WOMEN'S HEALTH QUEENSLAND WIDE Inc
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Health Journey

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Editor's view

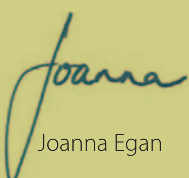
In June, Australian women are encouraged to step back, take a close look at how we live our lives and assess whether our health is in the red. Not only is June the month in which the Heart Foundation launches their Go Red for Women campaign, which raises awareness about heart disease, it is also a time when Red Aussie Apple Day, the flagship event of Bowel Cancer Awareness Month, takes place.

Heart disease is the leading cause of death in Australian women. Although it is largely preventable, some 200 women die of the disease each week. Eating well, exercising regularly and keeping your blood pressure and cholesterol in check can have a big impact on lowering your risks of developing and dying from the disease.

Maintaining a well-balanced diet is also important for preventing bowel cancer. Eating two serves of fruit a day can provide you with the fibre you need for a healthy bowel. One in 28 Australian women develops bowel cancer before the age of 50. Performing a bowel cancer screening test every two years can reduce your risk of dying from the disease by up to one third. A free faecal occult blood test (FOBT) is posted to Australians aged 50 and older as part of the National Bowel Cancer Screening Program.

Take control of your health this month by eating red apples and supporting Bowel Cancer Australia on Wednesday 19 June. And why not wear red while you do it, to help increase awareness about women's heart health. For more information about bowel health, visit www.bowelcanceraustralia.org and to find out how you can lower your risk of heart disease, visit www.heartfoundation.com.au.

You can also boost your perinatal health this month by joining the Women's Health team at the Brisbane Pregnancy, Babies & Children's Expo. The event will be held at the Brisbane Convention and Exhibition Centre in South Bank from 21-23 June. If you have a new baby or are expecting one soon, drop into our display and pick up a free gift pack that features our ***Looking After You*** booklet, a copy of our ***Preconception and Pregnancy Health*** factsheet and more. While you're there, chat to our midwives about your antenatal health. To download your free ticket, visit our website (www.womhealth.org.au).



Joanna Egan

About us

Women's Health Queensland Wide Inc (Women's Health) is a not for profit, health promotion, information and education service for women and health professionals throughout Queensland. Services include:

- **Health Information Line**
  A free information and referral service for Queensland women
- **Health information** and free lending library via www.womhealth.org.au
- **Health education** for community and health professionals

Mon | Tues | Thur | Fri **9.00am- 5.00pm**
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Myth busting: emergency contraception

Women's Health's communications team leader Lorraine Pacey sorts fact from fiction when it comes to the emergency contraceptive pill.

Often referred to as the morning after pill, this type of emergency contraception can be taken after unprotected sexual intercourse to prevent unwanted pregnancy. It contains levonogestrol, a type of progestogen that stops pregnancy occurring by preventing ovulation and possibly by preventing fertilisation if ovulation has already taken place. A dose consists of either 1 x 1.5mg tablet or 2 x 0.75mg tablets.

Myth 1: You can only take the emergency contraceptive pill the 'morning after'.

Current Australian guidelines recommend that emergency contraceptive pills are taken within 72 hours (three days) of unprotected sex. Despite this recommendation, research suggests this form of contraception can be effective up to five days after unprotected intercourse. However, its effectiveness declines over time and by day five, it drops to about 50 per cent. For this reason, you should take the tablet/s as soon as possible after unprotected intercourse, and preferably within 24 hours.

Myth 2: You need to see your doctor to get it.

Emergency contraceptive tablets are available over the counter from most pharmacies in Australia. If the pharmacy you go to doesn't have them for any reason they should be able to refer you to one that does. The cost varies but in Queensland it is generally in the range of $20 - $50.

When the pharmacist is dispensing the tablet/s to you, they will probably ask you some questions, such as when you had unprotected sex and when you last had your period. If it is more than 72 hours since you had intercourse the pharmacist may refer you to your doctor to have an IUD inserted instead (see *Myth 6* below).

Myth 3: It causes an abortion or a miscarriage.

Emergency contraception works by ***preventing*** pregnancy from occurring. It does not have any impact on an existing pregnancy. Therefore if you are already pregnant when you take emergency contraception it will not terminate the pregnancy. It's important to know that if you are pregnant and choose to continue the pregnancy, emergency contraception will not harm your baby in any way. If you choose to terminate the pregnancy you will need to have either a surgical or medical termination.

Some people confuse the emergency contraceptive pill with RU486 (mifepristone), a tablet used in medical termination (abortion). RU486 is not available over the counter in pharmacies in Australia; it must be prescribed by a doctor.

Myth 4: It will affect your fertility.

Regardless of how many times you take it, the emergency contraceptive pill will not affect your ability to have children in the future. However, it is important to be aware that if you have had unprotected sex you might be at risk of a sexually transmissible infection (STI) such as chlamydia. Chlamydia is a common infection that is easy to catch and is easily treated with antibiotics. However, it often doesn't have symptoms and is a major cause of infertility if left untreated. For this reason, it is important to have regular sexual health checks, particularly if you have had unsafe sex.

Myth 5: It will make you sick.

It is a common myth that taking the emergency contraceptive pill will cause vomiting. In fact, only one per cent of women who take emergency contraception will be sick. If you experience side effects they are generally mild and might include nausea, breast pain, dizziness, tiredness, headache and spot bleeding. These usually stop within two days. It's important to be aware that if you vomit within two hours of taking the emergency contraceptive pill it won't have been absorbed properly so you will need to take another dose.

Myth 6: The emergency contraceptive pill is the only type of emergency contraception available.

The term 'emergency contraception' can also refer to the insertion of a copper IUD (intra-uterine device) into the uterus. A copper IUD is the most effective form of emergency contraception – it can prevent 99 per cent of pregnancies if it's inserted within 5 days of unprotected sex. It also provides ongoing contraceptive benefits. However, it needs to be inserted by a health professional so it's not as accessible to women as the emergency contraceptive pill.

If you are a woman in Queensland you can have a confidential chat with a nurse/midwife by calling our Health Information Line on 3839 9988 or 1800 017 676 (toll free outside Brisbane). You can also ask a health question online by visiting our website: **www.womhealth.org.au**.

When three's a crowd

The arrival of a new baby can make life feel as though it has turned upside down. At this time, maintaining a close physical and emotional bond with your partner can be trickier than expected.

Life with a newborn baby can be stressful. Your daily routine changes and your priorities shift, putting pressure on your relationship. "It's important to adjust to life being different," says Bronwyn Buckley, a midwife, mother-of-two and the health promotion officer at Women's Health Queensland Wide. "When you have a new baby, there are a lot of things that can tip the boat."

After a baby arrives, most couples have less time for themselves and each other; they get less sleep; their finances tighten; and as they react to the daily stresses of parenthood, their relationship takes a backseat. An Australian study showed that in the first year after giving birth, most new mothers are less interested in sex. While some women feel this doesn't affect their relationship, for others, sexual and emotional intimacy go hand-in-hand. Many women are unprepared for the physical, emotional and social changes that occur after birth. These include:

Physical changes. During childbirth, women often experience bruising, tearing or episiotomies (when the tissues between the vagina and anus are cut to aid birth). Changing hormones reduce vaginal lubrication and some women experience vaginal tightness. These factors can cause sex to be painful. As a new mother, you may be worried about experiencing pain, and your partner may be concerned about inflicting it, leading to reduced sexual desire.

Concerns about body image. "Often mums worry that their partner won't find them attractive anymore," says Bronwyn. "They feel a lot of pressure to get back to normal as quickly as possible when in actual fact it takes nine months for your body to recover physically." Women may be concerned about weight gain, stretch marks, varicose veins, abdominal scars or reduced muscle tone in their vaginal area. Others may find breast changes uncomfortable – when a woman is sexually stimulated, the letdown reflex can trigger milk leakage. "Some women will also look in the mirror and may worry that their vagina looks different, or worry that their partner saw it in a different way during the birth," says Bronwyn.

Fatigue and exhaustion. Caring for a newborn baby is a full-time job. Parents get less sleep, are more stressed and have less time for themselves than they used to. This can lead to changes in your sex life and ultimately, to decreased libido.

Shifting roles. Your roles at home may need to be redefined. Caring for a new life may shift the way you feel about yourself and cause you to rethink who you are. "Everyone's identity is changing," says Bronwyn. "The baby is getting used to the parents; everyone is learning things for the first time; and it's a period of adjustment for everybody." Some women find it difficult to reconcile their new role as a mother with their sexual identity; others feel overwhelmed by the constant physical demands the new infant places upon them. "One minute you're a spouse, the next minute you're a mother and

the next minute you're a lover," says Bronwyn. "For many women, moving from the kitchen to the bedroom to the nursery can be difficult."

Feeling left out. Often parents, particularly breastfeeding mothers, develop a strong bond with their baby in the early months because of the close physical contact they share. This can cause the other parent to feel left out. "Women often get a lot of skin-to-skin contact with their baby because they're breastfeeding and there's a lot of cuddling and all those feel-good hormones circulating in their body, so they're getting their physical touch needs met by the closeness of looking after a baby," says Bronwyn. "This can be difficult for the other partner, who may feel left out."

What can I do to stay close to my partner?

Learning to communicate openly and honestly with your partner is important. Often, conflicts arise as a result of misunderstanding. Before your baby arrives, discuss issues such as: how much time you and your partner spend with each other and with the baby; how you plan to bring up your baby; and how you will manage caring for the baby, looking after the house and paid work.

Plan ahead: "Talking about your values and the parenting style you want for your child during pregnancy can be helpful," says Bronwyn. "You need to remember that you can't plan for everything, but coming to some agreement about practical things such as who is going to get up during the night, who is going to take care of the cooking, who will go to work and how you'll manage your finances, is worthwhile."

Talk to each other: Discussing what you expect from each other and how you plan to support each other during stressful times is important. "Sometimes you might just need a cuddle, or 10 minutes to yourself," says Bronwyn. "But you can't expect your partner to be a mind reader, you need to let them know what you're feeling."

Work together: It's easier to tackle the demands of parenthood as a team. "You're in for the long-haul, so you need to be on the same page," says Bronwyn, adding that it's important to let your partner know you appreciate them. "Make sure the person who is at work earning the money is valued equally to the person who is at home doing the caring."

Make time for each other: Spend time with your partner and make sure you both get some time to yourselves. "While you're pregnant, think about who you might ask to babysit so you can have an hour or two to be as a couple," says Bronwyn. "If you can't get a babysitter, try to get the mood going at home; light some candles, put on a DVD, and while one person puts the baby down, the other can get take-away," she says. "You just have to be adaptable."

Make sure you both bond with the baby: "It's important for both parents to focus on creating a strong relationship with the baby," says Bronwyn. "A good way for dads to do that is to have a nice long cosy bath with the baby." You can also encourage your partner to bond with the baby by learning how to express milk, so your partner can take a turn to feed the baby. "When mothers see their partner nurturing the baby, it often makes them feel close, connected, safe and loved," says Bronwyn. "For most women these feelings are desire-enhancers."

When can we get back in the saddle?

There are no hard and fast rules about when you and your partner can resume your sexual relationship. Recent studies show that most Australian mothers wait until six weeks after their baby is born to start having vaginal sex again. Women aged under 25 tend to resume sex earlier, while women 34 and older generally wait a little longer. Most women (86 per cent) experience pain the first time they have sex after giving birth.

"It's important that partners don't pressure each other for sex," says Bronwyn. "When you're ready might be different from when your partner's ready." She suggests couples discuss their sexual needs openly and honestly with each other. "If you or your partner isn't ready for intercourse, there are other things you can do to feel physically close," she says. Sensual massage, mutual masturbation and bathing together can increase intimacy between you and ease you back into a sexual relationship. When you and your partner are physically and emotionally ready for sex, there are some things you can do to make it easier:

- Use water-based lubrication. This can make intercourse more comfortable since women often experience vaginal dryness as a result of the hormonal changes that occur with childbirth and breastfeeding.
- Talk to your partner. Tell them if you feel any pain or tenderness, discuss what your desire-enhancers are and find out what turns them on.
- Have sex when you feel like it, regardless of the time of the day. To avoid being distracted, it can help to have sex when the baby is asleep.
- If your breasts are tender, you may feel more comfortable if you have sex after you've breastfed your baby, when your breasts aren't full.

Contraception

Once you become sexually active again, you will need to consider using a safe and reliable form of contraception in order to avoid another pregnancy. Breastfeeding is not a reliable form of birth control. If you are breastfeeding, you are advised not to take the combined oral contraceptive pill (the pill), use a vaginal ring or have monthly DMPA injections as the hormones in these methods can pass into your breast milk. Therefore you should discuss other contraception options with your doctor or midwife.

Where to go for help:

To speak confidentially with a Women's Health nurse or midwife, call our Health Information Line on 3839 9988 or 1800 017 676 (toll-free outside Brisbane).

For relationship counselling, phone Relationships Australia on 1300 364 277, or for information about how to overcome relationship problems, visit their website (www.relationships.org.au).

If you are experiencing discomfort during sex, pain, vaginal tightness or looseness, visit to your GP.

Diabetes and pregnancy

One in twenty pregnant women in Australia is affected by diabetes. Although the disease can cause serious complications for mothers and babies, good planning and comprehensive antenatal care can keep you and your baby healthy.

Diabetes is a chronic condition characterised by the body's inability to control glucose (sugar) levels in the blood. A hormone produced by the pancreas, called insulin, converts glucose from the food we eat into energy. When a person has diabetes, they either don't produce enough insulin or are unable to use insulin effectively. This causes glucose to build up in their bloodstream. There are several types of diabetes:

Type 1: People with type 1 diabetes don't produce insulin. As a result, they need to monitor their blood glucose levels carefully and require regular insulin injections (up to four times a day). Generally, type 1 diabetes arises in children and young adults, but it can occur at any age.

Type 2: This is the most common form of diabetes. Some people have a genetic predisposition to developing it, but it is also caused by lifestyle factors such as high blood pressure, obesity, insufficient exercise and poor diet. People with type 2 diabetes either don't produce enough insulin or are unable to use insulin effectively. Generally, the condition is initially managed with healthy eating and regular physical activity, but as it progresses, glucose-lowering tablets and/or insulin injections may be prescribed.

Gestational diabetes: This form of diabetes develops during pregnancy. It usually appears late in the second trimester and resolves after childbirth. Most pregnant women are screened for it between 26 and 28 weeks. Women with gestational diabetes are either unable to produce enough insulin or unable to use insulin effectively. Managing the condition involves regular exercise and healthy eating. Some women also require medication, such as insulin injections. Women with gestational diabetes have an increased risk of developing type 2 diabetes and cardiovascular disease later in life – 17 per cent of women with gestational diabetes develop type 2 diabetes within 10 years and 50 per cent develop it within 30 years.

How will diabetes affect me during pregnancy?

Diabetes can cause serious complications for you and your baby during pregnancy, labour and delivery. Women with pre-existing diabetes (type 1 or 2) are at higher risk than those with gestational diabetes.

Early pregnancy: Women with pre-existing diabetes have a high risk of miscarrying. Those with type 2 diabetes often need to adjust their medication early in pregnancy; many switch from tablets to insulin injections. Women with type 1 diabetes risk having severe 'hypos' (episodes of low blood glucose). Often, the usual warning signs, such as feeling sweaty or shaking, change or disappear during pregnancy. To avoid unexpected hypos, you should be careful not to skip meals. You should also always carry foods to quickly treat hypos, such as jelly beans, carbohydrate snacks and glucose tablets.

Mid-pregnancy: During pregnancy, hormones produced by the placenta interfere with the normal function of insulin. Rather than converting glucose from food into energy for your body's cells, the energy is directed to your baby. As a result, your insulin needs begin to rise rapidly from about week 20. By the time you reach 30 weeks, you may need to take two-to-three times your pre-pregnancy insulin dose.

Late pregnancy: Mothers with diabetes are more likely to have a pre-term (prior to 37 weeks), or very pre-term (before 32 weeks) birth. On average, one-in-five women with type 1 or 2 diabetes and almost one-in-ten mothers with gestational diabetes give birth at 32-36 weeks. Women with diabetes are more likely to have an induced labour, an instrumental birth (delivery with forceps or ventouse) or a caesarean section. Women are also at greater risk of developing hypertension (high blood pressure) and pre-eclampsia (a dangerous condition characterised by high blood pressure and water retention).

Post-birth: Some of the long-term complications of diabetes – kidney disease, eye disease and cardiovascular disease – can either appear for the first time or worsen during pregnancy. In many cases, eye and kidney deterioration resolve after childbirth, but for some women, the damage can be long-lasting or irreversible.

Can diabetes affect my baby?

Throughout pregnancy, labour and delivery, serious complications can occur. They can affect the short- and long-term health of your baby.

Early pregnancy: Babies of mothers with pre-existing diabetes are at an increased risk of suffering heart, spine and kidney damage if their mother has high blood glucose levels. To reduce your baby's risk, monitor your blood glucose carefully and try to maintain healthy levels.

Throughout pregnancy: When you experience high blood sugar levels, excess glucose passes through the placenta to your foetus. As a result, your baby produces high levels of insulin. This can cause your baby to grow faster and larger than it needs to. After birth, large babies may have low glucose levels for a day or two because they continue to produce high levels of insulin. They may also have trouble breathing and feeding.

Late pregnancy: Babies born to mothers with pre-existing diabetes are more likely to be stillborn than those born to mothers with

gestational diabetes, but all are at risk. In general, babies are also more likely to be born pre-term and as a result, they often require high-level resuscitation at birth. Many need to be admitted to special care nurseries or neonatal intensive care units.

Post-birth: The effects of heart, spine and kidney damage, which can occur during early pregnancy, can affect infants throughout their lives. Babies born to mothers with diabetes are also more likely to become obese and to develop type 2 diabetes in early adulthood.

How can I protect myself and my baby?

Women with diabetes can have healthy pregnancies and babies. It is important to establish healthy blood glucose levels before pregnancy. If you have an unplanned pregnancy, stabilising your blood glucose as soon as you find out you're pregnant is critical because your baby's major organs develop during the first eight weeks.

Before you conceive, or as soon as possible afterwards, your doctor will want to test you for diabetes-related complications. You may undergo a physical exam to check for nerve damage; you will be asked to provide a urine sample so your kidney function can be assessed and your doctor will recommend that you visit an ophthalmologist to have your eyes assessed.

During pregnancy, your diabetes medication will need to be carefully monitored. If you have type 2 diabetes and are taking tablets prior to pregnancy, your doctor may advise you to switch to insulin injections in order to better control your glucose levels. During labour and delivery, your endocrinologist will keep an eye on your levels. They will adjust your insulin dosage directly after your baby is born to safeguard you against hypoglycaemia.

If your baby is producing high levels of insulin during the pregnancy, their blood sugars could be low following birth. If left untreated, this could lead to seizures. Your baby's blood glucose levels will be tested (by heel prick) every four hours for the first 24 hours of their life. If their glucose levels are very low, they may need to have supplementary feeds. Insulin does not pass into your breast milk, so it is safe to breastfeed. Feeding your baby within 30 to 60 minutes of birth can reduce their risk of having low blood sugar and regular feeds (every three to four hours) can help them maintain healthy blood glucose levels.

Mothers with gestational diabetes will typically be offered an oral glucose tolerance test about 6-8 weeks after giving birth. This test assesses whether your blood glucose levels are within the normal range. The test should be repeated every three years.

Where can I go for help?

Diabetes Australia (www.diabetesaustralia.com.au) offers phone support and information sessions, and hosts face-to-face support groups for women. The Australasian Diabetes in Pregnancy Society (www.adips.org) provides up-to-date, evidence-based resources.

New infant feeding guidelines

The latest science reveals the healthiest ways to feed your baby.

In February, the Commonwealth Government released the updated *Infant Feeding Guidelines*. Based on 2700 of the latest peer-reviewed scientific studies, they provide information about the types and amounts of foods infants should consume, and advice about when these foods are best introduced.

"There are a few changes in these guidelines so mothers will hear some new messages," says Aloysa Hourigan, a senior nutritionist with Nutrition Australia's Queensland Division. "For example, the timing of when to introduce solids hasn't changed, but the idea of how you do it is different."

The guidelines recommend mothers exclusively breastfeed their babies for the first six months. After this, mothers are encouraged to start introducing solid foods, such as iron-fortified cereals. "The type of food that's being suggested hasn't really changed but what they are now saying is that you don't have to introduce just one food at a time," says Aloysa. "Instead, it's better to introduce a variety of age-appropriate foods and textures."

The new guidelines also state that if a food allergy runs in the family, there is no advantage in delaying the introduction of that food to the baby. "For example, if the mother has a wheat allergy, delaying the introduction of wheat isn't necessarily going to give the child any extra protection against developing wheat allergy," says Aloysa.

Once solid foods are introduced, mothers are encouraged to continue regular breastfeeding until babies are aged 12 months or older, for as long as the mother and child desire. Although the guidelines reinforce the benefits of breastfeeding, they acknowledge that not all mothers choose – or are able – to breastfeed. In these instances, they recommend the use of commercial infant formulas.

For more information, call Nutrition Australia's Queensland Division on (07) 3257 4393, or to read the guidelines head to www.eatforhealth.gov.au.

Get connected...

Learn to let go with this new app

Researchers have found that people who meditate regularly tend to be less stressed and have lower rates of depression than those who don't. To encourage more people to learn how to meditate, Relaxiapps has released a free version of their meditation app. It contains useful relaxation techniques that can help you unwind. To try it, download Complete Relaxation Lite from the iTunes store, pop on some headphones, get comfortable and press play.

Ask a Health Question

Our Health Information Line receives calls and emails from women on a broad range of health issues. This regular column features answers to some of them.

Q: I am 37 and my doctor has suggested that if I want to have children I shouldn't delay trying to conceive. Isn't it possible to have children well into our forties these days?

A: Many women assume it's safe to postpone having a baby until they are in their late 30s or 40s. However, age is the single most important factor affecting fertility and advanced maternal age is the most common reason women fail to conceive naturally or with assisted reproductive technologies.

Women are at their most fertile until their late 20s, when fertility starts to decline. From the age of about 35, this decline speeds up and many women struggle to conceive. We are born with all the eggs we will ever produce and with age, the quality of these eggs declines. Older eggs struggle to produce enough energy to successfully achieve fertilisation, implantation, cell division and growth in the developing embryo, which means it can take longer for conception to occur.

Fertility is further reduced by the progressive effects of gynaecological conditions such as endometriosis, untreated chlamydia or fibroids. For women in their 40s, opportunities for conception become even fewer due to approaching menopause, which causes irregular ovulation and menstruation cycles.

Almost a third of all women aged 35 and older take longer than a year to conceive. By the age of 36, a woman's chance of conceiving each month is half of what it was in her youth. By 45, her chance of conceiving is only about one per cent each month and there is a likelihood she will not be able to conceive at all.

If conception does occur, women aged 35 and older are more prone to complications during pregnancy and childbirth. By the age of 35, a woman's risk of miscarriage doubles and by age 40, it is actually greater than her chance of having a live birth. Women are also more likely to experience a stillbirth. By 35, the risk is two-and-a-half times higher and by 40, it is more than five times more likely to occur.

When an older egg is fertilised, it is less able to divide and grow effectively. This causes a higher risk of birth defects and chromosomal abnormalities (such as Downs Syndrome). For women in their early 20s, there is a 1-in-500 chance that a foetus will have a chromosomal abnormality. In contrast, by the time a woman reaches 35, her risk has increased to 1-in-190, and by 45, her risk is greater than 1-in-20.

As we age, our ovaries and eggs also become less responsive to hormones (either our own or fertility drugs), which makes assisted pregnancies less likely. It is the reason why IVF clinics prefer to use donated eggs from younger women.

For all of these reasons, women hoping to have children are discouraged from delaying childbirth until they are in their late 30s or 40s. However, if women are aged over 35 and have been trying to conceive for six months or longer without success, they should speak to their doctor about it.

call our Health Information Line

A free information and referral service for Queensland women

3839 9988

1800 017 676

(toll free outside Brisbane)

Staffed by nurse/midwives