tubes contain a hormone that prevents ovulation. The implants must be inserted by a trained health worker.	0.09%
INTRAUTERINE DEVICE (IUD): A plastic device inserted in the womb by a trained health worker.	0.1-2%

Family Planning and Child Spacing (cont.)	
FAMILY PLANNING METHODS VARY WIDELY, AND CAN BE DIVIDED INTO SEVERAL CATEGORIES:	**FAILURE RATE:**
SURGICAL CONTRACEPTION: These two methods are permanent and irreversible. Both must be carried out in a properly equipped health facility, by a trained health worker.	
MALE STERILISATION (VASECTOMY): An operation in which the vas deferens, which carries sperm, is cut and sealed. This prevents sperm (but not semen) from leaving the man's body.	0.15%

FEMALE STERILISATION (TUBAL LIGATION): An operation in which each fallopian tube is cut and tied to prevent the eggs from reaching the womb.	0.4%
NATURAL METHODS: These include a variety of methods that do not involve the use of medicines or devices to prevent pregnancy. For most of these methods, the woman uses various signs or calculations to determine when she can become pregnant, and avoids having intercourse during that time.	20%

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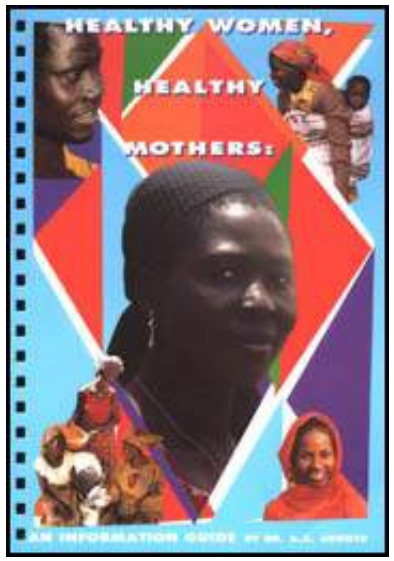


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EVALUATION FORM

PREFACE

As an obstetrician/gynaecologist who has worked in public health in Africa for many years, I have had the opportunity and the privilege to see women's health issues from a variety of perspectives. As a physician, I have delivered babies and cared for hundreds of women. As a programme manager, I have tried to ensure that essential services are available to meet women's needs. In the process, I have seen the powerful effect that information can have in changing women's lives by helping them gain the knowledge and the confidence to take care of themselves.

My main motivation in writing this book, therefore, was to present the basic information that women need to go through life in a healthy state of mind and body. Many women's health problems, including the complications of childbearing, could be prevented, or made less serious, if two things could be achieved: first, if women understood better how to take care of themselves before, during, and after pregnancy; and second, if they could recognise the early signs of complications and get treatment. Women's health and happiness is an important and valuable goal in itself. Experience from around the world has shown that it is also a basic requirement for a healthy baby, and indeed for a healthy family.

Many women cannot read, and their access to radio, television, and printed materials is often limited. Whatever information they receive about health issues

usually comes from trained health workers, especially nurses and midwives. This book is meant to serve as a resource to help these health workers provide complete and accurate information on women's health needs and problems. By using simple language and including many illustrations and boxes that summarise key points, my hope is that this book will be used for face-to-face counselling, for small group discussions, and to prepare posters, pamphlets, and other educational materials on women's health. It can also be used by others in the community who share information with women; these may include representatives of women's groups, traditional healers or birth attendants, and local leaders, as well as neighbours, family, friends - and women themselves.

This publication is a revised edition of *Your Health, Your Pregnancy: A Guide for the African Woman,* which was published in 1992. This new edition reflects the recommendations and responses of readers and users throughout Africa who participated in an evaluation of the first edition. Four major changes have been made: first, the book is targeted more specifically for health personnel and others who work with women at the community level; second, it covers a broader range of reproductive health issues, including the needs of adolescents; third, it includes more references to traditional practices and beliefs; and fourth, it contains many more illustrations and boxes. The book still emphasizes pregnancy and childbirth, because the complications of childbearing remain the leading cause of death and illness among women in Africa today.

Healthy Women, Healthy Mothers is the first of a set of materials published by Family Care International. The other two publications are *Getting the Message Out: Designing an Information Campaign on Women's Health,* a booklet that outlines the step-by-step process of producing health education materials on

women's health; and *Strengthening Communication Skills for Women's Health: A Training Guide.* (Information on how to request copies of these publications is provided in the order form at the end of this book.) Together or individually, these publications are designed to help organisations in Africa - ministries of health, family planning associations, women's groups, church organisations, and others working at the community level - in their efforts to promote better health for women and to reduce the number of deaths and disabilities caused by pregnancy and childbirth.

I hope that the information in this book will reach many of the women in Africa for whom pregnancy entails such hope and, sometimes, fear. It is written for the sake of their families, for the sake of their unborn children, and most of all for the sake of the women themselves.


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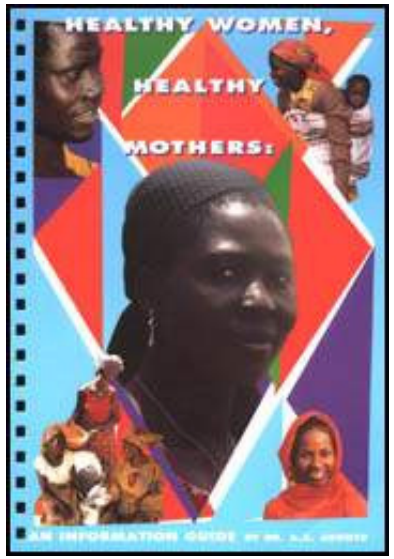

Healthy Women, Healthy Mothers - An Information Guide - Second Edition (FCI, 1995, 241 p.)

Chapter Eighteen - SEXUALLY TRANSMITTED DISEASES

Sexually transmitted diseases (STDs) are diseases that are passed from one person to another through sexual intercourse. They are sometimes called "venereal diseases". Some STDs can cause very serious complications and even death. Often, a person may have more than one STD at a time. It is very important to be aware of how STDs are caught as well as the signs of STDs.

Sexually transmitted diseases are widespread throughout the world, and they are on the increase almost everywhere. Many factors account for the growing number of people who have STDs. Many more people live in or travel to large cities these days, separated from their families. This gives them more opportunities, or more temptation, to have sexual relations with someone other than their husband or

wife. Also, many people become sexually active before marriage.

In addition, many of the germs that cause STDs are easily transmitted from person to person. It is possible to catch the disease even after only one act of sexual intercourse with an infected person. Some STDs can no longer be treated successfully with the medicines that were used in the past, because the germs that cause the disease are now resistant to the medicines. For these reasons, STDs are becoming more common in many areas. Anyone can get an STD - not just prostitutes or people with "loose morals".

The Most Common STDs

Many different types of germs can cause STDs. The most common STDs are gonorrhoea, chlamydia, syphilis, chancroid, genital herpes, genital warts, trichomonas, and AIDS. The next few pages will focus on those STDs that have important and significant health implications.

STDs are a problem not only because they cause pain and illness, but also because they can cause long-term complications in a woman and her child, as well as in a man. Some STDs can be passed from mother to baby either during pregnancy or during delivery. This can cause serious illness in the baby.

Most men can tell when they have an STD because there are usually clear signs. Women, however, often have an STD without knowing it, because there are often no signs that they have the disease. Sometimes only an experienced and trained person can find signs of an STD in a woman. This is especially true during pregnancy, when many STD symptoms (for example, an increase in the amount of

fluid produced by the vagina) are mistaken for side-effects of pregnancy itself. Sometimes it is necessary to examine samples of a woman's blood or vaginal discharge to find out if she has an STD, and which type of STD she has.

Counselling and treating women and men with STDs requires sensitivity and understanding. People are often embarrassed or ashamed of having an STD. They may not want to talk about their symptoms or how they got the disease. It helps if the health workers who are treating them are patient and non-judgmental. They should not be blamed for getting the disease. It is also very important for health workers to encourage both men and women to tell their sexual partners that they also need to go for treatment. Otherwise, the person can be reinfected if he or she has sexual relations with the infected person again.

If a woman needs to have a vaginal examination to diagnose an STD, it may help her feel more comfortable if the tests and procedures being used are explained to her. If she has to be referred to another health facility or hospital for laboratory tests and treatment, the importance of this treatment should be clearly explained.

If a treatment is not effective for some reason, referral may be necessary so that another drug can be prescribed.

GONORRHOEA

Gonorrhoea is the most common STD. In men, the disease usually causes a burning sensation when passing urine and a thick discharge from the penis. These symptoms begin within a week of being infected (see Figure 18.1). Some women have the same symptoms - pain with urination and discharge from the vagina -but

about 80% of women have no symptoms at all. Therefore, it is very important for a man to tell his wife or sexual partner that he has the disease, since she is likely to have it as well but may not know it. Even if there are no symptoms, the disease can be transmitted. It is possible to catch gonorrhoea from just one act of sexual intercourse with an infected person.

Gonorrhoea can be a serious disease. It can usually be treated with penicillin, but not always. If penicillin is not effective, other drugs that can be used are cefixime, ceftriaxone, ciprofloxacin (which should not be given to pregnant women), and spectinomycin. If the symptoms do not go away within a week of treatment, the patient needs to go back to the clinic and get another type of antibiotic. All the tablets prescribed by the doctor must be taken to make sure the disease is completely gone.

If a pregnant woman has gonorrhoea that is not treated, there is a chance that her baby will catch the infection in the eyes. This can lead to blindness. If a woman has gonorrhoea repeatedly or does not seek treatment, she may develop pelvic inflammatory disease (PID), an infection of the reproductive organs. PID is a very serious disease. Its signs are constant lower abdominal pain, painful menstruation and menstrual disorders, fever, and bad-smelling vaginal discharge (see Figure 18.2). Sometimes the symptoms of PID go away without treatment, but this does not mean that the disease has been cured. There can still be serious complications. If a woman with PID does not get treatment, the fallopian tubes can become blocked from scarring, and she can become infertile. Some 15-20% of women who develop PID become infertile (see Chapter 19).

Figure 18.1: Signs of an STD in Men

The most common STDs are gonorrhoea and chlamydia; signs of these diseases in men include a burning sensation while urinating, and a thick discharge from the penis. They can be treated in most health clinics, and in special STD clinics.

Figure 18.2: Signs of Pelvic Inflammatory Disease (PID)

If an STD such as gonorrhoea or chlamydia is not treated, it can lead to PID. The signs of PID are constant pain in the lower abdomen, painful menstruation, fever, and bad-smelling discharge from the vagina. A woman with these signs should seek treatment immediately.

CHLAMYDIA

Chlamydia is an infection of the tissues lining the urethra and the opening of the womb. It is becoming common in Africa. In some countries, as many as one in five women attending antenatal clinics have the infection without even being aware of it. The signs of chlamydia are similar to those of gonorrhoea, except they are usually milder. Up to 75% of people with chlamydia have no symptoms at all. The disease can be treated with tetracycline or doxycycline, although these should not be given to pregnant women. Alternative treatments are erythromycin or sulfisoxazole.

If not treated correctly, chlamydia can lead to the same complications as gonorrhoea, such as PID and infertility. It can also cause infertility in men. If a pregnant woman has chlamydia and is not treated, her baby is likely to weigh less than normal because the disease affects the growth in the womb. The baby can also catch the infection during delivery. If untreated, this may cause an eye infection or, in severe cases, pneumonia in the newbom.

SYPHILIS

Syphilis has been around for thousands of years. At one time it appeared to be on the decline as a result of the widespread use of penicillin. Recent studies indicate, however, that the disease is becoming more common. Syphilis is a very serious disease for women, especially pregnant women, because it can be passed on to the baby during pregnancy or labour, with tragic consequences. One-third of the babies born to women with untreated syphilis are born dead. Another third are born with syphilis. Children born with syphilis are often deaf, blind, or mentally retarded; many of them die very young.

Like other STDs, syphilis is transmitted during sexual intercourse with an infected person. The first signs of syphilis usually show up about 25 days after infection, but are easy to overlook. They consist of a small and painless sore in the genital area or vagina, which heals by itself in 3-4 weeks. There may be swellings in the genital area which are not painful. The second stage of syphilis is marked by fever, headaches, and pain in the bones and muscles, usually 6-8 weeks after infection. A rash, which causes no itching, appears on the body, particularly on the soles of the feet and palms of the hands. Warts may appear in the genital area.

The third and last stage of syphilis may not appear for many years; in some cases, as long as 15 or 20 years. By this time the disease has attacked almost the entire body: the heart and major blood vessels, the bones, and the nervous system, including the brain. Late syphilis causes insanity and eventually death from damage to one of these organs. This late stage of the disease is rarely seen any-more because syphilis can be effectively treated at any stage with injections of penicillin.

CHANCROID (GENITAL SORES)

This disease causes shallow, painful sores or ulcers around the genital area and inside the vagina. The sores are accompanied by painful swelling in the genital area. Without treatment, the sores take 2-3 months to heal. Women often have the disease without developing any symptoms, but they can still transmit the disease if they have sexual intercourse. Chancroid does not affect newborns. Like syphilis, it can be treated with penicillin. Chancroid is a serious cause for concern because a woman with chancroid has a high risk of getting the virus that causes AIDS if she has sexual relations with someone who has that virus.

GENITAL HERPES

Herpes is a disease that causes painful, swollen blisters or sores on the penis in a man, and in the vagina of a woman. It can also cause sores in the anus. These sores are usually tender or itchy. The disease is caused by a virus. Unfortunately, herpes cannot be cured. After the first outbreak has healed, the sores can come back. The disease can be transmitted when the sores are actually present, or just before the sores come back. It is possible to tell when the sores are coming because there is a feeling of burning or itching at the place where the sore will come. Sex should be avoided or a condom should be used from the time the itching is felt until the sore has completely disappeared and the skin is whole again. Herpes is not a serious disease in itself, although it can be uncomfortable; but the open sores can make a person much more likely to catch other STDs, including AIDS. A pregnant woman who has an active outbreak of herpes at the time of delivery should have a Caesarean section. The baby can catch the disease by coming into contact with the sores.

GENITAL WARTS

Genital warts are fleshy growths in the genital area caused by a virus. They are not painful. They are easily transmitted from person to person by sexual contact. The warts can be removed, but they are likely to grow again. Treatment usually involves applying an acid preparation repeatedly to the warts. There are many types of viruses that can cause genital warts. Some of these viruses have been linked to an increased risk of getting cancer of the cervix. A woman who has genital warts should have a Pap smear every year to check for cervical cancer.

TRICHOMONAS

Trichomonas is an infection caused by germs or bacteria. The signs are increased fluid from the vagina, and fluid that looks frothy. Itching and pain with urination may also be signs of a trichomonas infection. The disease is diagnosed by looking at fluid from the vagina under a microscope. It may cause low birth weight babies, or premature labour. Trichomonas is easily treated with metronidazole.

CANDIDIASIS

Candidiasis is actually not a sexually transmitted disease, although its symptoms - increased fluid from the vagina and itching - may be confused with other, more serious infections. Candidiasis, otherwise known as a "yeast infection", occurs when some of the bacteria or germs that are normally found in the vagina grow out of control. It can be diagnosed by examining a sample of fluid from the vagina under a microscope. It is treated with medicated suppositories or creams placed in the vagina. Wearing loose clothing or cotton underwear and not douching will help prevent yeast infections. Candidiasis is common during pregnancy, but it will not hurt the baby. If a woman has Candidiasis repeatedly, or if the case is very severe, it may be a sign that she is infected with HIV.

BACTERIAL VAGINOSIS

Like candidiasis, bacterial vaginosis (BV) is not considered a sexually transmitted disease. The signs of BV are an increase in the fluids from the vagina, vaginal fluids that have a bad smell, and sometimes itching. As with candidiasis, the disease is diagnosed by looking at the vaginal fluids under a microscope. It is

treated with metronidazole. If a pregnant woman has BV it should be treated since it may cause premature rupture of membranes. However, the disease poses no direct threat to the baby.

Acquired Immune Deficiency Syndrome (AIDS)

AIDS is a very serious STD, a deadly disease for which there is no cure. The disease is the result of infection with the virus known as the human immunodeficiency virus, or HIV. Everyone infected by HIV will eventually develop the disease AIDS.

The virus kills by attacking and destroying certain white cells in the blood that defend the body against diseases. Once a person is infected, the virus can remain in the body for many years without any sign that something is wrong. This phase can last for as little as a few months, or as long as ten years. During this phase an infected person appears healthy and may not even know he or she has the virus, but the disease can be transmitted to others.

Once AIDS actually develops, the infected person begins to get sick often because the body is less able to fight off diseases. In Africa, the most common symptoms are fever, diarrhoea that will not go away, severe weight loss, persistent cough, tiredness, loss of appetite, and skin diseases. The most common diseases developed by people with AIDS are tuberculosis, cancer, meningitis, pneumonia, and - for women - gynaecological infections.

HOW IS HIV TRANSMITTED?

HIV infection is spreading very quickly in sub-Saharan Africa. Scientists believe

that already about eight million people are infected, and more than 600,000 have developed the disease. HIV is not transmitted in any of the following ways: by sitting on toilet seats, sharing drinking cups or utensils, touching or other casual physical contact with an infected person (such as hugging or shaking hands), or mosquito bites. The virus can be transmitted in three ways:

SEXUAL TRANSMISSION: The virus is usually passed from one infected person to another through sexual intercourse. About 80-85% of the people in Africa who have HIV were infected through sexual transmission. This happens because the virus is present in the semen or vaginal fluids of an infected person. Sometimes the virus is caught during only one act of sexual intercourse with an infected person. Other times a person has sex many times with an infected person and still does not get the virus. To help protect themselves against the virus, people should:

- **Use latex (rubber) condoms every time they have intercourse.**
- **Avoid sexual intercourse if they or their sexual partners have a sexually transmitted disease. If one person has an STD and one person also has HIV, the chances of transmitting HIV are very high.**
- **Avoid having sexual relations with different people. In fact, the best way to avoid getting AIDS is to stay with one person who does not have the HIV virus and who does not have sexual relations with other people.**
- **Avoid causing scrapes, cuts, or scratches in the genital area when having sexual intercourse. Women who have been circumcised may be at**

increased risk for catching the virus, since sexual intercourse is more likely to cause bleeding and cuts. Anal sex should also be avoided since this causes sores that can easily be infected by the HIV virus.

TRANSMISSION THROUGH BLOOD OR BLOOD

PRODUCTS: Since the virus is present in the blood of an infected person, it is possible to catch it if some infected blood gets inside the body. This can happen through blood transfusions with infected blood, or through injections with a needle that has not been sterilised. Women sometimes need blood transfusions during pregnancy and childbirth if they have severe bleeding or a serious case of anaemia. This means they are especially likely to get HIV through transfusions with infected blood. It has also been suggested that some rituals, such as female genital mutilation, male circumcision, and scarification (tribal markings), could transmit the virus by sharing blood on instruments. The best way to avoid transmission through blood is for health workers to:

- **Make sure that needles and surgical instruments are always sterilised.**
- **For blood transfusions, use only blood that has been tested.**
- **Wear surgical gloves during delivery, when there is the risk of being exposed to large amounts of blood.**

In addition, communities should be encouraged to avoid rituals that involve cutting the skin, or to make sure that the instruments are sterilised.

MOTHER TO INFANT: If a pregnant woman is infected with the HIV virus, her

infant will also get the virus in about 25% of the cases. HIV-infected infants usually become seriously ill by the age of six months. Most die before they are two years old. It is not known for sure whether transmission from mother to child takes place before, during, or after childbirth. HIV can be present in the milk of an infected mother, and there have been a few cases where the virus was transmitted to a baby through breast milk. However, because breastfeeding has so many benefits for the baby (see Chapter 15), it is recommended that women continue breastfeeding even if they are infected with HIV.

HOW TO TELL IF A PERSON HAS BEEN INFECTED BY HIV

The only way to tell whether someone has been infected by HIV is to have a blood test to see whether the antibodies to HIV are in the blood. Otherwise infection can only be confirmed when the disease AIDS has developed.

The blood test for HIV antibodies is fairly widely available now. Most hospitals and blood banks can do it. Some cities have clinics or counselling centres that can perform the blood test (see Figure 18.3). It is important to get diagnosed early so that the infected person can take steps not to infect other people.

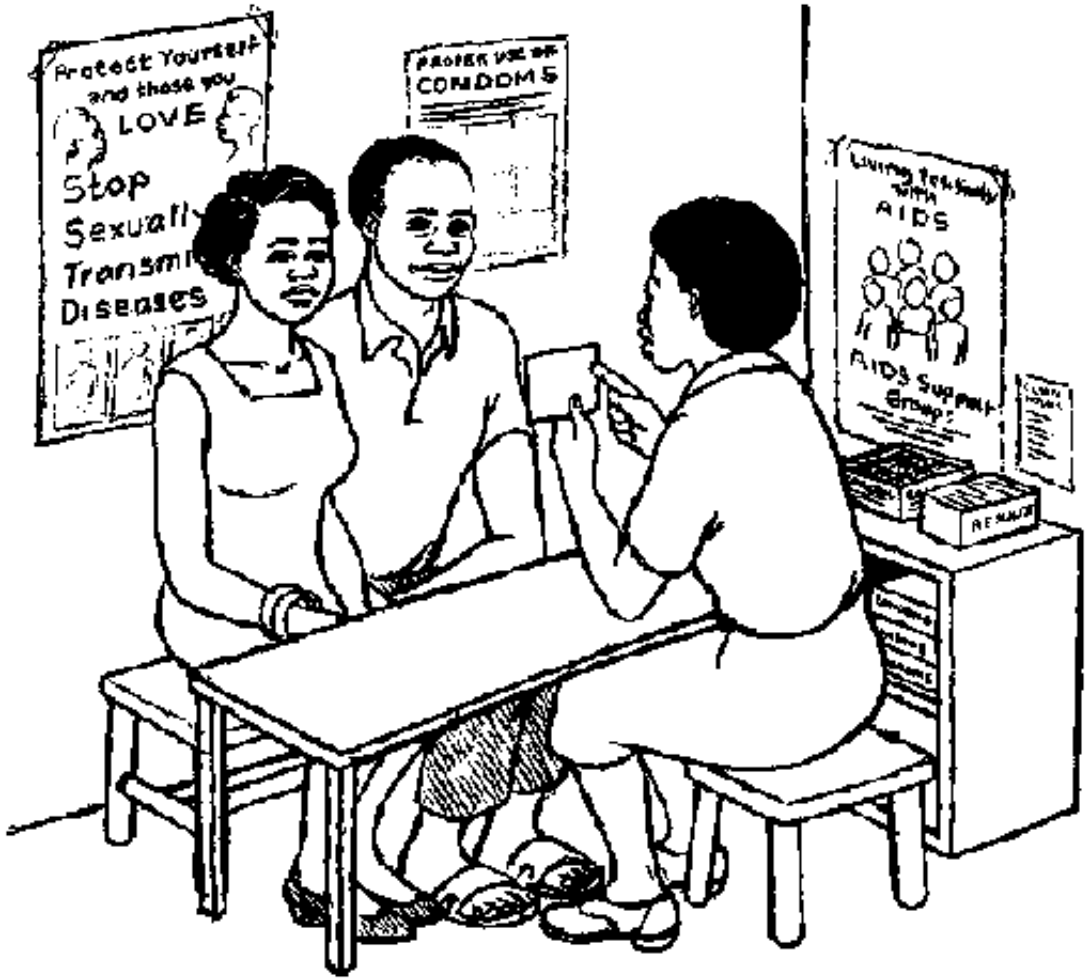

Figure 18.3: Testing and Counselling for HIV/AIDS

Many cities now have clinics or centres where a person's blood can be tested for signs of HIV, the virus that causes AIDS. Couples may want to be tested before marrying, or before having a child. The test should always be accompanied by counselling from a trained person.

Box 18.1: ***Kev Facts About AIDS***

AIDS is an STD which is 100% fatal; there is no cure. AIDS weakens the body's immune system, making it susceptible to other diseases which lead to death.

HOW AIDS IS TRANSMITTED:	**WAYS TO AVOID IT:**
SEXUALLY: During sexual intercourse	• Don't have intercourse with more than one person • Don't have intercourse that causes cuts or scrapes in the genital area • Avoid having intercourse with people who already have HIV or other STDs • Always use a condom
THROUGH BLOOD: By contact with HIV-infected blood, such as from a needle, a blood transfusion, or a cut	• Only use sterile needles • Use surgical gloves • Test blood used for transfusions, and use only non-infected blood • Avoid genital mutilation and rituals that cause bleeding
FROM MOTHER TO INFANT: A pregnant woman who has HIV can pass it along to her infant	• A woman who is HIV positive should not get pregnant

Signs of HIV/AIDS: The only way to tell if someone has HIV is through a blood test. Even people who appear healthy can have the virus, and can infect others.

IS IT POSSIBLE TO PREVENT OR CURE AIDS?

Right now, there is no cure for AIDS. Nor is it likely that there will be any vaccine in the near future. If a person is already infected, certain medicines may delay the onset of symptoms. These medicines are very expensive, however, and are only available in Europe and the United States.

The best way to avoid getting infected with HIV is not to have sexual relationships at all, or to have relations only with someone who is not infected and is faithful. The next best option is to use a condom, but condoms are not 100% effective. A condom can prevent sexual transmission of the HIV virus only if it is used correctly so that no semen spills, and if the condom does not break. Even if they have been stored properly, about one out of every 100 condoms breaks. Another way to reduce the chance that a condom will break is to make sure that the vagina of the woman is wet or lubricated. Creams or oils can be used (except for petroleum jelly, which can damage the condom).

Many women find it very difficult to start a discussion about AIDS with their husbands, and to suggest that they use condoms. It might appear that they think their husbands are not being faithful, or it might make their husbands suspect them. One way to begin talking is to raise the possibility of infection from an injection or blood transfusion. This way, AIDS can be brought up without talking about sexual relations right away. AIDS can be a life or death issue. Everyone owes it to themselves, their children, and their families to do something if they

think there is a chance they have been infected, or might become infected.

Prevention and Treatment of STDs

The popular saying "prevention is better than cure" is very true in the case of sexually transmitted diseases. In the first place, anyone can have an STD. Since the signs are often difficult to see, it is hard to tell who has an STD. Therefore, having sexual intercourse with a number of people should be avoided, since this increases the chance that one of them might have an STD. People who continue to have sexual relations with several partners should at least use condoms. Condoms, particularly if used together with spermicides, offer protection against catching STDs, although this protection is not 100% guaranteed.

In women, the signs of STDs are often not obvious, so diagnosis is more difficult. Those who believe they might have an infection should go to a health facility. Any unusual amount of vaginal discharge, pain during urination, or sudden lower abdominal pain should be investigated. Ulcers, sores, or warts around the genital area also require a visit to a health facility. All women should get a blood test early in pregnancy to check for syphilis so that treatment can be given soon to protect the baby.

Health centres or clinics, especially in rural areas, do not always have the laboratory facilities to test for STDs. Various organisations have developed charts that say what kind of treatment can be given, depending on the symptoms the person has and his or her sexual history (for example, a woman whose husband has a discharge from his penis is almost certain to have gonorrhoea or chlamydia). If the Ministry of Health has accepted this system, these charts should be

available. Health workers need to be trained in how to use them.

AIDS and genital herpes are the only STDs which cannot be cured. All other STDs can be treated, as long as the medicines are available. That is why it is important to go to a health facility immediately after getting an STD. Some of the medicines can be quite expensive, but often only a single dose is needed. People should not take medicines without going to a clinic first, since taking medicine without proper directions can cause problems. Herbs or other treatments may also be available from traditional healers. These may not do any harm, but little is known about them. Therefore, people should be advised to use medicines from regular clinics.

Summary: Sexually Transmitted Diseases	
The following are the most common signs that someone has an STD. But often, people can have an STD without showing any signs or symptoms that they are ill.	
SIGNS IN WOMEN:	**SIGNS IN MEN:**
Sores or bumps inside the vagina, or around the entrance	Sores on or around the penis or anus
to the vagina or anus	Discharge (fluid) from the penis
Pain during urination	Pain during urination
Discharge from the vagina that is: bad-smelling unusual looking (green or yellow in colour, or frothy) much more abundant than normal	

All STDs except genital herpes and AIDS can be treated, as long as they are identified early enough.

If an STD is not treated it can lead to pelvic inflammatory disease, which can make a woman infertile. The signs of PID are:

Pain or tenderness in the lower abdomen High fever

Pain during menstruation (the period), or pain and bleeding during sexual intercourse

Bad-smelling discharge from the vagina

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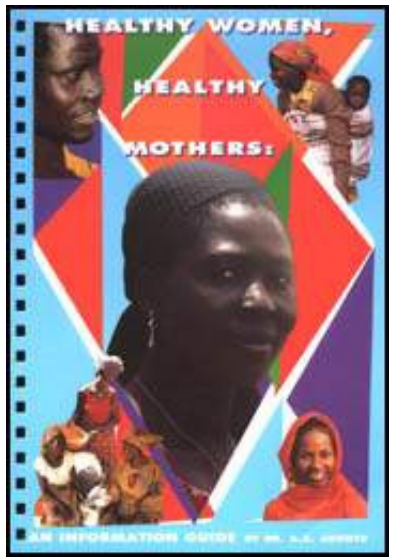

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Chapter Nineteen - INFERTILITY

A couple is described as infertile if the woman has not gotten pregnant after having normal sexual intercourse two or three times a week without using any contraception for at least one year. Normally, 85 out of 100 young couples who want to have a child can do so within a year of trying. The chances are slightly lower if the woman is over the age of 30, and significantly lower if she is over the age of 40.

Sexually transmitted diseases and other infections of the reproductive organs are fairly common (see Chapter 18). These infections can cause permanent damage to the reproductive organs of both men and women. As a result of these diseases, as many as one in four couples in Africa may experience some difficulty getting pregnant. In a culture where fertility is highly prized and children are seen as gifts from God or a sign of approval from ancestors, infertility may be regarded as a great misfortune for the couple. It can be especially hard for a woman. She may suffer unhappiness, social rejection, and a sense of personal failure in a society where childbearing is seen as one of the most valuable contributions a woman can make to the family.

This chapter will review some of the common causes of infertility. It will also review tests and investigations that can be conducted to try to find the causes of infertility, as well as possible treatments and their chances of success.

Causes of Infertility

Infertility is a problem involving two people. On average, the cause of the problem lies with the man 40% of the time and with the woman 40% of the time. In the remaining 20% of cases, both the man and the woman contribute to the problem.

CAUSES OF INFERTILITY IN MEN

As discussed in Chapter 3, the man's role in reproduction involves producing sperm and transporting them into the woman's vagina. Male infertility has two main causes:

POOR QUALITY OF SEMEN: Most infertile men have poor quality semen, especially a low number of sperm or sperm that cannot move. There may be too little semen (the normal amount in each ejaculation is about one spoonful), or it may be too thick or too watery. The causes of poor semen quality include:

- **Physical factors such as excessive heat due to wearing tight underwear or working for long periods near ovens or furnaces; direct injury to the testes; excessive smoking and drinking; drug abuse, especially the use of marijuana, heroin, cocaine, etc.; any general and prolonged illness; and certain specific diseases such as diabetes or thyroid disease.**

- **Infection or disease of the testes; for example, mumps infection after puberty.**

- **Failure of the testes to descend from the abdomen at an early age.**

- **Abnormally small testes.**

INABILITY TO DEPOSIT SEMEN IN THE VAGINA:

The failure to deposit semen in the vagina can be due to a number of reasons. Sometimes the semen cannot come out of the testes because the passage is blocked (see Figure 19.1). This can result from a sexually transmitted disease, especially gonorrhoea or chlamydia (see Chapter 18). Tuberculosis can have the same effect. Impotence, the inability to have an erection or to maintain it during sexual intercourse, is another fairly common cause of infertility. It can be caused by emotional, psychological, or physical stress. Sometimes the man ejaculates his semen before the penis is inside the vagina; this is called premature ejaculation.

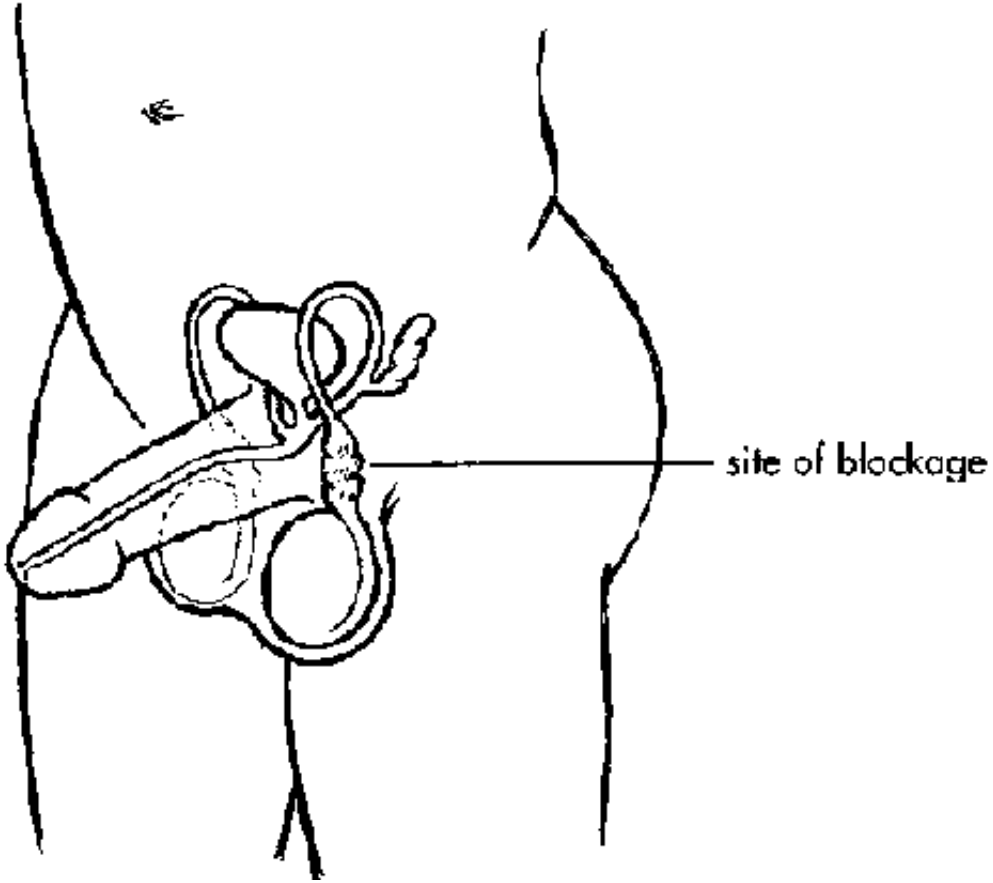

Figure 19.1: Blockage of the Vas Deferens

A common cause of infertility in men is blockage of the vas deferens, the tube that carries sperm out of the penis. It is usually caused by a sexually transmitted disease such as gonorrhoea or chlamydia.

CAUSES OF INFERTILITY IN WOMEN

For a woman to become pregnant, several things must happen, as described in Chapter 4:

- **An egg must be released from the ovaries (ovulation);**
- **The egg must find its way into the fallopian tube where fertilisation takes place;**
- **After fertilisation, the egg must be moved along the fallopian tube to reach the womb within seven days;**
- **The lining of the womb must be properly prepared for the egg to attach itself securely.**

If for some reason any of these conditions is not met, pregnancy cannot occur. The common causes of infertility in women include the following:

FAILURE TO OVULATE (ANOVULATION): Ovulation is a complicated process, which involves parts of the brain, the ovaries themselves, and several chemicals produced by different organs in the body. A problem with any of these organs can make ovulation irregular or infrequent, or cause it to stop altogether. In most cases, a woman's menstrual periods will be irregular or stop altogether if she is not ovulating. Failure to ovulate is the cause of infertility for about 20% of infertile women.

TUBAL BLOCKAGE: By far the most frequent cause of infertility in women in Africa (about 75% of cases) is blockage of the fallopian tubes. The blockage may prevent the sperm from reaching the egg, or it may prevent the fertilised egg from reaching the womb (see Figure 19.2). It is usually caused by infection, which in turn is most often due to:

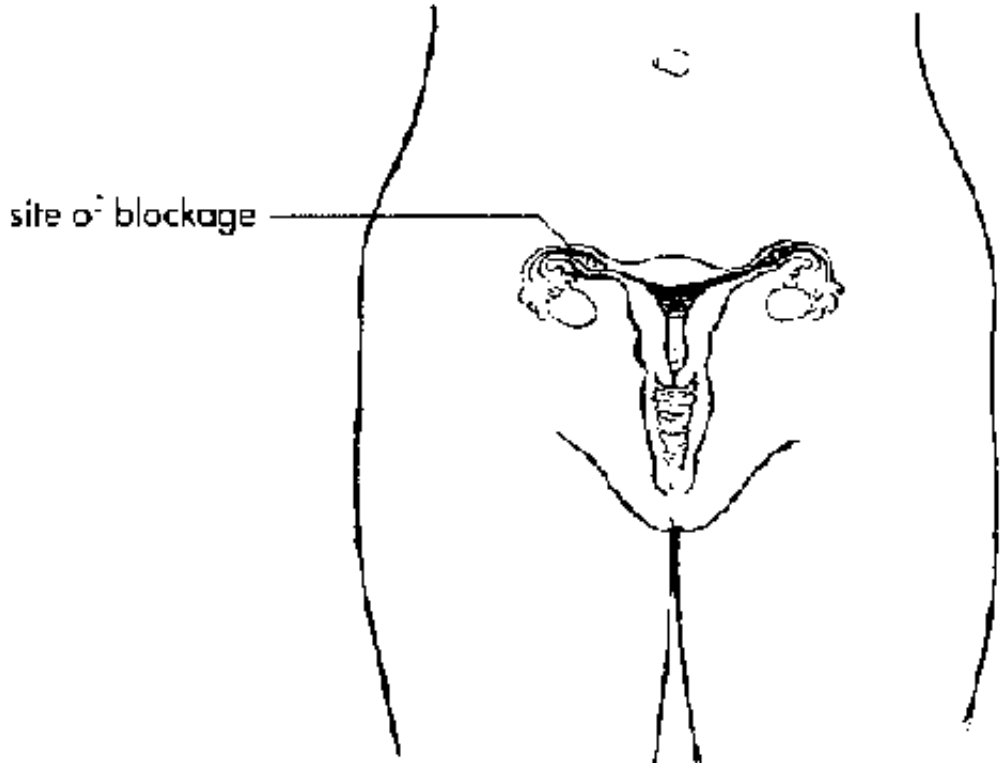

Figure 19.2: Blockage of the fallopian Tubes

The most common cause of infertility in women is blockage of the fallopian tubes. It is usually caused by repeated cases of gonorrhoea or chlamydia.

• STDs, particularly repeated attacks of gonorrhoea and chlamydia (see Chapter 18).

• Infection of the reproductive organs following miscarriage or, more often, unsafe induced abortion. Infection can damage the fallopian tubes as described above, or it can damage the lining of the womb and make it difficult for the fertilised egg to implant itself. Infection can also cause constant pain in the pelvis; this pain may be so severe that sexual

intercourse is not possible.

Tests and Counselling for an Infertile Couple

In order for the testing or investigation of infertility to be complete, both the man and the woman must cooperate and participate fully. Often they must also cooperate for the treatment to be successful. A couple should understand that the proper investigation may take a year or even longer. It involves many tests, so it can cost a lot of money, cause a lot of inconveniences, and take a lot of time. For many of the tests, the couple must have immediate access to the hospital or clinic where the investigation is being done. For these reasons, it would be very difficult, if not impossible, for a couple who is poor or who lives far from the hospital to go through the investigation. Finally, the couple must be prepared to accept an unfavourable outcome of the tests without blame.

WHEN SHOULD TESTING BEGIN AND WHAT WILL IT INVOLVE?

If a woman has not conceived after having regular sexual intercourse (without contraception) for one year, she may want to begin investigations, especially if she is more than 25 years old. Testing will involve the following steps:

COUNSELLING: The first meeting with the doctor is extremely important, and both husband and wife must attend. The doctor will want to have a full and frank discussion with the couple about their general health, past medical history, social habits, and attitudes towards children in general and their specific problem in particular. They will be asked questions about their sexual relationship: the frequency and timing of sexual intercourse, and whether or not they have any

problems. After this general discussion, the doctor may talk to each member of the couple alone because there may be things one partner does not want to say in front of the other.

PHYSICAL EXAMINATION: After discussions with the couple, the doctor will examine the man and woman separately to rule out any illness or other obvious medical explanation for infertility. After these examinations, the couple and doctor need to decide whether further tests are needed and when to start. Some of these tests are described briefly below. A specialist should be consulted for more information.

TESTS FOR INFERTILITY IN MEN: It is easier to find out whether it is the man who is infertile, so tests should usually begin with him.

- **Semen analysis: The aim of semen analysis is to find out if the man is producing enough normal sperm capable of fertilising an egg. The most important things to look for are number of sperm and the percentage of sperm that is active. The doctor will explain how the semen is collected.**

- **Biopsy of the testes: Since the sperm are produced by the testes, the doctor may suggest an examination under a microscope of the tissue of the testes. This involves making a small cut in the skin and the testes and removing a tiny bit of tissue.**

TESTS FOR INFERTILITY IN WOMEN: Many tests can be carried out on women who have difficulty getting pregnant. To understand some of the tests described here, it will be helpful to look again at Chapter 4 where the processes of

menstruation, ovulation, fertilisation, and implantation are described. It will also be helpful to read Chapter 17 on family planning.

- **Tests for ovulation: Chapter 17 described several ways to identify a woman's "fertile phase", that is, the phase during her menstrual cycle when she can become pregnant. These methods - the calendar, temperature, and cervical mucus methods - provide some indication that she has ovulated. However, the tests take a lot of time, and are not very reliable.**

- **Tests for tubal patency: There are two tests that can be done to find out whether the fallopian tubes are blocked. They require advanced equipment or an operation, and are therefore expensive. For more information, a specialist should be consulted.**

- **Cervical mucus test: The mucus or fluid produced by the cervix can either help or hinder the movement of the sperm into the cervix, through the womb, and into the fallopian tubes. On rare occasions, the cervical mucus and the fluids in the vagina may contain chemicals (antibodies) that paralyse or inhibit sperm.**

- **Tests after intercourse: For this test, the woman goes to the hospital within six hours of having sexual intercourse. A specimen of semen combined with cervical and vaginal fluids is examined under a microscope to detect the number of live and mobile sperm.**

Treatment of Infertility

There is no general treatment or "cure" for infertility. In general, treatment depends on the specific cause of infertility for that couple. The majority of couples who seek advice, testing, and treatment for infertility do conceive. As many as 50% of the women become pregnant within 12 to 18 months of starting the investigation, most of them even before investigations are completed or treatment has started. Another 20% of couples achieve pregnancy and have a baby when the cause of their infertility is treated.

When no obvious explanation can be found for infertility, counselling may improve the couple's chances of achieving pregnancy. For example, advice on general health, regular exercise, and avoiding excessive drinking and smoking can sometimes help. The couple can also be taught how to identify the most fertile phase in the woman's menstrual cycle, when sexual intercourse is most likely to result in pregnancy.

Unfortunately, about three out of ten couples (30%) who come for help do not conceive. In these cases, adopting a child to love and raise is an option.

TREATMENT OF INFERTILITY IN MEN

The majority of infertile men produce too few sperm, or no sperm at all. A few men who have this problem can be helped by treatment with male hormones, but in general not much can be done to increase the number of sperm.

TREATMENT OF INFERTILITY IN WOMEN

ANOVULATION: When a woman does not ovulate regularly, she can be treated with drugs or hormones to induce ovulation. This treatment can be expensive,

however, and only about 40% of women who receive it and begin ovulating regularly become pregnant. There is also a high chance that women who receive treatment for anovulation will produce twins or multiple births. For reasons that are not fully understood, pregnancies that result from this treatment often miscarry.

TUBAL BLOCKAGE: Most cases of infertility in women are due to blockage of the fallopian tubes caused by previous infection. Such women often need an operation to try to open up the fallopian tubes. An operation may also be needed to repair problems in the womb. The chances of becoming pregnant after such operations are not very good.

Summary: Infertility

Many factors can make a couple unable to have children. The problem can be either with the woman or with the man. The major causes of infertility are:

CAUSES OF INFERTILITY IN MEN	CAUSES OF INFERTILITY IN WOMEN
Poor quality of semen: Not enough sperm Problems with the sperm Not enough semen Semen that is too thick or too watery	**Failure to ovulate (release an egg)** **Blockage of the fallopian tubes that carry the egg to the womb, usually due to infection of the reproductive organs, caused by:** Sexually transmitted diseases, especially gonorrhoea or chlamydia (see Chapter 1 8)

Inability to put semen in the vagina, caused by:

Blockage of the tube in the man's penis that carries the semen. This is usually due to sexually transmitted diseases

Impotence (the inability to maintain an erection)

Premature ejaculation ("coming" before the man's penis is in the vagina)

TREATMENT: The most common cause of infertility in men is inadequate sperm. Some men can be treated with male hormones, but in general not much can be done.

Spontaneous miscarriage or, more commonly, induced abortion

TREATMENT: If the problem is with ovulation, some women can be treated with hormones. This is not always successful. If the problem is blocked fallopian tubes, an operation can be tried, but again this is not often successful.


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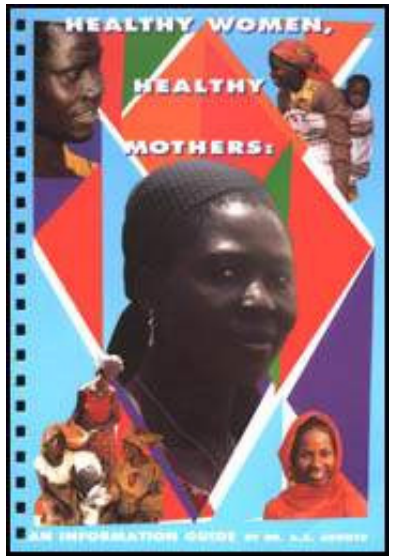

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Chapter Twenty - OTHER REPRODUCTIVE HEALTH NEEDS

The Gynaecological Exam

Many women do not have routine gynaecological examinations. This may be because they lack money, because there is no clinic or hospital nearby that can do the exam, or simply because they do not know that such exams are important. If possible, women should have examinations and screening tests of their reproductive systems every 2-3 years even when they are feeling fine. This is especially true because many sexually transmitted diseases, cancers, and other gynaecological problems do not show symptoms until the illness is very far advanced. By then it may be difficult or even impossible to treat the problem effectively.

HISTORY: The first part of a routine gynaecological examination involves taking a careful history. Information should be gathered on the woman's age, gynaecological-obstetric history, medical-surgical history, family history, and social history. Specific problems, questions, and family planning choices are then discussed.

PHYSICAL EXAMINATION: A complete physical examination is then done, including an examination of the breasts and vagina. The vaginal exam usually has two parts. First the vagina and cervix are inspected with a speculum - an instrument placed inside the woman's vagina which, when opened, allows the health worker to check for any sores, bleeding, unusual fluids, or unhealthy tissue in the vagina or on the cervix. If the lab facilities are available, a Papanicolaou exam or Pap smear (a test for cervical cancer) may be done at this time. Swabs may be taken to test for infections like gonorrhoea and chlamydia. Genital warts, herpes blisters, and the sores caused by syphilis are other things that could be found during this part of the vaginal examination (see Chapter 18 on Sexually Transmitted Diseases).

The second part of the vaginal examination is done by placing one hand on the woman's abdomen and two gloved fingers inside the vagina. The size and tenderness of the womb, cervix, and ovaries can then be felt between the two hands. A rectal examination may or may not be done, depending on symptoms.

Many women find this part of the physical examination uncomfortable and embarrassing. It will help them to relax if they are told what is being done, and why it is done. A cloth or drape placed over the abdomen and thighs may also help them feel more comfortable.

LABORATORY TESTING: If the health facility has the necessary equipment and supplies, laboratory testing may include blood tests for sexually transmitted diseases such as HIV and syphilis. It may also include a complete blood count to look for anaemia.

Any problems found during the history, physical examination, or laboratory testing should be followed up as necessary. If a family planning method has been chosen, the health worker reviews its use, side-effects, and danger signs (see Chapter 17 on Family Planning and Child Spacing).

Self-Care and Monitoring

In addition to regular visits to a health facility, women can also monitor their own health. Health education that teaches women how to care for themselves and how to recognise danger signs is critical, especially in places where access to good medical care is limited.

BREAST SELF-EXAMINATION: It is perfectly normal for women to have lumps in their breasts. These can change in size and shape at different points in the menstrual cycle. Sometimes - fortunately, quite rarely - a lump in the breast that does not go away and does not change in size can be a sign of breast cancer. Most cases of breast cancer can be discovered by women themselves. For this reason it is important that women learn how to examine their own breasts, and how to tell when there is something wrong.

Breast self-examination should be done once a month, about one week after menstruation stops. Before menstruating, the examination is more difficult

because the breasts are often more tender and slightly swollen. Women who have already gone through menopause, or women who are pregnant, may choose any time of the month that is easy for them to remember.

During the first part of the examination, women look at their own breasts in a mirror, if one is available. They should look first with their arms down and then with their arms raised, to check for any differences between the two sides (see Figure 20.1). It is normal to have breasts that are unequal in size. Signs of an abnormality would include: dimpling or puckering in one area, one nipple turning in a different direction, swelling, enlarged veins in a non-pregnant woman, or sores.

The second part of breast self-examination requires lying down and gently pressing all parts of the breast tissue against the chest. It is best if the arm next to the breast being examined is raised and placed under the head (see Figure 20.2). The area under the armpit should also be examined. Any lump that is new or feels different from a previous examination should be inspected at a hospital that can do the necessary tests and, if necessary, surgery. In most African countries, this treatment is available at teaching hospitals, usually in the capital city. It is important to begin treatment as soon as possible.

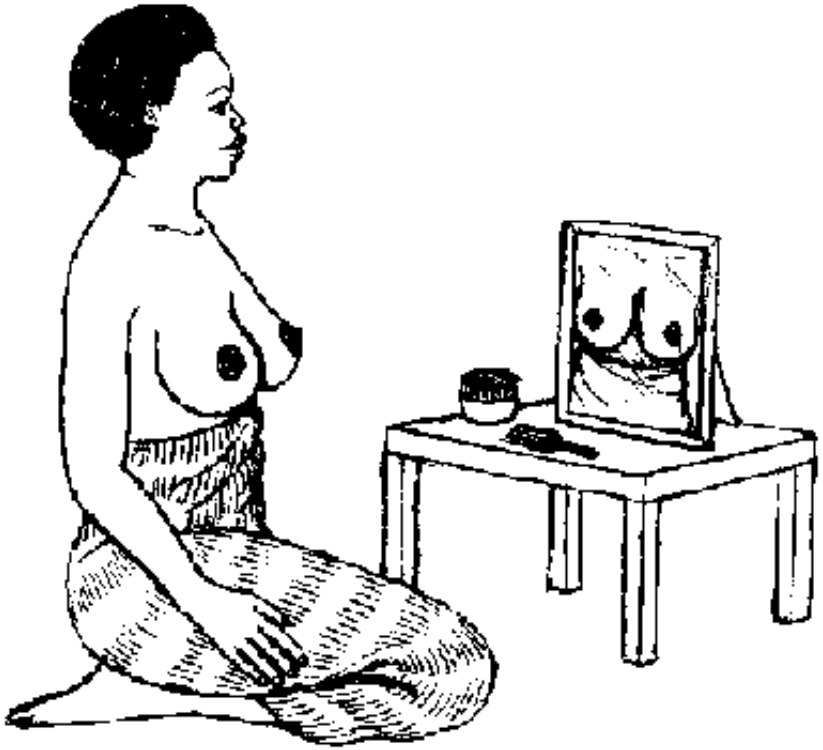

Figure 20.1: Breast Self-Exam while Standing or Kneeling

A woman should examine her breasts once each month. The first part of the exam should be done by standing in front of a mirror if available, and looking at the breasts.

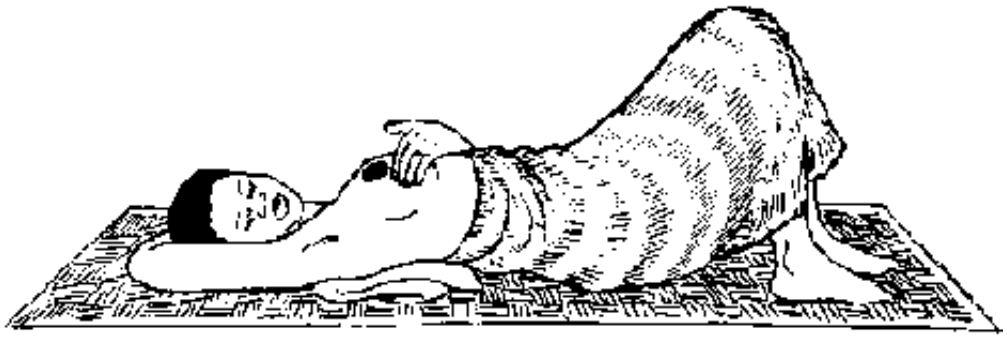

Figure 20.2: Breast Self-Exam while Lying Down

The second part of the monthly breast exam should be done lying down. The woman should press each part of the breast to check for lumps.

Other Reproductive Health Problems

MENSTRUAL IRREGULARITIES: Contraceptive methods that contain hormones (like oral contraceptives, implants, injectables, and some lUDs) can cause changes in a woman's normal menstrual cycle. The changes may include some bleeding in between periods, prolonged bleeding, or much less bleeding than normal. Stress, sudden weight loss, or weight gain are other reasons that bleeding patterns may change. In addition, the following women might have irregular periods: young girls who have recently started menstruating, women starting menopause, and women who recently delivered a baby.

However, unusual bleeding in a woman who does not belong to one of these groups may indicate cancer, an infection, or hormonal problems. In this case the woman needs to be examined by a doctor. Unusual bleeding may include prolonged bleeding, frequent bleeding, or very reduced bleeding. It may or may not be accompanied by pain. Women who have already passed menopause (no bleeding for one year) and start bleeding again should go as soon as possible for evaluation at a hospital.

PELVIC PAIN: Pain in the pelvis or abdomen that is not the normal discomfort of ovulation or menstruation can be a sign of a problem. There are two types of pain that are a cause for worry: pain that occurs during sexual intercourse, and pain

that is constant.

Physical causes of painful intercourse may include vaginal infections or infections of the pelvic organs, female genital mutilation, bladder infections, cancers, uterine prolapse, and poorly healed episiotomies. An examination by a midwife or doctor is usually necessary to determine what the cause is. Women who are going through menopause (see page 193) and women who are breast-feeding may also find intercourse uncomfortable. This can be caused by the lack of fluids in the vagina, which is normal for women during this period. Using creams or oils during intercourse may help with this problem.

Painful intercourse may also be due to emotional or psychological difficulties. Women who are forced to have sex against their will or in ways that are not pleasurable will often find the experience painful. Sexual intercourse is a very private and personal topic, and many women are reluctant to talk about it. If they do admit to having a problem, however, there are various things a health worker can do to try to help. If there is a physical cause, such as lack of fluids in the vagina, they can advise the woman to use cream or oil. They can also encourage the woman to try speaking more openly with her husband or sexual partner about her individual needs and preferences.

Women who are abused, psychologically or physically, should be helped to make realistic changes or, if possible, leave the relationship entirely. Because the subject of abuse is difficult to talk about, and because some degree of abuse is accepted in many cultures, many women find it easiest to describe their physical symptoms first. By asking open-ended questions about sexual relations in a non-judgmental, supportive way, health care providers can give women the

opportunity to discuss problems more openly.

Constant pelvic pain is most often caused by infections. Other causes can include cysts, cancers, endometriosis (a disease in which the inner lining of the womb starts to grow on the other parts of the internal organs), or other diseases of the pelvic organs. Women experiencing such pain should go to a hospital for evaluation.

Box 20.1: ***Signs of Reproductive Tract Problems***

There are various signs that could indicate a problem with the reproductive organs. These include:

- Prolonged bleeding from the vagina (more than ten days)
- Much less bleeding than is normal for a menstrual period
- Frequent bleeding (bleeding in between menstrual periods)

If a woman is using a contraceptive method that contains hormones (the pill, implants, injectables, or some IUDs), unusual bleeding is common, and is not a cause for worry.

OTHER SIGNS OF A PROBLEM INCLUDE:

- Pain during sexual intercourse

- Constant pain in the pelvis

URINARY TRACT INFECTIONS: Symptoms of urinary tract infections include pain when urinating, having to urinate frequently, and blood in the urine. Women with these symptoms should go to a clinic for treatment immediately, since infections in the bladder and lower urinary tract may spread quickly to the kidneys. Kidney infection is a much more dangerous and painful illness. Women with kidney infections often have high fever and chills, nausea, vomiting, and back pain. Permanent scarring or damage to the kidneys may occur if not treated promptly. Admission to a hospital for treatment is often necessary.

Urinary tract infections can be avoided with good personal hygiene, especially by cleaning from front to back after a bowel movement in order to avoid bringing any of the stool near the urinary opening. Other steps that can help avoid infections include drinking plenty of fluids, urinating often (especially just after having intercourse), and wearing cotton under-wear or clothing that allows the area to stay dry. Having sexual intercourse very frequently or vigorously may also contribute to urinary tract infections. If a woman using a diaphragm experiences frequent infections, she should have the size of the diaphragm carefully checked or try a different form of contraception.

MENOPAUSE: Most women go through menopause between the ages of 45 and 55. During this time, their menstrual cycles usually become irregular and eventually stop altogether (see Box 20.2). They may experience short periods of sweating or flushing, rapid beating of the heart, and sleep disturbances. These changes naturally occur as the hormonal balance changes and the ovaries stop releasing eggs.

In addition to physical changes, menopause is also a time of emotional change, as

women come to the end of their childbearing years. This may mean assuming a new role in the family or the community. For some women this can be a difficult process, and they may need extra support and understanding from their family members. Menopause may also be accompanied by new feelings of freedom, energy, and increased sexual desires.

CANCERS OF THE WOMB: The womb, like other organs in the body, can be afflicted with cancer. The part of the womb known as the cervix is the most frequently affected. Generally this disease is only found in older women (over age 40-45), although it can occur in women who are in their thirties. Women who have had genital warts (see Chapter 18) are more likely to develop cervical cancer, although any woman can develop the disease.

The most common sign of cancer of the womb or cervix is irregular bleeding from the vagina. This bleeding may start after menopause, or it may occur after sexual intercourse. This bleeding is a sign that the disease has already started spreading, so a woman with this symptom should go immediately to a hospital for an examination and treatment.

The disease is difficult to treat once it has reached the cancerous stage. Only a few hospitals in Africa can provide the necessary treatment. This treatment can involve an operation to remove the cancer from the cervix, or radiation therapy. Sometimes the entire womb and cervix have to be removed. While the prospect is a frightening one, it may be necessary to save the woman's life.

Box 20.2: ***Evaluating Unusual Bleeding During Menopause***

Menstrual periods normally become irregular as women start menopause. Women going through menopause should go to a health facility if:

- bleeding occurs more frequently than once every three weeks
- bleeding is very prolonged
- bleeding starts again after menstrual periods have stopped for a year or more

Cancer of the cervix can be detected much earlier by the special test called a Pap smear, which was described earlier in this chapter. In its early stages, the disease can be treated much more easily, if the facilities are available. However, few health facilities can do the test. Some Ministries of Health are starting programmes to test for the early signs of cancer of the cervix, especially in older women. If possible, any woman over the age of 30-35 should be encouraged to go to a hospital or other health facility that can do the Pap test, especially if she has had genital warts. It could save her life.

Summary: Other Reproductive Health Needs

Women can have other problems related to their reproductive organs besides STDs and complications of pregnancy. Knowing about these problems, and how to prevent or defect them, can help a woman to get proper care early.

MONITORING AND SELF-CARE

Gynaecological examination: This examination should be performed every 2-3

years if possible, even when the woman is feeling healthy. It involves taking a medical history, a complete physical examination (including the breasts and vagina), and laboratory tests.

Breast examination: The breasts should be examined once a month. A woman can do this herself. Any lumps in the breasts that have changed in size or shape should be checked at a health clinic.

OTHER REPRODUCTIVE HEALTH PROBLEMS

Menstrual irregularities: Menstrual changes such as irregular periods, prolonged periods, or no periods can occur if a woman is using certain family planning methods, or if she is sick. However, they can also be signs of a disease in the reproductive organs. A woman with menstrual irregularities should go for an examination.

Pelvic pain: Pain in the pelvic area, including severe pain during sexual intercourse, can be a sign of a serious problem. This problem may be the result of certain diseases or physical abuse. Constant or severe pain should be checked at a health facility.

Urinary tract infections: Frequent and painful urination, or blood in the urine, is a sign of a urinary tract infection. Women with these symptoms should go to a health clinic immediately.

Menopause: Between the ages of 45-55, women's menstrual periods become irregular and then stop altogether. This physical change can be accompanied by emotional changes as well.

Cancers of the womb: Cancer of the cervix is very serious and must be detected and attended to as soon as possible. Signs of the disease are bleeding from the vagina after sexual intercourse, or bleeding after menopause. In the early stages, the cancer can be detected by a test called the Pap smear.

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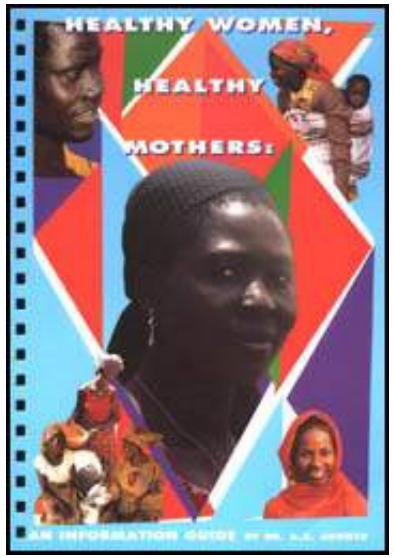

Healthy Women, Healthy Mothers - An Information Guide - Second Edition (FCI, 1995, 241 p.)

Chapter Twenty-One - ADOLESCENT HEALTH

Numerous health surveys and social studies have shown that in many African countries today:

- **Most teenagers (60-70%) are sexually active. As a result, in some areas as many as 70% of girls have been pregnant at least once by the time they are 18 years old;**

- **Sexual activity at an early age is associated with several serious risks and complications;**

- **The majority of sexually active adolescents are unaware of these risks, or are dangerously misinformed about the potential consequences of their behaviour;**

- **As a group, adolescents lack access to health and social services, or are reluctant to use these services even when they are available (see Figure 21.1).**

This chapter discusses some of the problems associated with sexual activity in young people, and examines why and how complications arise. It also suggests how young people, especially young women, can be helped to avoid problems related to sexual activity. Many of the health issues discussed here, such as sexually transmitted diseases and problems with pregnancy, are discussed in detail in other chapters as well.

Adolescence is the stage when a child grows and develops into an adult. In terms of age, adolescence begins at 10-12 years and continues until the age of 18-19 years. The change from childhood to adulthood is a gradual process that occurs at

different ages and at different speeds in different people. It is always marked by profound changes in the individual.

- **PHYSICAL CHANGES: During adolescence, both boys and girls generally grow and gain weight quickly. Their genital organs also increase in size. Other changes take place as well, such as the growth of hair in the genital area and (for boys) on the face.**

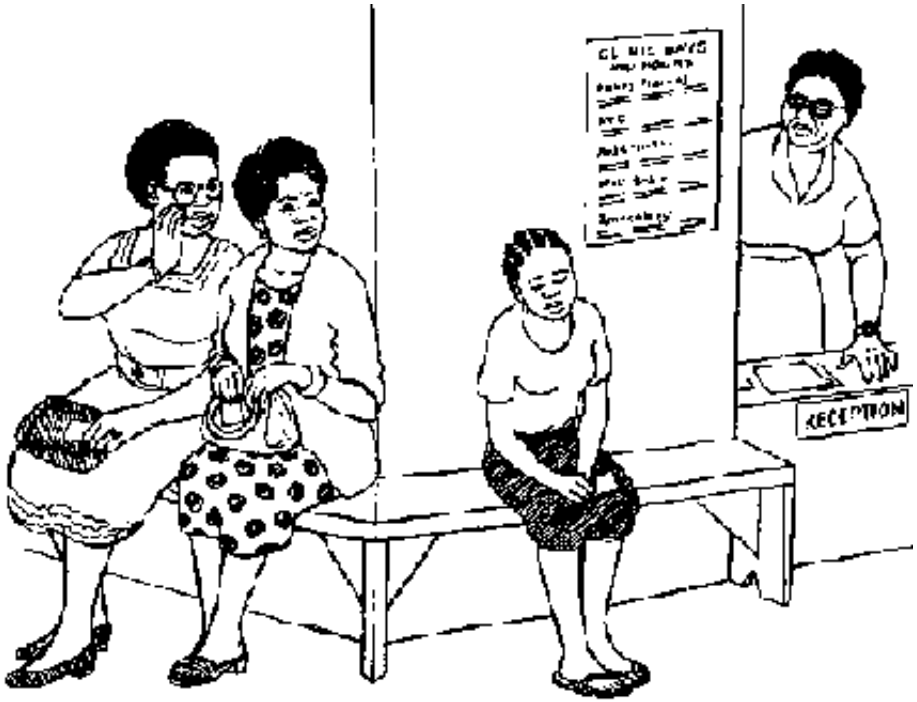

Figure 21.1: Adolescent Visiting a Health Clinic

Many teenagers do not feel comfortable in health clinics; other patients, or sometimes the health workers themselves, may make them feel unwelcome. As a consequence, they may not get the health services they need. Health workers can help by treating teenagers with sympathy and

understanding, and by ensuring confidentiality.

- **BIOLOGICAL MATURATION: At the same time that the body is maturing on the outside, the internal reproductive organs are also changing. In boys, the testes begin to produce sperm. In girls, the ovaries begin to release eggs, and they begin to menstruate. This usually happens between the ages of 12 and 15, although it can happen earlier or later (see Chapters 3 and 4).**

- **PSYCHOLOGICAL CHANGES: Boys and girls become increasingly self-conscious and aware of the changes taking place in their bodies during adolescence. They also begin to be aware of their own sexuality, and feel sexual desire, sometimes quite strongly. This is nearly always a difficult period emotionally, as young people struggle to understand their own feelings and reactions. Their capacity to think in abstract terms and to empathize with others also develops during this time.**

- **SOCIAL ADJUSTMENT: In most African societies, becoming accepted as an adult is determined more by tradition and cultural values than by age or physical size. Adolescence can be a difficult and confusing period. Adolescents may want to be recognised as adults, but their peers, parents, and society in general may not see them that way yet. Many societies practise rituals to recognise that girls and boys are becoming adults. These rituals are important because they help the adolescent feel that everyone recognises him or her as an adult, and because they can mean new responsibilities as well as new freedoms.**

Adolescent Sexuality

Sexual activity among adolescents is both widespread and increasing, contrary to what many parents, teachers, health workers, and religious leaders may believe. The growing numbers of pregnancies and abortions among teenagers, both in and out of school, confirm that many young people are indeed sexually active.

Biologically, boys as young as 14 or 15 years old can father a child. Girls can become pregnant at an even younger age - 12-14 years - even before they have had their first menstrual period. While many African cultures favour or promote early marriage and childbearing, especially for girls, pregnancy before the age of 18-20 years may be harmful to the health and well-being of the girl. Specifically, it can involve serious obstetrical, psychological, and other health risks. For young girls, sexual activity and pregnancy may be the result of sexual abuse or exploitation, often by older men. For others, it is a reaction to the urgings of boys of their own age who are feeling sexual desires and needs. Other girls may be exploring their own sexual feelings.

Adults who talk with and counsel adolescents, whether they are parents, teachers, health workers, or others, need to understand the many different feelings and pressures that young people have, especially with regard to sexuality. First, adults need to address their own reluctance to talk about sexual issues. Next, they need to recognise that talking with young people is easier if they do not make judgments or criticise. It is more effective to be supportive and offer guidance in a way that the adolescent boy or girl will understand and accept. After all, advice is no good if it is not acted upon.

Health Risks of Adolescent Pregnancy and Childbearing

Having a child always carries a certain risk, and complications from childbearing may occur regardless of the age of the mother. However, the risk of having serious complications during pregnancy or childbirth is much higher for girls in their early teens than for women aged 20-24 years or older. The major difference between girls in their early teens and older women is that girls aged 12-16 years are still growing. The pelvis or bony birth canal of a girl can grow wider by as much as 20% between the time she begins menstruating and the time she is 16 years old. This widening of the pelvis can make the crucial difference between a safe delivery and obstructed labour. In addition, most adolescent girls are not yet capable of fulfilling all the responsibilities of an adult. In particular, they are not yet ready to have children themselves.

Because they are often inexperienced, poor, and alone, their infants are more likely to be sick and poorly fed. The major risks that young teenagers and their babies face during pregnancy and childbirth include:

- **ANAEMIA: A high proportion of teenagers are anaemic before they become pregnant, usually because of poor nutrition. The anaemia tends to get worse during pregnancy unless treated (see Chapter 9).**

- **ABORTION: The majority of teenage pregnancies are unplanned, unwanted, and come as a complete shock. Many teenagers attempt to terminate the pregnancy. Since they usually lack the funds and the information to get a safe abortion, they often resort to illegal, unskilled abortionists who operate with dirty instruments in unclean surroundings. The results of unsafe abortions can be tragic; they can include infection, injury to the reproductive organs, or even death. Other common**

consequences are pelvic inflammatory disease (PID) and infertility (see Chapters 18 and 19).

- **PRE-ECLAMPSIA: The risk of developing high blood pressure during pregnancy is greater for teenagers. So is the danger that the condition will progress to eclampsia or fits (see Chapter 11).**

- **PREMATURITY AND LOW BIRTH WEIGHT: Teenagers are more likely than older women to go into labour early. Even when the pregnancy goes to term, the babies of adolescent mothers tend to weigh less than full-term babies of older women. Babies born early, and underweight babies, are more likely to get various diseases such as respiratory infections and diarrhoea. They have a higher risk of death before their first birthdays.**

- **PROLONGED LABOUR: Labour usually lasts longer for teenagers than for older women for two reasons:**

    - **the contractions of the womb, although strong and painful, may be quite irregular and therefore not effective in opening up the neck of the womb or pushing the baby down;**

    - **the mother's birth canal or pelvis may be too narrow for the baby to pass through.**

Whatever the cause, prolonged labour carries risks for both mother and baby. These include infection, exhaustion, injury, or even death.

Because of the risks faced by teenage mothers, they need more tender loving care

than most. Pregnant teenagers should be encouraged to report early for antenatal care. They should receive supportive and sympathetic care during pregnancy, labour, and the early weeks after delivery. If they receive good care, the vast majority of them will come through safely and deliver healthy children.

Other Reproductive Health Problems of Adolescents

Apart from pregnancy and its related risks, sexual activity among adolescents carries other dangers.

SEXUALLY TRANSMITTED DISEASES (STDs) AND HIV/AIDS: Young people are just as likely as adults to catch sexually transmitted diseases - gonorrhoea, chlamydia, syphilis, etc. - as a result of sexual intercourse with an infected person. However, young people with STDs are less likely than adults to seek help and proper treatment. This may be due to ignorance, inexperience, fear, or shyness. It can have serious consequences; when treatment is delayed, the risk of complications such as pelvic inflammatory disease or infertility is much higher.

Adolescent girls may be even more at risk of infection with HIV/AIDS than older women, for both social and physiological reasons. Socially, young women and girls are often targeted for sex by older men (sugar daddies) who believe that young teenagers are less likely to have been infected with HIV (see Figure 21.2). These youngsters may be shyer and more reluctant to say no, or to ask the man to use a condom. As a result, they find themselves at greater risk of infection. Physically, if an adolescent girl is not yet fully grown, having sexual intercourse can be painful, and may result in sores or scrapes in the genital area. These make it easier for her to get an STD, including AIDS.

PELVIC INFLAMMATORY DISEASE (PID): Any infection of the genital organs, whether following an abortion or sexually transmitted disease, can spread to other pelvic organs unless it is treated promptly and effectively. The major signs of pelvic inflammatory disease, as discussed in Chapter 18, include fever, pain in the lower part of the abdomen, pain during sexual intercourse, bad-smelling vaginal discharge, and heavy bleeding during menstruation. PID often results in damage and scarring of the fallopian tubes, and can lead to infertility or ectopic pregnancy (see Chapter 19).

Figure 21.2: "Sugar Daddy"

Many teenage girls are tempted into sexual activity by older men, who may offer them money or presents in exchange for sexual favours.

Psychological and Social Consequences of Adolescent Sexuality

Young people, especially young women, face other problems and disadvantages as a result of early sexual activity. Besides struggling to understand and cope with their sexual feelings, young people also have to deal with their own ignorance and confusion. They may feel a sense of guilt, fear of discovery and disapproval from parents, or outright rejection. For the young teenager this can be a major psychological trauma.

Girls who become pregnant almost invariably have to drop out of school, thereby losing their chance for a good education or missing out on opportunities for training (see Figure 21.3). This means it will be much more difficult for them to acquire useful and practical skills that could help them to earn a living and contribute economically to the welfare of their families as well as themselves.

Girls who marry young and start childbearing early tend to lack social and survival skills. They may become completely dependent on their husbands for their needs. Such women may have low self-esteem and tend to believe that the only useful contribution they can make in life is to have many children.

Figure 21.3: Consequences of Teenage Pregnancy

Schoolgirls who become pregnant are usually forced to leave school. They may lose the chance for education and training that can provide opportunities later in life.

The Role of the Health Worker

The health worker has two major roles to play in meeting the reproductive health needs of young people who are sexually active. The first role, of course, is to provide health care. This includes good antenatal, delivery, and postpartum care for the pregnant adolescent (see Chapters 6-13). It also includes family planning information, counselling, and services in order to prevent unwanted pregnancies (see Chapter 17). And it includes guidance on how to prevent STDs, and treatment for them when necessary (see Chapter 18). The second role of the health worker is to be an educator and a counsellor for young people themselves, their parents, and their guardians, as well as the community at large (see Figure 21.4).

Married or single, the sexually active teenager runs the risks described above. Parents, teachers, community and religious leaders, as well as teenagers themselves, need to understand that waiting until a later age - 18 or 20 years - to begin sexual activity has important health and social benefits for all. The health worker is in a unique and privileged position to provide this information and education.

Some health workers may find it difficult to provide information and services to young people because they may see it as encouraging promiscuity among the young. This is understandable, given the personal experience, religious beliefs, and principles of many health workers, and the traditional and cultural values in society.

Health workers must appreciate, however, the need for empathy and understanding in dealing with young people. For many troubled teens, the health worker is the only person they can turn to for support and help. A health worker knows the risks that sexually active teenagers are exposed to, and the potential

consequences of failing to provide adequate care. Health workers should therefore strive to prevent any negative feelings or judgments from coming between them and the young person in need of help and attention. They have a responsibility to provide adolescents with information on sexual and reproductive health. They also have a responsibility for making health and family planning services available to them, or referring them to a place where they can get care.

As respected and knowledgable persons in the community, health workers can also play a role in encouraging parents and others to understand the issues involved in teenage sexual activity. They can help the community look for positive and constructive ways to deal with the issues, and help inform and reassure parents themselves. Sometimes health workers can play a valuable role in encouraging communication and understanding between teenagers and their parents.

Figure 21.4: Adolescent and Mother Being Counselled by a Health Worker

Health workers can be an important source of information and guidance for teenagers and their parents on issues related to sexuality and reproductive health. They can encourage parents to be more understanding and communicate more openly with teenage children.

Summary: Adolescent Health

Adolescents face many physical and psychological problems related to sexual activity. Young women who become pregnant face a higher risk than older women of developing the following complications:

- Anaemia
- Pre-eclampsia
- Premature and low birth weight babies
- Prolonged labour

Because so many adolescents do not understand how their bodies work, and because they do not have access to health and family planning services, many teenage pregnancies are unplanned. As a consequence, adolescent pregnancies often end in abortions - many of which are performed incorrectly and unsafely, leading to tragic deaths or disabilities.

Adolescents who are sexually active also risk getting a sexually transmitted disease. However, they are less likely to know the symptoms, and less likely to seek help.

The health worker is one of the most important participants in the adolescent's life as a provider of both services and information. Sensitivity and sympathy are essential in talking with, and treating, adolescents.