Ministry of Defence

Servicewomen's Health Handbook

Contents

Chapter 1: Body basics

Chapter 2: Urinary health

Chapter 3: Menstrual health

Chapter 4: The menopause

Chapter 5: Contraception and sexual health

Chapter 6: Becoming a parent

Chapter 7: Health screening

Chapter 8: Consent and confidentiality

Chapter 9: Further information

Chapter 10: Quick guide to servicewomen's health considerations

Introduction

Our differences are what make us exceptional and contribute to the operational effectiveness of the UK Armed Forces. We strive for excellence and to enable service personnel to always be their best. This includes supporting everyone's basic human needs associated with health and hygiene. Everyone should be encouraged to understand and look after their own health, to treat themselves and their colleagues compassionately, and to seek help if they have any concerns.

This handbook is for **all** service personnel, regardless of gender. It is for servicewomen who are directly affected by female-specific health issues, for commanders and line managers who have a responsibility to enable their people to be their best, and for colleagues to better understand and support.

The handbook's purpose is to improve understanding, assist with personal management and normalise conversations regarding female-specific health issues. It provides basic information about female body parts, how they work and how to look after them. It offers servicewomen information to make informed choices on how to be their best at work while also offering top tips and considerations for commanders and servicewomen. This will allow appropriate and professional discussions in the workplace and awareness about what is best left to healthcare professionals.

The terms women and female are used interchangeably throughout this handbook without any intention to exclude individuals who do not identify as women but may experience some of the topics discussed. We recognise and appreciate that gender is a spectrum and hope the information contained within the handbook will benefit all.

Chapter 1: Body basics

Introduction

Being female

A person's sex describes the physical and biological characteristics which classify them as male, female, or intersex. A person's gender is how they socially identify, as a man, or woman, or somewhere else on or outside the spectrum of genders.

Females, who will also be referred to as women throughout this handbook, have the reproductive anatomy that, once they reach puberty (typically between the age of 8 and 13 years) enables pregnancy, childbirth and breastfeeding.

Different language can be used to describe body parts (anatomy) and how they work, which can be confusing and sometimes stops people being able to talk about issues properly. This means people do not always understand how to stay healthy, know what's normal or that they may need to get help.

This section introduces the correct language to use when discussing female health issues within military environments. It explains the external parts and internal parts of the body that only females have. It describes the correct names to use, their normal functions and how to look after them to stay healthy. It covers the basics about what is normal, not normal and when, why and how to get help.

Basic body functions

While every woman is slightly different, women should expect to:

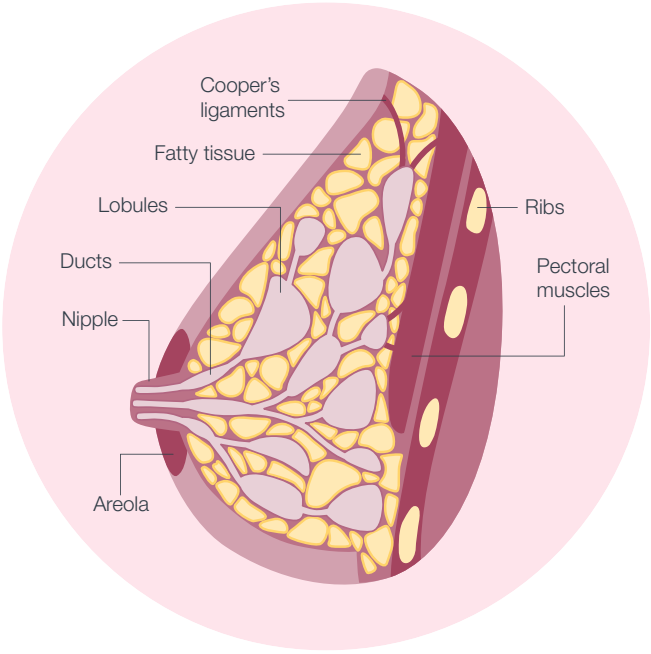
1. Pass urine 5 to 7 times per day.
2. Not leak urine when doing physical exercise.
3. Empty the bowels between 1 to 2 times every 1 to 2 days.
4. Have a regular period of vaginal bleeding, lasting several days and occurring every 21 to 35 days unless pregnant, on certain types of hormonal contraception or after the menopause.
5. Experience breast changes throughout the menstrual cycle until after the menopause.

Breasts

Breast anatomy

Breasts vary in shape, size and consistency. Commonly one can be slightly larger than the other.

Breasts lie in front of the pectoral muscles on the chest. On the outside is the skin, nipple and areola. The areola is the bumpy area of skin around the nipple that is darker than the rest of the breast. On the inside is glandular and fatty tissue, with blood vessels.



The glandular tissue is made up of lobules, which can produce breast milk after pregnancy. When a woman is breastfeeding this milk passes through the ducts and out through the nipple.

Breasts do not have any substantial supporting structures, only the overlying skin and thin hair-like internal fibres known as Cooper's ligaments. If a woman is not wearing a properly-fitting bra, the breast tissue can move against the chest wall in all directions. This can cause soreness of the nipple and breast tissue.

Breasts can swell and become tender or painful in response to hormone changes throughout the menstrual cycle, when pregnant and during the menopause. Around the time of menstruation some women may have tender, lumpy breasts, especially near the armpit. After the menopause breasts may feel softer, less firm and not as lumpy.

Breast care

- Women need to keep breasts clean.
- Women should regularly check their breasts for changes. Knowing when to get medical help, is essential for keeping breasts healthy.
- Women need to support breasts properly during exercise.

Keeping breasts clean

The whole breast can be washed with soap and water and needs to be fully dried before putting clothes on, to help prevent skin infections like thrush.

Breast self-examination

Women should get to know their breasts and what is normal for them at different times of their menstrual cycle. They can do this by regularly examining themselves.

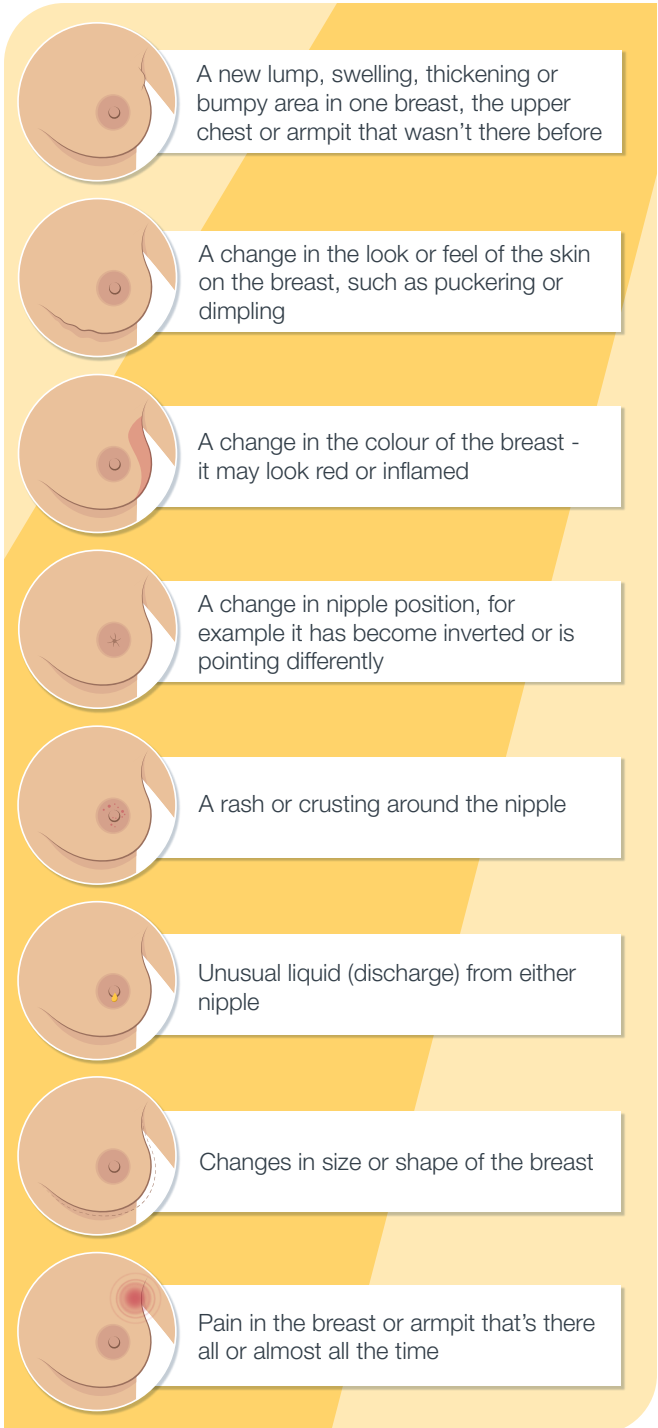
There is no right or wrong way to self-check breasts. The important thing is for women to know how their breasts usually look and feel so they can spot any changes and get checked by a medical professional.

Each breast should be felt across the whole surface and up into the armpit and to the collarbone (upper chest). This should be done for each breast with the arm at the side of the body and then again with the arm raised above the shoulder. Some women find this easier to do in the shower or bath. Breasts should also be visually examined in a mirror.

Remember **TLC** for self-examining breasts:

- **T** — **Touch** the breasts: does anything feel new or unusual?
- **L** — **Look** for changes: does anything look different?
- **C** — **Check** any new or unusual changes with a GP.

Women should go to a doctor if they find any of the following changes:



Any lumps or changes found should be checked out quickly by a medical professional. Changes like these can happen for many reasons and most of them are not serious or cancerous. However, ruling out cancer can only be done by medical professionals, not by self-diagnosis.

Supporting breasts during exercise

Due to the physical nature of military training and employment, it's likely that servicewomen will need to wear a sports bra every day.

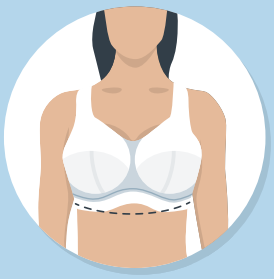
Sports bras are designed to support the breasts during exercise by reducing motion and preventing the breasts becoming over-stretched.

Movement of the breasts during exercise can be both painful and a source of embarrassment, which can also become a reason not to exercise. A properly fitted bra, whatever the size of the breasts, is important for comfort, health and physical performance.

Women can experience pain in the shoulders from bra straps, and women with larger breasts can also suffer upper limb and upper back discomfort. It is really important that women wear a sports bra which properly fits them.

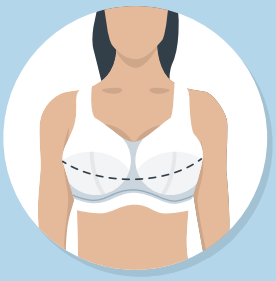
How to measure bra size

Sizing: To calculate her correct bra size a woman should be measured when wearing an unpadded bra or when braless. These measurements are taken in inches, using a tape measure:



Band Size: Measure directly under the breast tissue where the bra band would normally sit, ensuring the tape measure is quite tight.

The measurement should be rounded up to the next whole number. If this is an even number add 4 inches and if this is an odd number add 5 inches to calculate the band size.



Cup Size: Measure over the fullest part of the breast tissue and round up to the nearest number in inches. Then subtract the calculated band size from this measurement to work out what the correct cup size is.

Difference in inches	<1	1	2	3	4	5	6	7
Bra cup size	AA	A	B	C	D	DD	E	F

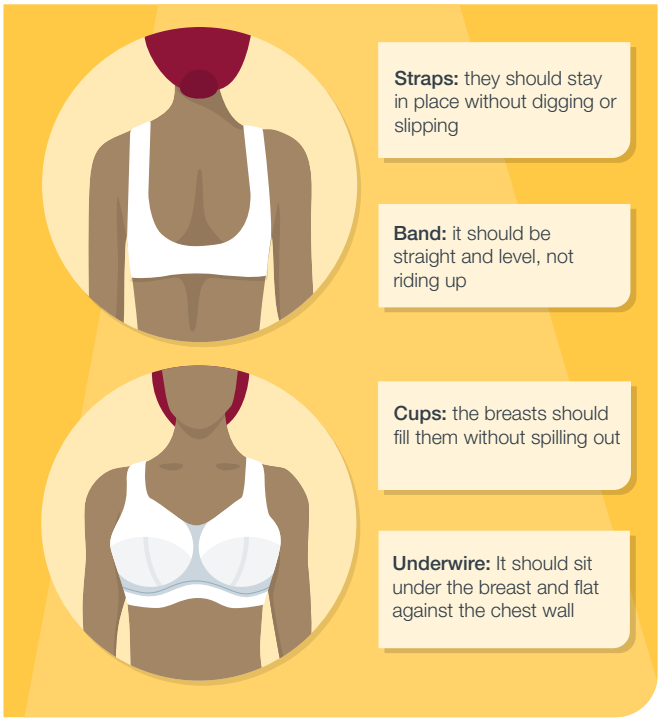
The band size and cup size are combined to provide a bra size.

A woman still needs to try on the bra to check it fits properly because the fit may vary between brands and styles.

The use of a sports bra should be considered for any physical activity. This includes drill, marching, and any activity where the woman is jumping or moving around a lot or is exposed to vibration. Crop-tops sometimes look like a sports bra but the construction and material are unlikely to be supportive enough to protect the breasts during a physically active working day.

Choosing the correct sports bra is often down to personal comfort and choice. There are several things to consider when choosing the right sports bra, including breast size and the activity it is needed for. Each of the Services support the provision of sports bras for servicewomen.

Fit: The band should sit snug and straight across the back and rib cage. The straps should lie flat and not cause indentations in the skin. The bra cup should sit flat against the breast, without any bulging or creases. When leaning forward the breast should stay within the cup and not spill out. If the bra has a wire it should sit under the breast and flat against the chest wall.



Impact rating: Sports bras are rated as either low, medium or high impact. This refers to the physical activity and movement they are designed for, not breast size. Most military physical activity will demand a high impact bra.

- Low - yoga/pilates, walking.
- Medium - strength sessions/spin classes.
- High – running, jumping, ball sports, horse-riding.

Type: Sports bras reduce movement of the breasts by either encapsulating the breasts, compressing them against the chest wall or a combination of both. For high-impact activity it is best to choose a high-impact bra with both encapsulation and compression. Some women with larger breasts may need to wear two sports bras at the same time to give them enough support, being careful not to restrict their chest movements when they need to breathe heavily.

Compression

Encapsulated

Combination

Straps:

Vertical straps provide more support for larger breast sizes (above a C cup) and limit motion.

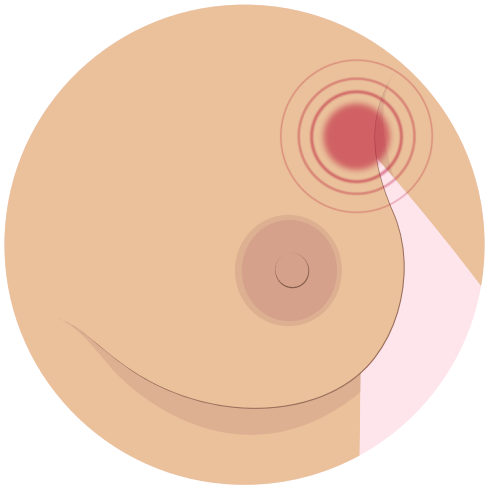
Racer backs provide enough support in lower breast sizes (below a C cup) but for bigger sizes they can make neck and upper back discomfort worse during high impact activity.

Spaghetti and crossover straps are likely to only provide enough support for smaller breast sizes during low impact activities.

Fastening: Being able to adjust the straps and the clasps along the bra band is useful to allow for the changes in breast size which can happen throughout the menstrual cycle.

Fabric: The tighter the weave of fabric, the more supportive it will be. Specialist sports fabrics will also help keep the skin and bra dry, which will help reduce chafing and rubbing.

Replacing a sports bra: The quality of a bra will reduce with time, use and washing. A sports bra should work effectively for up to 100 workouts. When the straps become looser around the shoulders, the band loosens against the chest and cannot be adjusted any tighter or when the breasts start to move more during exercise, it is time for a new sports bra.



Breast pain

Breast pain is often linked to the hormone changes of the menstrual cycle.

This typically is:

- Dull, heavy or aching pain which can vary from mild to very bad.
- Pain that begins up to 2 weeks before a period, gets worse and then goes away when the period ends.
- Affecting both breasts (although not always).

Breast pain can be treated by:

- Using paracetamol or ibuprofen, or rubbing painkilling gel on the breasts.

- Wearing a properly fitting bra during the day and sleeping in a soft supportive bra.

There is little evidence that vitamin E tablets or Evening Primrose Oil reduce breast pain, but some women think they are helpful.

Sometimes breast pain is caused by:

- a lot of movement without good enough breast support – a well-fitted sports bra should prevent this.
- injuries or sprains to the neck, shoulder or back.
- medicines such as the contraceptive pill and some antidepressants – these side effects will be listed in the packet's information leaflet.
- conditions such as mastitis or a breast abscess – these cause breast pain along with other symptoms including feeling generally unwell.
- pregnancy – breast pain is related to hormone changes and can be an early sign of being pregnant.
- hormone changes during the menopause – once the menopause is over the pain should stop and not return.

Breasts can become painful for many reasons, but breast pain by itself is unlikely to be a symptom of cancer.

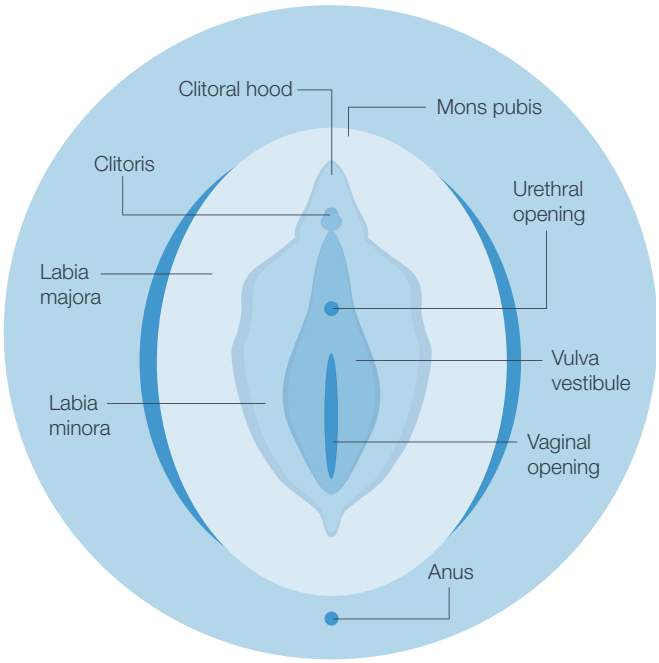
It is important for a woman to see a doctor about breast pain if:

- it is not improving or helped by painkillers.
- the pain is associated with a very high temperature or feeling hot and shivery.
- any part of the breast is red, hot or swollen.
- there is a history of breast cancer in the family.
- there are any signs of pregnancy.

Lower female anatomy

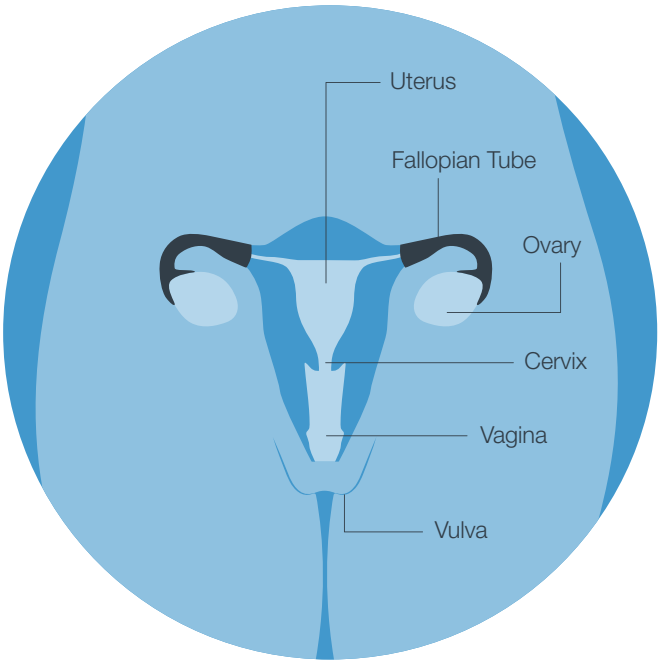
Anatomy

The outer parts of a woman's genitals (or groin area) are collectively called the vulva. The vulva protects the vagina, which is inside a woman's body, by helping stop harmful bacteria from getting inside. Pubic hair in the vulval region also helps, by trapping moisture and maintaining a good environment for healthy bacteria.



The inner parts of a woman's genitals start with the vagina. This is a muscular tube between the external genitalia and the cervix. It can expand, to accommodate a penis during sexual intercourse or a baby during childbirth.

The vagina creates a fluid discharge to get rid of harmful bacteria and replace them with good bacteria. Vaginal discharge is completely normal and can change throughout the menstrual cycle.



The cervix is the opening to the uterus. This is normally closed but opens slightly during a period to let blood out or opens widely to pass a baby during childbirth.

The uterus is sometimes referred to as the womb. It is a muscular and vascular organ that accommodates and sustains a developing foetus during pregnancy. Its lining changes throughout the menstrual cycle and is shed during a monthly period.

The ovaries secrete hormones and will release an egg, typically every month, unless the woman is using hormonal contraceptives. The fallopian tubes connect the ovaries to the uterus and are where sperm will usually fertilise an egg at the start of a pregnancy.

When a woman has a period, blood is lost from the uterus lining, comes through the cervix and out of the body via the vagina.

Lower body hygiene

Toileting

Toileting is the way to describe getting rid of solid (faeces) and liquid waste (urine) from the body.

After toileting women must wipe themselves clean from the front of the body to the back, to avoid getting unhealthy bacteria into the vulval area, which increases the risk of getting an infection.

Washing

A woman should wash her vulva with water only. No soap is needed because the vagina and vulva work to get rid of harmful bacteria and encourage good bacteria. Using soap can disturb this bacterial balance and cause irritation.

Wearing sweaty or wet underwear and clothes for a long time can also cause irritation as warm, wet conditions encourage the growth of harmful bacteria. Women should try to wash and change into clean and dry clothing as soon as possible.

Do

- Clean the vulva and vagina using warm water.
- At night wear loose-fitting clothes without underwear where possible.

Don't

- Clean the inside of the vagina with soap or a cleansing wipe.
- Stay in wet or sweaty clothes for long periods of time.

Avoid

- Scented products for use around the vulva and vagina.
- Douching or steaming.
- Ill-fitting or abrasive underwear.

Pubic hair removal

There is no medical or hygienic reason to remove pubic hair. It is not cleaner to do so and removing pubic hair is associated with an increased risk of people passing on sexually transmitted infections (STIs). However, some women will prefer to remove pubic hair and there are different ways to do this, including:

- shaving
- waxing
- laser hair removal

Removing pubic hair can cause complications such as ingrown hairs, severe itching as the hair returns, waxing burns, cuts or abrasions and skin infections. A woman who experiences these problems should try a different method of hair removal or trimming the hair shorter rather than completely removing it.

Lower body health concerns

Yeast infections

Yeast infections (known as thrush) are a common infection in women and men. It can happen in any damp, moist areas, including under folds of skin, under breasts, in the armpits, between fingers and toes, in the groin area, under a man's foreskin or inside the vagina. It is usually harmless but can be really uncomfortable and keep coming back (although it is not a sexually transmitted infection which are discussed in Chapter 5: Contraception and sexual health). Cleaning the body regularly and keeping these skin areas dry are important prevention measures.

Symptoms of thrush can include:

- a thick, white discharge (sometimes described as like cottage cheese) which does not usually smell.
- itching or irritation in the affected area.
- soreness or stinging when urinating or having sex.

Treatment is simple and usually effective with what are called 'antifungal' treatments. These can be a cream to apply in the area, tablets to swallow, or for women a pessary can be placed inside the vagina overnight.

These treatments are available for free from military healthcare staff, or can be bought from a pharmacy or supermarket if a person wants to start treatment more quickly.

A woman should see a doctor or nurse the first time she gets thrush symptoms (to confirm it is thrush) or if treatment is needed more than twice in 6 months.

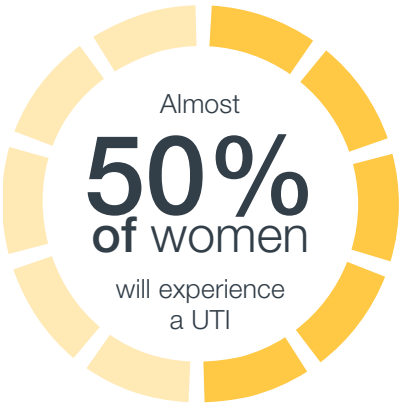
Urinary tract infections

Urinary tract infections (UTIs) are very common in women. They are usually caused by bacteria getting into the urinary tract and can affect the urethra, bladder, ureters or kidneys.

Symptoms of a UTI include:

- pain or burning when urinating (dysuria)
- needing to urinate more often than usual (urinary frequency).
- urinating more during the night (nocturia).
- needing to urinate suddenly (urgency).
- having blood in the urine or its colour turning darker or more cloudy.
- the urine having a strong smell.

If symptoms develop it is worth seeing a healthcare provider straightaway as UTIs can be treated quickly and easily, often with a short course of antibiotics. A sample of urine usually needs to be given, which is tested to see if there is an infection, although treatment may be provided on the basis of the symptoms alone. The antibiotics usually work within 48 hours of starting treatment and with proper treatment symptoms have usually disappeared by the end of day 3 with proper treatment. Cranberry juice can make symptoms feel better but it does not treat the infection medically (and drinking it regularly has not been shown to reduce the likelihood of getting a UTI).



Almost half of all women will have a UTI at some stage in their life. The risk of infection for women is higher than for men because their urethra is shorter and the anus and urethral openings are closer together so it is easier for bacteria to enter the urinary tract.

Factors that increase the likelihood of a UTI include not drinking enough fluids (dehydration), the bladder not being fully emptied, constipation and hormonal changes during pregnancy and around the menopause.

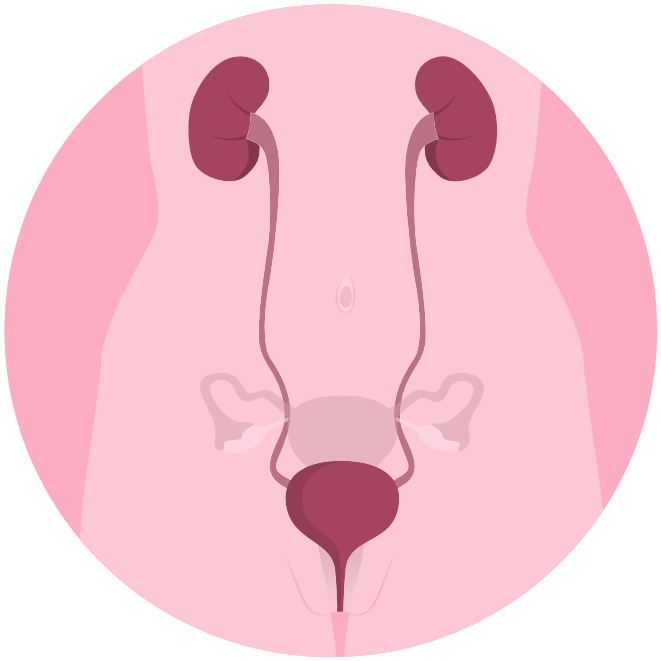
Keeping the vulval area clean, wiping from front to back and flushing the bladder out regularly by drinking fluids and urinating regularly will help to reduce the risk of getting a UTI.

See Chapter 2: Urinary health for more information on this.

Female genital mutilation

Female genital mutilation (FGM) is any procedure that involves partial or total removal of, or injury to, the outer parts of a woman's genitals for non-medical reasons. FGM is a common practice in some cultures but it is illegal under British law. There can be many complications following FGM, both immediately and in the longer term. If a woman thinks she may have been affected, she must see a medical professional as soon as possible to access the right care.

Chapter 2:
Urinary health



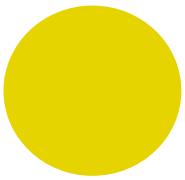
Introduction

Keeping well-hydrated reduces the risk of heat illness and optimises performance. It is recommended that people drink around 2 litres of water per day, but individual requirements vary. More fluids will be needed when working in particularly hot environments or during heavy exercise, to replace fluid lost through sweating. Passing straw-coloured urine is the most reliable indication that a person is well-hydrated. The following emphasises the importance of adequate fluid intake and why servicewomen must be enabled to regularly pass urine to optimise their operational effectiveness and health.

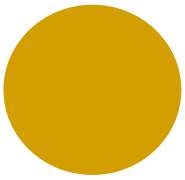
Urine colour chart

Doing okay. You're probably well hydrated. Drink water as normal.

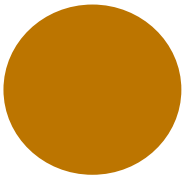
You're just fine. You could drink a small glass of water now.



Drink about 250ml water within the hour, or drink a whole 500ml bottle of water if you're outside and/or sweating.



Drink about 250ml water right now, or drink a whole 500ml bottle right now if you're outside and/or sweating.



Drink 1 litre of water right now. If your urine is darker than this and/or red or brown, then dehydration may not be your problem - see a doctor.

Passing urine

Fluid is essential for the constant filtration process which the kidneys perform to remove waste products from the blood. This process produces urine which is then stored in the bladder until a person can pass it from their body.

As the bladder fills and stretches it sends nerve signals to the brain, which give the person the urge to pass urine. Normally muscle sphincters can hold the urine in the bladder until an individual chooses to relax them and pass urine. It is important to pass urine regularly to stay healthy and optimise performance. Passing urine should occur 5 to 7 times a day, including once at night.

In the military environment it can be more challenging to pass urine regularly. Examples include when:

- Travelling within an aircraft with no easily accessible toilet facility.
- Needing to be focussed on a critical operational task.
- Working within an unsafe operational environment.

Servicewomen face additional challenges if toilet facilities are unavailable:

- They need to partially undress, which takes more time and increases skin exposure. This may have health implications in cold environments or where there are biting insects.
- Military clothing and personal protective equipment (PPE) sometimes need to be removed to enable squatting.
- Squatting strongly engages the muscles in the thighs and groin and pelvic floor. When passing urine this potentially stops the bladder from fully emptying, leading to Urinary Tract Infections (UTIs).
- They may want some privacy and have to leave the security of a team location to get this.

These circumstances can cause a servicewoman to try to remove the urge to pass urine. They might try to ignore the urge and hold on for a long time or reduce their fluid intake and risk dehydration.

Why the urge to pass urine should not be ignored

An individual who needs to pass urine is distracted and irritable and can make increased errors as they struggle to focus on what they should be doing.

In addition, holding urine beyond the point where the body is sending strong signals to pass urine can overstretch the bladder, leading to future bladder muscle weakness.

Eventually this can lead to the need to pass urine more often because people develop:

- Difficulty holding urine in and leakage of urine (incontinence).
- Poor bladder muscle contraction preventing the bladder from fully emptying, which increases the risk of a urine infection.
- Increased irritability of the bladder and feeling the urge to pass urine more often.

DID YOU KNOW?
Passing urine before the bladder needs to be emptied "just in case", in anticipation of restricted access to toilet facilities, may seem like a good idea. However, this can confuse the message the bladder sends to the brain, triggering the urge to pass urine more frequently.

Why reducing fluid intake is bad

Deliberately dehydrating to reduce the urge to pass urine can cause headaches, irritability, poor concentration and poor physical performance. The effects can be equivalent to being at the UK drink drive limit, with implications for safety critical tasks like weapon handling and operating machinery. For those in roles under the sea or in high altitude, dehydration can increase the risk of decompression illness and can reduce endurance to acceleration forces.

Within the bladder itself, more concentrated and strong urine can:

- Irritate the bladder muscle, increasing the urge to pass urine.
- Encourage the growth of bacteria, which can lead to a UTI. A UTI can be painful, distracting and make an individual feel extremely unwell and will usually result in being unfit for duty for a period of time.

Planning to overcome urination challenges

Simple planning measures can ensure it is easier for servicewomen to pass urine. These will allow a servicewoman to focus better and maximise her operational effectiveness.

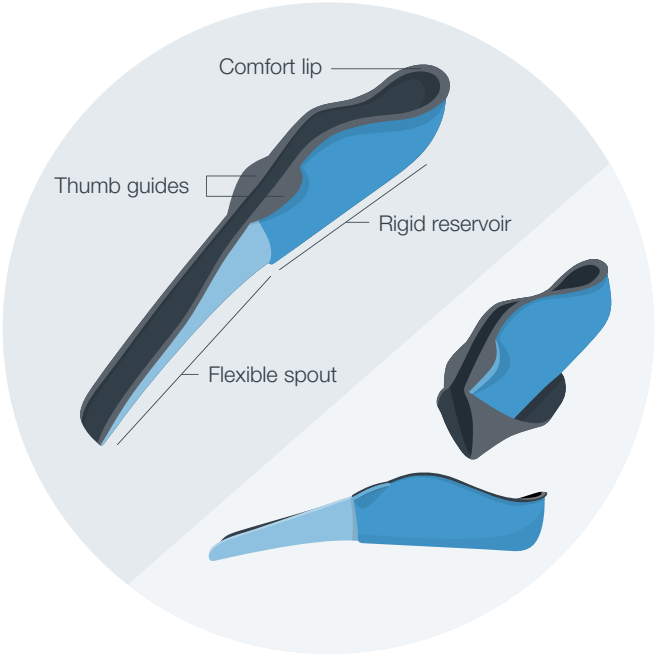
Measures include:

- Making and advertising sensible plans for the provision of toilet facilities which maintain privacy and dignity.
- Factoring in time and secure transport options if the only available toilet facilities are some distance away.
- Where stopping for long time periods or accessing private facilities is impractical or impossible, provide a Urinary Support Device (USD).

Urination Support Device (USD)

A USD enables servicewomen to pass urine in a standing position, like men, and reduces the need to undress in challenging environments. The UK Armed Forces previously provided a urination device called the SheWee. The device was small, challenging to use and often caused urine to spill onto clothing. It was very unpopular with servicewomen and has now been replaced by the USD.

The USD is a plastic and silicon funnel that is inserted through clothing. It has a large rigid reservoir which is held against the vulval area and collects urine as it leaves the body, channelling it away through a spout. The spout is flexible, enabling easy-storage, and long enough to direct urine away from the body and either into a toilet, urinal or bottle, or onto the ground and away from the feet. The USD reservoir is contoured so that it fits well against the vulva and provides gentle pressure to allow the user to know it is in the right position without looking. It has anchor points above the spout which also help guide its positioning and are useable with one hand, even if gloved.



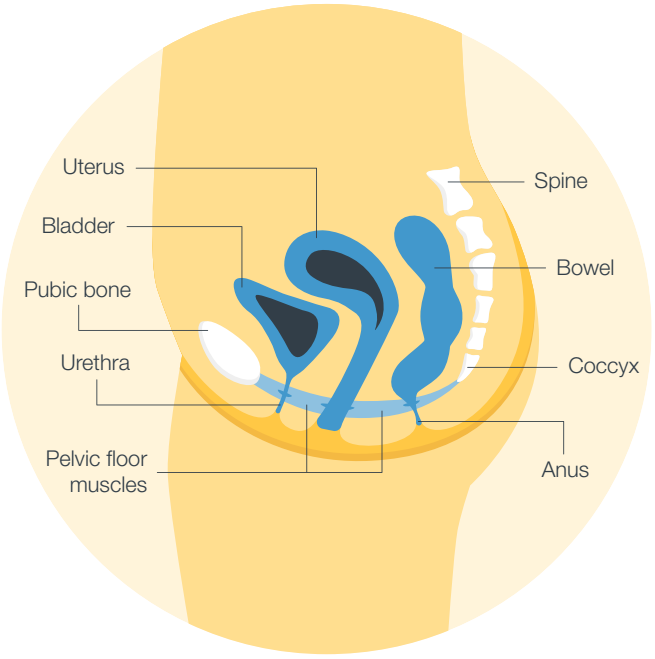
The USD is made of material which repels fluid and prevents the growth of bacteria, helping keep it hygienic between uses. After use it should be quickly rinsed with water or wiped with tissue, before storing it within its discreet pouch. A detailed information leaflet is provided with each USD.

USDs are available through normal supply chains to anybody who wants one for personal use.

TIP:
Servicewomen should practise using the USD in the comfort of their home environment, to get used to it before they need to rely on it in an operational setting.

The pelvic floor

The female pelvic floor describes a group of muscles and ligaments that sit in the lower part of the pelvis. These hold up the internal organs in the right place, as gravity tries to push them down. The pelvic floor can become weak in women of any age, but this is often worsened by changes during pregnancy, the menopause and being overweight. A weak pelvic floor becomes unable to maintain the vagina and uterus within the pelvis (leading to prolapse) or unable to support the bladder emptying properly so that urine accidentally leaks (known as incontinence) with activities like exercise, coughing or laughing.



Strengthening the pelvic floor

A strong pelvic floor will reduce the risk of urine leakage and prolapses. Pelvic-floor exercises, also known as Kegel exercises, strengthen the pelvic floor muscles and can be used as prevention or treatment of incontinence or prolapse. They are not an overnight fix and at least 1-3 months of regularly carrying out these exercises is usually needed to see improvements. These can be started by all women at any age to maintain good pelvic floor function and reduce the risk of developing problems in the future. This may be especially important for those in roles with lots of high impact activities (running, jumping), or sudden jolts, or those taking part in prolonged physical activity, including standing. Apps are available to help set a discreet, personal kegel exercise routine and teach appropriate technique. Servicewomen may want to consider including these within their daily health and wellbeing routine.

Pelvic organ prolapse

Pelvic organ prolapse is when one or more of the organs in the pelvis slip down from their normal position and bulge into the vagina. It can be uncomfortable, increase urinary leakage, and cause vaginal bleeding and low back pain. Around 10% of women over the age of 50 will have some pelvic organ prolapse but it can also occur in young women.

Mild prolapse often has no symptoms and treatment is not always needed but if women experience any symptoms of prolapse they should seek medical review. Symptoms include:

- Sensations of fullness, dragging or discomfort in the vagina.
- Increasing urinary leakage or bowel problems.
- Discomfort when having sex.

Pelvic floor and the menopause

The hormone oestrogen plays an important role in keeping the tissues within the pelvis healthy. With reduced hormone levels that accompany the menopause, the tissues can become dry and weak and fail to provide the same level of support. Pelvic organ prolapse, urinary incontinence and UTIs become more common in the post-menopausal period. See the menopause section for further discussion about risk reduction and treatments that may be considered by medical staff. See Chapter 4: The menopause.

Urinary incontinence

Incontinence is when a person leaks urine. It is more likely with increasing age but can affect women of any age. It is rarely talked about in the context of young, fit and healthy women but is more common than most people think.

DID YOU KNOW?
A survey undertaken in UK general practice patients found that just over two-thirds of woman over the age of 18 reported some episodes of leaking urine in the previous 4 weeks and just under half of these women felt this affected their hygiene or was socially embarrassing.

The unintentional passing of urine can range from leaking a few drops of urine to losing complete control and passing a lot of urine.

There are two types of incontinence.

Stress incontinence

This happens with physical exertion such as exercising, coughing, laughing or sneezing. It is caused by an increase in pressure within the abdomen. Military studies have identified that urinary leakage is common in servicewomen. Treatment to strengthen the pelvic floor can be provided within the military. Some physiotherapists have specialist training in women's health to support specific needs for all women, not just those who may need support recovering from childbirth.

Urge incontinence

This happens when a person experiences a sudden and intense urge to pass urine and is unable to hold on. The walls of the bladder include a muscle (known as the detrusor) which relaxes and stretches as the bladder fills, then contracts to push the urine out when an individual goes to pass urine. The muscle can contract too often creating an urgent need to go to the toilet. Drinking too much alcohol or too much caffeine, not drinking enough fluids (causing strong concentrated urine which irritates the muscle), or being constipated may all cause symptoms of urge incontinence.

Discussing symptoms with a healthcare professional will help identify potential causes and identify suitable treatment options.

Even mild symptoms and small amounts of urine leakage can cause embarrassment. These can be improved with medical help ranging from exercises to medications. Simple measures like reducing caffeine, increasing fluid intake (which may feel counter-intuitive initially) and increasing fibre within the diet can help.

If any issues are being experienced medical advice and help should be sought. Ignoring the symptoms will not help them improve.

Chapter 3:
Menstrual health

Introduction

Periods are a completely natural, normal process. They are a key part of human reproduction and being female. However, many people do not feel comfortable talking about them. Research tells us that around one in five women would feel uncomfortable discussing their periods with their female friends, mother or partner.

Lots of different language is used to describe periods, but this can be confusing. Not being able to talk openly about periods can prevent people from understanding what is normal and healthy, or when and how to seek help if they think something is wrong.

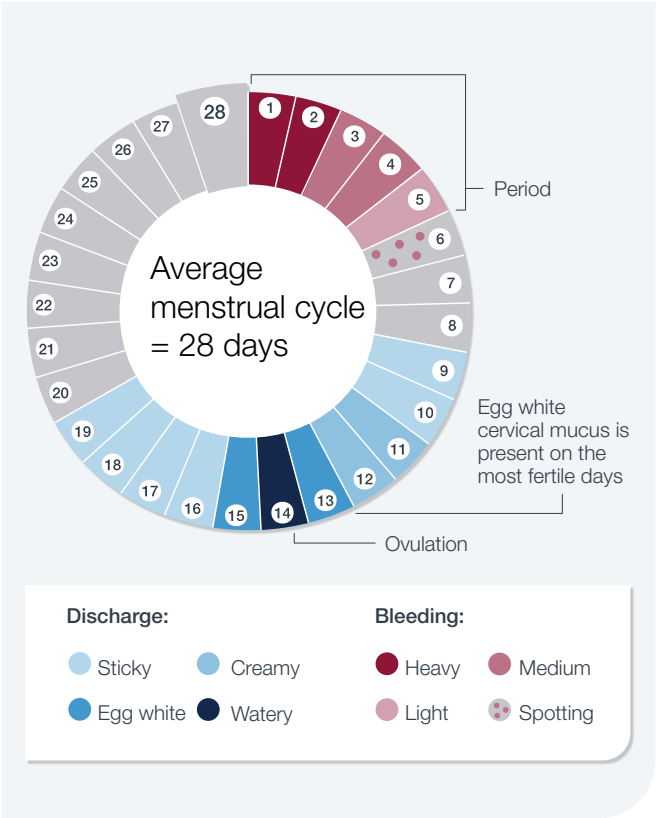
DID YOU KNOW?
1 in 5 women are uncomfortable talking about periods.

The following section provides all the basic information needed to confidently manage periods in the military setting.

The menstrual cycle

The menstrual cycle represents a series of hormonal changes. These cause a woman's body to prepare for a possible pregnancy and can cause symptoms such as mood changes, headaches and breast tenderness. The menstrual cycle begins on the first day of a woman's period, and typically lasts between 21 and 35 days, with the average menstrual cycle length being 28 days.

A period is the time during the menstrual cycle when a woman bleeds. The blood is the lining of the uterus which has grown in preparation for pregnancy. It is shed when a pregnancy does not occur.



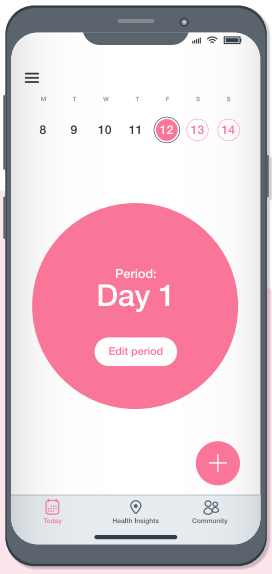
Ovulation occurs at the mid-point of the menstrual cycle. This is around day 14 if a woman's cycle lasts 28 days. This is when an egg is released from the ovaries and the woman is most fertile (i.e., most likely to get pregnant). See Chapter 6: Becoming a parent.

Menstrual cycles can be affected by normal age-related hormonal changes, pregnancy, contraception use and certain medical conditions.

Vaginal discharge varies throughout the menstrual cycle, in response to the changing hormone levels. It is usually clear or white and varies from being creamy and sticky to being egg white and watery around the time of ovulation.

Women can better understand what is normal for them during their menstrual cycle by keeping track of bleeding patterns, vaginal discharge and other symptoms they experience. This helps women to recognise when something is wrong and seek out advice if needed.

TIP:
There are lots of tools available to track menstrual cycles, varying from paper-based diaries to mobile applications. These can be helpful to use when talking to a health care professional about any concerns.



Periods

Periods usually start between 11 and 14 years of age and stop when a woman is between 45 and 55 years of age and experiences the Menopause (see Chapter 4: The menopause). A female's first ever period is called the 'menarche'.

Periods typically last around 5 days but can last between 2 and 8 days. If a period is regularly any shorter or longer then the servicewoman should discuss this with a medical professional.

Normally women pass between 30-72 ml (5-12 teaspoons) of blood during their period, but some women bleed more than this. Bleeding is heaviest on the first 2 days of the period.

Changes to the menstrual cycle can be normal but any concerns should be discussed with a healthcare professional. Periods can often become unpredictable when a woman's body is under high levels of physical and emotional stress.

This can happen to servicewomen in military environments and they may experience:

- heavier and longer periods.
- lighter and shorter periods.
- unexpected periods or bleeds.

A servicewoman needs to know what to do if she experiences bleeding whilst at work and should be supported by her chain of command. Some of the products available to manage period blood are described below. It is important to respect a woman's privacy and recognise that how she manages her periods is her personal choice.

Managing periods and female hygiene

Women need to be allowed to hygienically manage their periods and any bleeding without fear of embarrassment or loss of dignity. This means providing some privacy, access to soap and water whenever possible, ensuring period products are available if needed, and enabling the disposal of used products in a hygienic manner.

Servicewomen may need to try several options to find the management method(s) and products which work best for them. Different products may be preferred at different stages of the period, different times of day and when living and working in different environments. A servicewoman may also choose to use contraceptives to manage her bleeding but she will still need to be prepared to manage unexpected breakthrough bleeds that may occur.

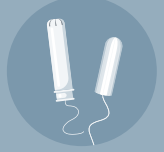
Period products

There are 2 main groups of products available to help women manage their periods:

- Products that absorb menstrual blood.
- Products that collect menstrual blood.

These products can be used internally or externally, and a combination of internal and external methods can be used to provide extra protection. These products are available in disposable and re-usable forms.

The table below provides a quick reference guide to enable comparisons between different menstrual products.

	Absorb	Collect
Period pants/ Menstrual underwear 	Look like normal underwear but are made of multiple absorbing layers. Can absorb 3-8 tampons worth of blood, and should be changed every 12 hours. Come in a variety of shapes including shorts and swimwear. Allows women to participate in all physical activities including swimming. Several pairs are needed. Also useful for women experiencing urine leakage (incontinence). See Chapter 2: Urinary health.	
Sanitary pads 	Are fixed within normal underwear. Should be changed every 3-4 hours. Come in different shapes and sizes. Can become loose/rolled up if used during physical activity. Reusable pads are available and usually come in two parts; they will need to be stored hygienically until they can be washed.	
Tampons 	Inserted inside the vagina by hand or using an applicator tube. Should not be felt when being used. Should be changed every 4 hours to avoid Toxic Shock Syndrome (TSS). Can be used for up to 8 hours overnight but should be removed/changed first thing on waking. Allows women to participate in all physical activities including swimming.	
Menstrual cups 		Inserted into the vagina. Should not be felt when being used. Collect blood internally. Should be worn for no longer than 12 hours to avoid Toxic Shock Syndrome (TSS). Cup should be emptied then rinsed with water before it is reused. Should be sterilised between periods. A cup should always be removed before any penetrative sex and is not a form of contraceptive. The majority are resuable and can last up to 10 years with proper care.
Menstrual discs 		Inserted into the vagina. Collect blood internally. They are available in reusable and single-use forms. Can be worn during penetrative sex. Not a form of contraceptive.

Toxic shock syndrome

Toxic shock syndrome (TSS) is a rare but life-threatening condition caused by bacteria getting into the body and releasing harmful toxins. Around half of all cases occur in women having a period. During periods the natural acidity of the vagina changes and this can lead to an increase in the growth of bacteria in the vagina. Internal menstrual care products, like tampons and menstrual cups, introduce oxygen into the vagina. These conditions may create a breeding ground for bacteria, which very rarely can lead to TSS. TSS gets worse very quickly and can be fatal if not treated promptly. But if it is diagnosed and treated early, most people make a full recovery.

The following things can reduce the risk of toxic shock syndrome (TSS) associated with tampons and menstrual cups:

- Washing hands before and after inserting a tampon or menstrual cup.
- Always using a tampon with the lowest absorbency possible for the heaviness of your bleed.
- Changing tampons or emptying menstrual cups regularly – as often as directed on the pack (usually at least every 4 to 8 hours for tampons and 12 hours for menstrual cups).
- Alternating between internal collection devices (eg tampons and menstrual cups) and external sanitary pads during the period.
- Never having more than one tampon in the vagina at a time.
- If using a tampon or menstrual cup at night, inserting a fresh tampon or clean menstrual cup before going to bed and removing it as soon as possible on waking up.
- Always removing a tampon or menstrual cup at the end of a period.

Managing periods in the military

Being prepared should help reduce a servicewoman's anxiety about bleeding whilst at work in the military. The following points should be considered and supported by her chain of command. Importantly, how a woman manages her periods is her personal choice and she may want or need to change her approach dependant on the environment she is operating in.

Hygiene considerations

Hand washing before and after changing period products is strongly advised to reduce the risk of infection. Hand hygiene is essential where women need to insert their fingers into the vagina to insert or retrieve a product (non-applicator tampons, menstrual cups and discs). Washing visibly dirty hands with soap and water is preferred, but hand gel can be used if water supply is restricted.

The chain of command should support hand hygiene but if this is impossible for operational reasons, servicewomen should seriously consider alternative period management options.

Daily body washing is recommended to reduce the risk of infection and odour production for women having periods. Products worn externally may also result in additional blood around the groin area. Where water is unavailable, non-scented wet-wipes can be used.

Women who choose to use reusable products will also need access to washing facilities.

Access to privacy

All products require changing at some point during the day and at night. A woman should be provided as comfortable, safe and private a location as possible, as well as some time to do this.

TIP:
In certain circumstances it may be easier for a servicewoman to choose period products that require less frequent changing but the risk of TSS should always be considered. Women should never be encouraged to use higher absorbency products than recommended for their blood flow.

Activities

Swimming can be undertaken using internal methods and swim versions of period pants are now available. Pads may sometimes roll up in underwear with excessive movement and may cause chafing. Menstrual cups can sometimes be uncomfortable with high impact activity; using a less rigid construction material and design during activity may reduce this but may increase the risk of leakage. Women should be encouraged to experiment to find out what product works best for them, to enable full participation in all activities.

Uniform choices

Light-coloured clothing and certain fits of uniform or sportswear may highlight that a woman is having a period, either because the period product is visible or if blood unexpectedly leaks. Some women may choose to use two methods at the same time to minimise the likelihood of leakage, but this may increase the likelihood of products being seen. Wherever possible individuals should be provided appropriate choice about what uniform they wear to minimise anxiety and maximise comfort.

Deployable supplies

Servicewomen want choice about what period products they use and to provide these themselves, but there are times when this supply may fail or a bleed is unexpected or heavier than usual. Women should be encouraged to take enough supplies to last slightly longer than they expect to need under usual conditions as well as spare underwear and cleaning wipes in case of any leaks. Scented cleaning wipes and products are not advised as they may cause vulval or vaginal irritation. These supplies should be kept waterproofed to ensure they are in good condition when needed.

Menstrual Supply Box

The Menstrual Supply Box (MSB) is a kit-box which provides a selection of disposable products to meet any period needs. The MSB is provided to support anybody with an unexpected bleed or where their own supply is insufficient or has been lost. It should be easily accessible in a place known to all but which maintains any user's privacy and dignity.

The MSB has a range of period and hygiene support products, including new underwear, available for women to use. It should be available for any woman deployed on exercise or operations in austere environments; this includes ships, submarines and field-based environments.

Practice before deployment

Some period products require a bit of practice using them, to ensure a comfortable and secure fit. It is recommended that a servicewoman experiments with new methods in advance of any deployment, whilst still in her usual home environment. This should provide greater confidence when using the products in more challenging deployed environments. She should also consider using different methods in different environments and for different activities, effectively adopting a "pick and mix" approach.

Effects of contraceptives on periods

Hormonal contraceptives are medications used to prevent pregnancy. These typically affect period patterns and can be very useful for managing period bleeding. Many servicewomen choose to use contraceptives to stop period bleeding, but this should not be expected. Servicewomen must always be supported to manage their periods in the military workplace. More detail about contraceptives and how they should be used to prevent pregnancy and their effects on periods is provided in Chapter 5: Contraception and sexual health.

Waste disposal

Managing reusable products. Reusable products need washing between use. They may need to be hygienically stored until it is possible to do this.

- All blood should be rinsed out of the products by hand, using running cool or warm water until the water runs clear. This dirty water needs to be hygienically disposed of.

- Absorbent period products then need washing with soap or detergent and will need to dry before they are next used. Most reusable absorbent products have a longer lifespan if they are washed in cool water, either in a washing machine or by handwashing and allowed to air dry. However, most group laundry facilities are likely to use hot water and tumble dry personal laundry which may reduce the effectiveness of the products.

- Menstrual cups need sterilising between periods. Sterilising fluid, boiling water or access to a microwave may be needed.

Managing disposable products. The management of menstrual waste differs depending on the product being used.

- Period products should not be flushed down a toilet to dispose of them. They cause blockages and pollution.

- Within communal areas, like the military environment, disposable period products cannot be thrown away in the bathroom bin like a servicewoman may do at home. Sanitary disposal bins should be provided within the ablution blocks and regular workplaces, to enable safe and hygienic waste disposal. If these are not available then Personal Menstrual Waste Pouches (PMWP) can be used.

Personal Menstrual Waste Pouches are now available to enable discreet management of any used period product in any location.

- 20 bags are provided in 1 unit.

- The inner part of the PMWP is a totally opaque, fully sealable bag that locks in odour. These bags can be opened and used with one hand (making things easier when multiple layers of clothing and kit are being worn), to contain used period products.

- This bag can either be immediately disposed of with normal waste or stored within the outer part of the PMWP until appropriate waste facilities can be accessed.

Period problems

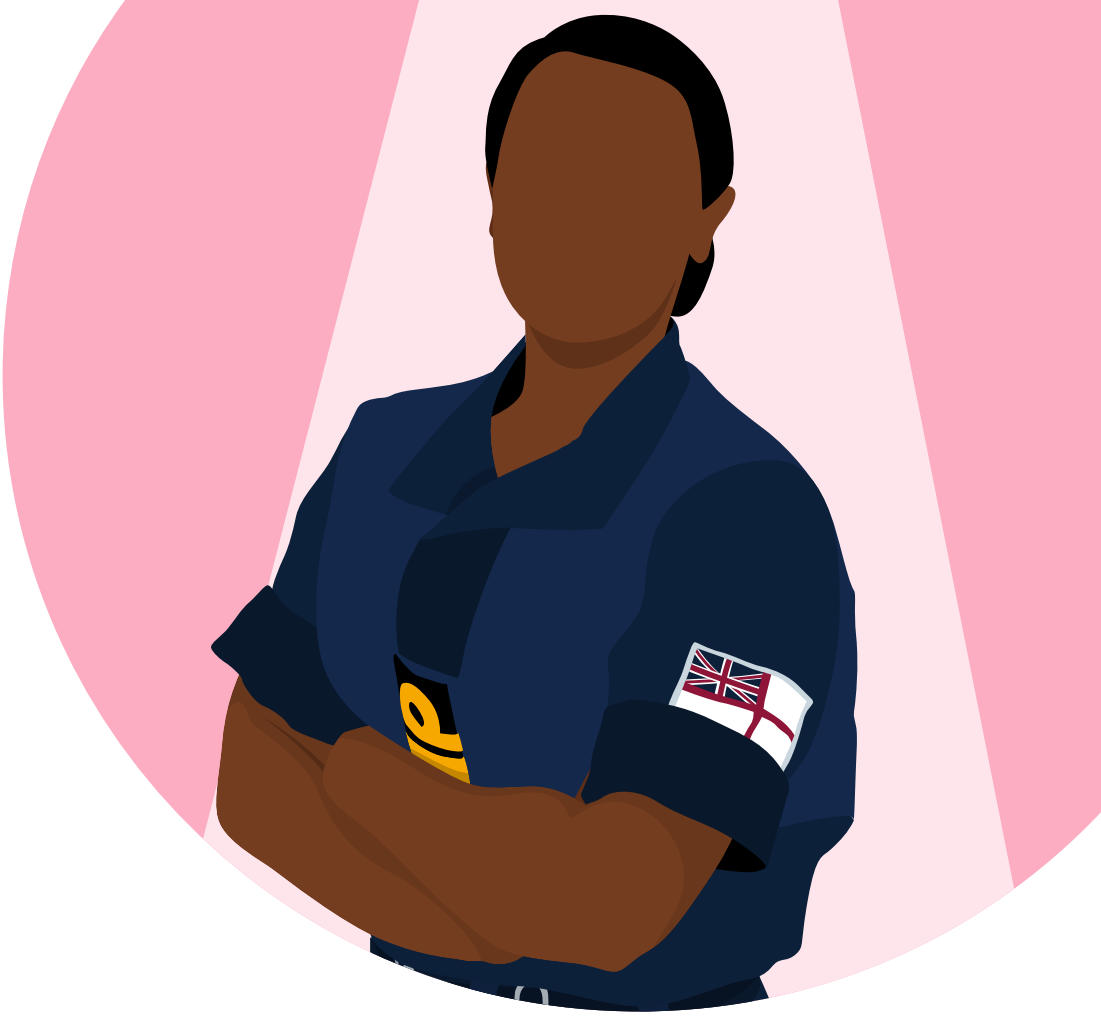
Periods can sometimes be accompanied by pain, mood changes and heavy bleeding. These can negatively impact on a woman's work and social life but several treatment options exist.

A servicewoman should speak to her healthcare practitioner about any concerns.

Condition	Symptoms	Considerations
Pre-Menstrual Syndrome (PMS)	There are many possible symptoms of PMS but the typical symptoms include: • feeling bloated or abdominal pain. • tiredness or trouble sleeping. • headaches. • breast tenderness. • mood swings. • feeling upset, anxious or irritable. • spotty skin or greasy hair. • changes in appetite and sex drive.	If symptoms are impacting on work and activities, women should keep a diary of symptoms over the last few menstrual cycles and discuss with their GP to decide if prescribed medications may help Treatment options • regular exercise. • eating a healthy and balanced diet. • getting at least 7-8 hours sleep a night. • avoiding alcohol and smoking. • using simple painkillers.
Painful periods (dysmenorrhoea)	Aching or cramping pains in the lower abdomen	If period pain is impacting on exercise and normal daily routines, women should discuss with their GP as it could be due to a medical condition like endometriosis. Treatment options • taking simple painkillers. • gentle exercise. • soaking in a warm bath. • applying a heat pad or hot water bottle.

Condition	Symptoms	Considerations
Heavy periods (menorrhagia)	• Blood clots larger than the size of a 10p coin. • A sanitary pad or tampon needs changing every 1 to 2 hours. • A menstrual cup needs emptying more often than is recommended for that particular product. • 2 types of sanitary products together are needed to absorb the flow (eg pad and a tampon). • Bleeding regularly leaks through to clothes or bedding. • Bleeding lasts longer than 7 days. • The woman needs to avoid activities like exercise or take time off work.	Not all women will need or choose to have treatment for heavy periods, but they should be aware that help is available and they should always see a GP if: • Heavy periods are affecting their activities and work. • They have severe pain during their periods. [Pain is considered severe if it is always there and it distracts from other activities, including thinking and talking, it affects sleep or it interferes with normal daily activities like walking, washing and dressing.] • They have had heavy periods for some time. • They bleed between periods or after sex. • They have other symptoms with their periods, which include pain when passing urine or stools or when having sex.
Absent periods (amenorrhoea)	No period bleed	Typically occurs if a woman is pregnant or after menopause. It is a side effect of some contraceptives. It can also be caused by some medical conditions, including eating disorders, polycystic ovarian syndrome and other hormone disorders. A woman who unexpectedly misses a period should discuss this with a medical professional.

Chapter 4:
The menopause



Introduction

The menopause is a natural event which all women will experience. However, the symptoms of menopause vary greatly from person to person. Some women may transition through the menopause and quickly adapt with minimal support. Knowing their symptoms are typical for this normal biological process may be enough to help them manage their experience.

For other women, menopause symptoms may be challenging, significantly impact on the quality of their life and those around them, and need treatment. Although openness is encouraged, servicewomen retain the right to privacy with respect to their health and wellbeing. Menopause transition is no exception.

For most servicewomen experiencing the menopause, it will come at a point in their career where they are likely to be experienced and play a senior part in the organisation. The menopause can negatively impact on their professional performance and confidence. Menopause does not only affect women. Other personnel may be indirectly affected if a colleague or close family member is experiencing menopausal symptoms.

Servicewomen should seek medical advice and talk to their chain of command if they feel their performance at work is being negatively affected, either on a regular basis or just the occasional “bad day”. Their chain of command and colleagues should also seek advice from healthcare providers about how to support employees affected by the menopausal transition.

DID YOU KNOW?
Women who live in countries where menopause is viewed as a normal life event and where aging is not considered to be negative are generally less affected by menopause symptoms. Creating a menopause positive workplace, where there is no stigma around menopause may help symptom management.

The menopause and perimenopause

The menopause has occurred when a woman's hormone levels have decreased and she has not had a period for 12 months (or 24 months if younger than 50). Women can experience a wide range of symptoms as their hormone levels lower. These can be present for up to 10 years before the menopause, during a phase referred to as the perimenopause. On average symptoms last for up to 4 years after the menopause, but some women experience symptoms for up to 12 years. The symptoms eventually settle as the body adjusts to lower hormonal levels.

For most women, the menopause occurs naturally as their ovarian function declines with age. This typically occurs between 45 and 55 years of age. Eventually the ovaries stop functioning, menstrual cycles end, periods stop and the woman is no longer able to become pregnant naturally.

Around 1 in 100 women experience premature menopause, due to premature ovarian insufficiency. Menopause is premature if it occurs before the age of 40. For some other women menopause may occur as a result of surgical or medical treatments. All these women should be under medical supervision.

Symptoms

The symptoms of menopause and perimenopause are wide ranging and affect women in different ways. These symptoms can impact quality of life and daily functioning. This is an important consideration in all military roles, and particularly safety critical roles.

Symptoms can be experienced independently but are often interrelated. This can create a 'domino' effect whereby one symptom can cause or worsen another.

Women with pre-existing medical conditions may find that the menopause and perimenopause can aggravate their existing health conditions. The symptoms can in turn, also be made worse by an existing health condition.

Common menopause and perimenopause symptoms (this list is not exhaustive) are:

- Hot flushes – short, sudden feelings of heat, usually in the face, neck and chest, which can make skin red and sweaty.
- Night sweats – hot flushes that occur at night.
- Difficulty sleeping – this may make you feel tired and irritable during the day.
- Changes in sex drive (libido).
- Problems with memory and concentration.
- Vaginal dryness and pain, itching or discomfort during sex.
- Headaches.
- Mood changes, such as low mood or anxiety.
- Palpitations – heartbeats that suddenly become more noticeable.
- Joint stiffness, aches and pains.
- Reduced muscle mass.
- Recurrent urinary tract infections (UTIs).
- Changes to hair and skin.
- Weight gain.

Symptom relief

Servicewomen will be asked about menopause-related symptoms at routine health screenings but can consult their healthcare practitioner at any time.

There are a number of options to treat menopause and perimenopause symptoms. These include Hormone Replacement Therapy (HRT), lifestyle changes and management of individual symptoms.

HRT can relieve symptoms and is generally safe if started before or around the time of the menopause. It also offers additional benefits by reducing future health risks from cardiovascular disease, dementia and osteoporosis.

Servicewomen should speak to their healthcare practitioner to explore what treatment options would work best for them, assess whether workplace adjustments are needed, and decide whether further health checks are needed.

Symptom relief options

Treatment	Examples	Considerations
Lifestyle changes	• Exercise • Weight loss • Trigger avoidance (eg caffeine, alcohol, spicy foods) • Cooling (clothing choices, fans) • Stop smoking	• Can help relieve hot flushes, poor sleep, low mood and musculoskeletal symptoms • Benefit overall health
Hormone Replacement Therapy (HRT) (Oestrogen +/- Progesterone)	• Patches • Gels • Tablets • Nasal spray • Intra-uterine (mirena coil)	• Can relieve all symptoms • Additional benefits of reducing risk of cardiovascular disease, dementia and osteoporosis • Hormone treatments may be unsuitable for some women with other medical conditions
Individual symptom management	• Cognitive Behaviour Therapy (CBT) for low mood and anxiety • Serotonin Specific Reuptake Inhibitor (SSRI) for hot flushes antidepressants • Clonidine for hot flushes	• Can relieve specific symptoms and suitable for women unable to take hormones • Typically not as effective as HRT
Alternative treatments	• Soy • Black cohosh • St John's Wort • Evening Primrose Oil	• Limited evidence of effectiveness • Whilst marketed as "natural", preparations can vary in quality, purity and ingredients and therefore safety

Chapter 5: Contraception and sexual health

Introduction

Any method that reduces the risk of pregnancy following sexual intercourse is known as contraception. This includes medication, devices and surgery. Some methods also protect against sexually transmitted infections. Contraception is not only a woman's responsibility. Appropriate methods should be discussed between sexual partners.

When deciding on the most suitable contraceptive method, a servicewoman should consider her lifestyle and priorities. For example, some women may prefer to use the hormonal contraceptive pill that will reduce the amount they bleed, whilst others may prefer a 'fit and forget' method.

The following discusses contraception, factors that may influence a servicewoman's choices and the importance of good sexual health.

How contraception works

Some contraceptives prevent sperm entering the body, some are toxic to the sperm, some stop an egg being released from the ovaries and some stop a fertilised egg from implanting in the uterus and a pregnancy being established. Some people have religious or personal views and beliefs about what types of contraception are acceptable. It is important these are discussed with healthcare professionals to help identify what will work best for the couple.

Barrier methods

Condoms (both male and female) and diaphragms are barrier methods. These prevent sperm travelling through the cervix and fertilising an egg from the ovaries. To be most effective these should be used with spermicide, which is toxic to sperm. These methods need to be fitted before intercourse and can get damaged and then become ineffective at preventing pregnancy. If properly used, condoms are the most effective way to reduce the risk of sexually transmitted infections from sexual intercourse.

Hormonal contraception

Hormone-containing contraceptives work in several different ways. Some stop the ovaries from releasing an egg and all affect the uterus, to prevent a pregnancy establishing. Hormonal contraceptives are very effective methods for preventing pregnancy and the hormones can be given systemically or locally. Systemic contraceptives, like the contraceptive pill, implant or injection are absorbed into the blood stream and can affect all parts of the body. This may give rise to side-effects like headaches, breast tenderness and acne. In contrast, locally-released hormonal contraceptives like the intrauterine system (IUS) or vaginal ring deliver a lower dose of hormone directly to the female internal reproductive system, with limited amounts absorbed into the bloodstream and minimal effects on the rest of the body.

Intrauterine devices

The copper intrauterine device (IUD) does not contain hormones. It works by creating an environment that is toxic to sperm, reducing the likelihood of an egg being fertilised. It then also prevents a fertilised egg implanting into the lining of the uterus, stopping any pregnancy that might have started from progressing, which is unacceptable to some people. The intrauterine system (IUS) works in a similar way but uses hormone which can also affect ovulation.

Knowledge methods

Fertility awareness methods rely on women monitoring their vaginal discharge, temperature and menstrual cycle lengths to identify when they are ovulating. To prevent pregnancy, a couple must abstain from sexual intercourse or use another contraceptive during the woman's fertile window. The fertile window is calculated taking into account that sperm can typically survive inside the female body for up to 7 days and the egg can survive for up to 2 days after ovulation. This is not a reliable contraceptive method for women with irregular menstrual cycles.

Sterilisation

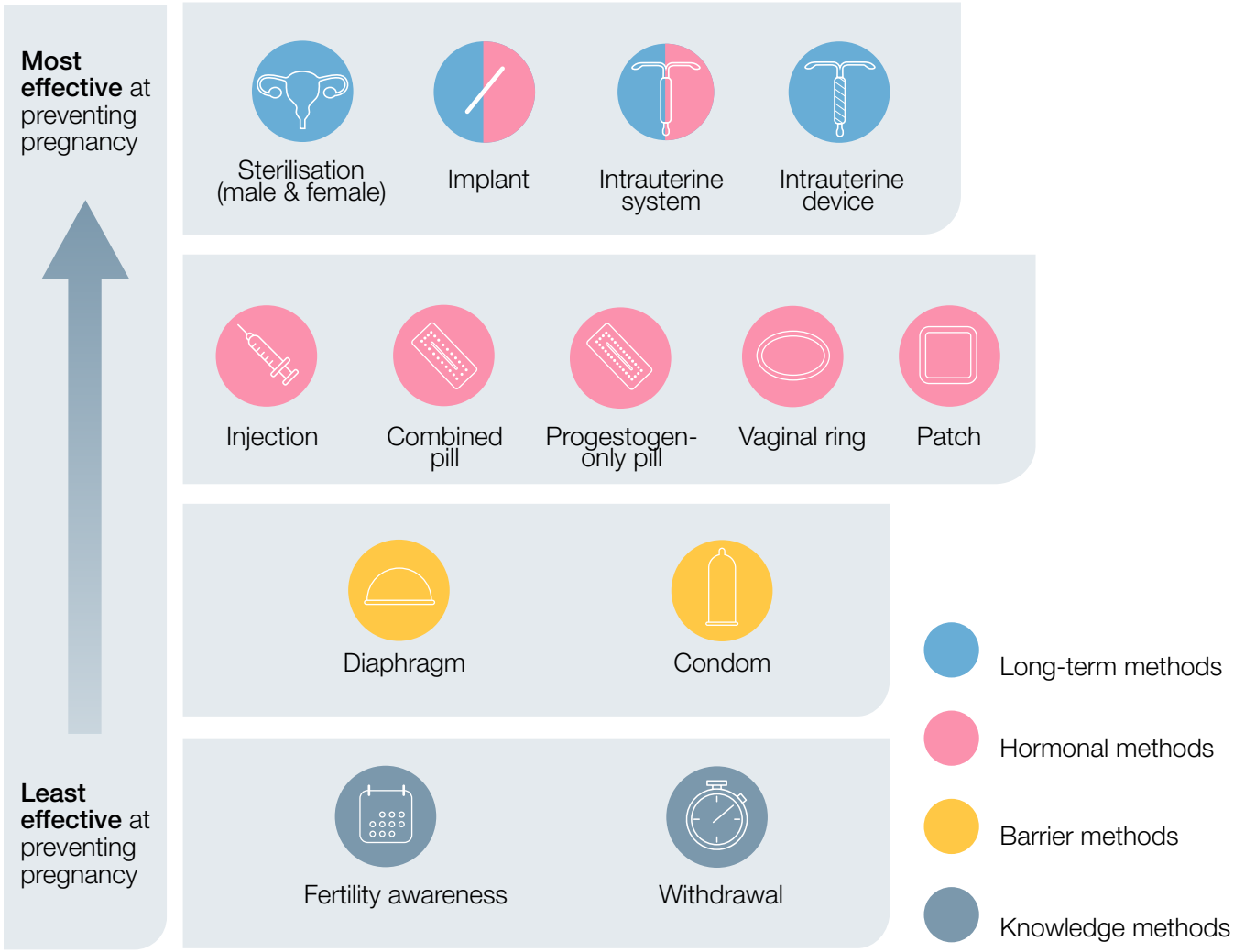
Male and female surgical sterilisation are both effective contraceptive options which ensure that a sperm and egg cannot meet. These should be considered permanent options; reversal options exist but are not always successful.

Choosing a contraceptive

When deciding on the right contraception method for her, some important considerations for a servicewoman making an informed choice are:

- Effectiveness at preventing pregnancy
- Duration of contraceptive effect
- Hormonal impacts and effects on bleeding

Effectiveness at preventing pregnancy

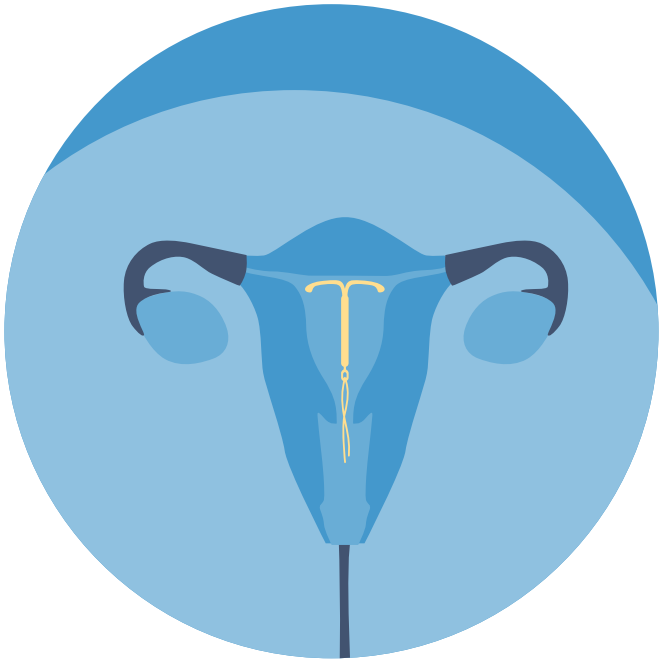


Duration of contraceptive effect

Some methods of contraception can be implanted or fitted for a woman, and then can protect against pregnancy for a long time. These are called “fit and forget” methods, referred to medically as Long Acting Reversible Contraceptives (LARCs). Female sterilisation is also very effective and may be suitable for some women with no intention of ever becoming pregnant but it should be considered permanent.

A woman using a LARC will not have to remember to regularly take, use or carry her contraception. The IUD, IUS or implant are all very effective forms of LARC that can be removed should a woman want to become pregnant later.

LARCs may be useful for servicewomen with unpredictable work demands. These methods usually need administering or fitting, and then removing by a healthcare professional.



Injections are also an option but they are known to affect bone strength. This may increase the risk of musculoskeletal injuries for servicewomen using them. They can also sometimes have a delayed effect on fertility after stopping them.

If a servicewoman does not want a ‘fit and forget’ method she should consider how easily she will be able to access repeat prescription or other contraceptive options which may not be possible in all locations. She should also consider how frequent changes of time-zones or increased physical and psychological stress may trigger unscheduled bleeding with some contraceptives.

Hormonal impacts and effects on bleeding

Some contraceptives affect the heaviness of bleeding during periods or even stop bleeding altogether.

A regular period pattern can be a helpful sign of good personal health so some contraceptives which interfere with bleeding patterns prevent women from observing this.

Hormonal contraceptives can cause unpredictable bleeding and other hormonal side effects. A copper Intrauterine Device (IUD) can increase the heaviness and duration of bleeding.

Contraceptives affecting periods

Contraceptives can change bleeding patterns. Some contraceptives, usually hormonal methods, can lighten and reduce the number of days bleeding. Some stop periods altogether, which is referred to as menstrual suppression. Reducing bleeding can be an advantage for servicewomen. Contraceptives can also cause irregular and unpredictable bleeding and some can cause longer and heavier bleeding.

Most changed bleeding patterns settle into something predictable within the first 12 months of use. There is no way of predicting what the end-result will be for each woman. If a servicewoman wants to start using a contraceptive that may change her bleeding pattern, it is sensible to do this a few months ahead of any military activities that could make managing unexpected bleeds more challenging.

If a woman wants to use contraceptives to deliberately suppress her periods she should discuss this with a healthcare professional to help choose her best option.

The following contraceptives affect bleeding patterns:

Combined hormonal contraceptives

These use oestrogen and progesterone and include the Combined Pill, Vaginal Patch and Vaginal Ring, which can be used to control the timing of bleeding or used continuously to avoid bleeding altogether. Around 20% of people experience irregular bleeding in the first three months of using these methods, but this commonly settles down and then only occurs when the woman takes a controlled break from the method. The bleed that happens when a woman has a break is not a normal period. It is a hormone withdrawal bleed that is typically lighter than the woman's normal period. Sometimes women will have a bleed at other times, which is known as breakthrough bleeding. This is common but should always be investigated in case it is a sign of infection or abnormalities of the cervix.

Progesterone only hormonal contraceptives

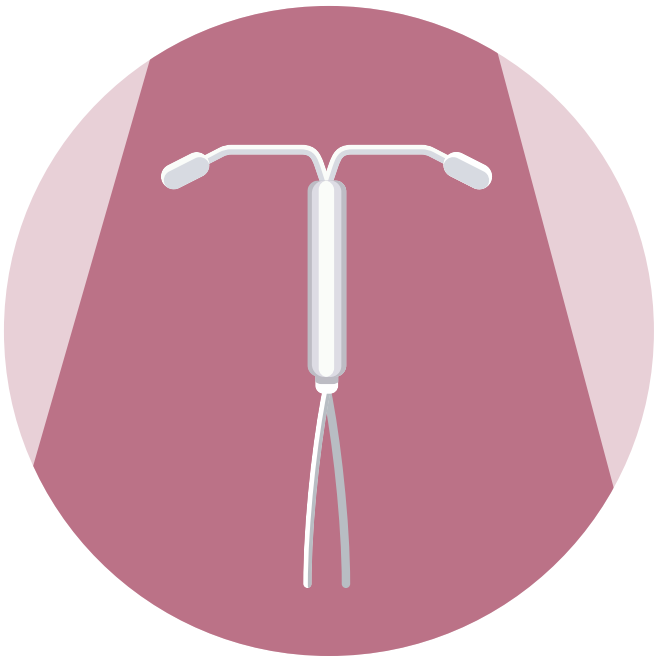
Bleeding can be unpredictable when women use progesterone-only methods, which must be taken continuously to prevent pregnancy.

- **Progesterone only pill.** Approximately 50% of women using this are likely to have either very infrequent or no bleeding, and 20% will experience prolonged spotting or bleeding (lasting more than 14 days).

- **Injection.** Bleeding disturbances are common for those who use the progesterone only injection, and about 50% will stop bleeding in the first year of use. The return to a normal menstrual cycle can be delayed for up to one year after stopping this method.
- **Implant.** Bleeding is often lighter for users of the contraceptive implant, but the bleeding pattern can also be unpredictable. Approximately 20% of users will stop bleeding and 20% will have prolonged bleeding.
- **Intrauterine system (IUS).** These are sometimes referred to as coils but are different because they release progesterone. They will usually reduce blood flow by approximately 85% and some users will stop bleeding altogether. This is known as amenorrhoea. There are brands of IUS (Mirena/Levosert) that are used to treat heavy menstrual bleeding because they are able to thin the uterine lining and cause amenorrhoea. It is common to have some irregular bleeding in the first three to six months following the insertion of an IUS but this should still be discussed with a GP. A GP will be able to rule out any other possible cause of irregular bleeding such as pregnancy, infection or abnormalities of the cervix. Bleeding patterns usually return to the woman's previous normal after an IUS is removed.

Non-hormonal contraceptives

Most of these options do not affect bleeding patterns. However, the Copper intrauterine device (Cu-IUD) can; this is sometimes referred to as a copper coil. The Cu-IUD can cause a woman's periods to become heavier, longer, or more painful and it is common for women to experience irregular bleeding in the first three to six months after it is inserted. A woman experiencing this should discuss it with a healthcare professional who will consider investigations to rule out other causes; these include pregnancy, infection or abnormalities of the cervix.



Access to Female Hygiene Support

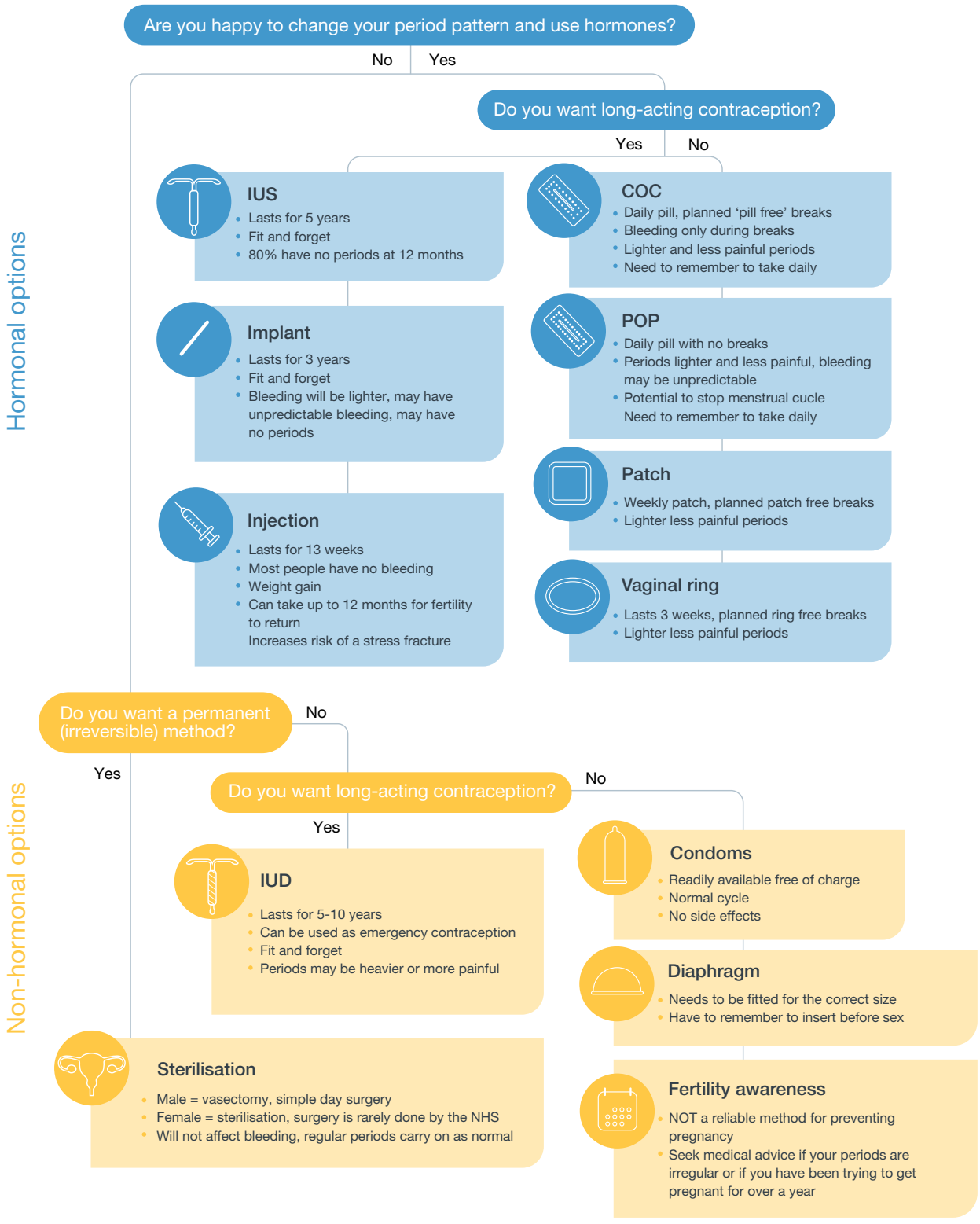
Access to female hygiene support remains essential for all women. A woman may make an informed personal choice to use hormonal contraception to suppress bleeding, but she might still experience unexpected breakthrough bleeding. Other women will not be able to use hormonal contraceptives for medical reasons, and many may not want to, preferring to maintain their normal menstrual cycle and period pattern.

DID YOU KNOW?
Bleeding that is experienced with hormonal contraceptives is not a normal period. If someone uses the combined contraceptive pill their normal menstrual cycle is stopped - the bleed that occurs during a controlled 7-day break between packets is simply due to the hormone levels dropping and provided only to reassure people that they are not pregnant, like a normal period would.

Breastfeeding and contraception

Some contraceptive methods are not advised when breastfeeding. Breastfeeding can reduce the likelihood of pregnancy if certain criteria are followed but should not be relied on for contraception. Breastfeeding should be discussed with a healthcare provider when choosing appropriate contraception.

Choosing the right contraception



Failed contraception

Emergency contraception

Unplanned pregnancy can occur following unprotected sexual intercourse. Sex is unprotected if contraception fails during sexual intercourse. Taking action as soon as possible after unprotected sex can reduce the risk of having an unplanned pregnancy.

NOTE:
Remember if barrier contraception has failed there is a risk of developing a sexually transmitted infection.

Emergency contraception is not as effective as other methods of regular contraception and will not prevent sexually transmitted infections. There are two methods that can be used in the days after unprotected sexual intercourse to reduce the chances of becoming pregnant:

- **Emergency contraceptive pills.** These are sometimes referred to as the Morning After Pill. Two types are available and they are most effective the sooner they are taken after unprotected sexual intercourse, but can still be effective for a few days afterwards. They are available from the medical centre, including on deployment, and can be purchased privately in pharmacies in the UK.
    - Levonelle can be used within 72 hours (3 days) of unprotected sexual intercourse (but is most effective if taken within 12 hours).
    - EllaOne can be used within 120 hours (5 days) of unprotected sexual intercourse (but is most effective the earlier it is taken). This is available to servicewomen on deployment and can be accessed from supporting medical staff.
- **The intrauterine device (IUD)** can prevent pregnancy if fitted within 5 days of unprotected sexual intercourse. Some medical centres have trained fitters but if none is available a local arrangement can be made to get one fitted. Contraception and Sexual Health clinics (iCASH) in the UK can provide this service for free. If well-tolerated the IUD can then stay in place for between 5 and 10 years (depending on type used) and provide a longer-lasting and reliable form of contraception. Alternatively it can be removed after a few weeks, once pregnancy has been ruled out.

Unplanned pregnancy

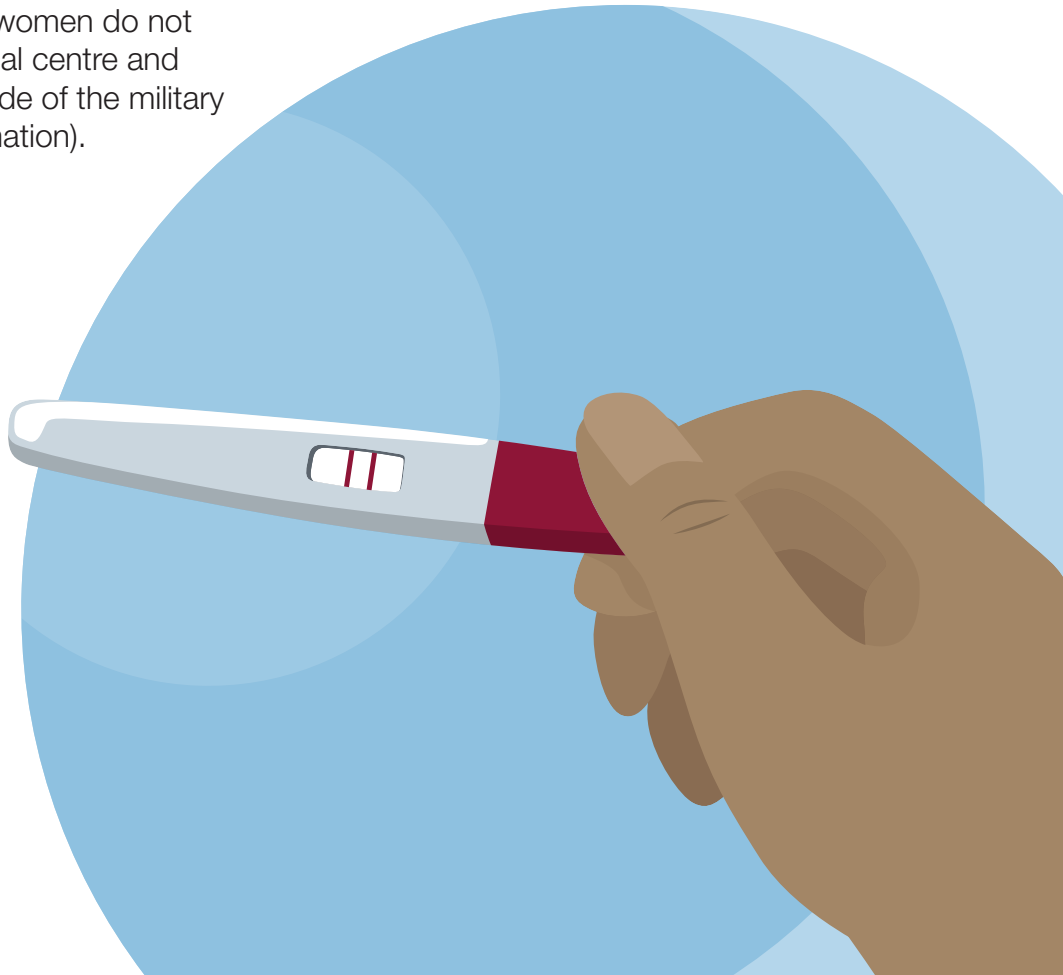
Sometimes emergency contraception fails or a woman is unaware that her routine contraceptive has been ineffective and an unplanned pregnancy occurs. The arrival of a routine bleed or period provides some reassurance that a pregnancy has not started but taking a pregnancy test after the first expected day of the period will confirm this. If the test is positive knowing early enables early action and options. If the test is negative, but there is still no bleeding after a week, the test should be repeated and the woman should seek medical advice.

If a woman finds herself unexpectedly pregnant, she should consider discussing her options with people she trusts and who can help support her whilst deciding what to do next. This could include the potential father, her family, friends, medical staff, a padre or her chain of command. Any advice and support given should always be provided in a confidential, non-judgmental way, recognising that an unplanned pregnancy can make a woman feel confused, frightened and lonely.

Several external organisations offer non-biased counselling for women throughout the UK and details are available on the internet or from any UK sexual health clinic or medical centre. Medical advisors are allowed to exercise personal choice about whether they become actively involved in managing unplanned pregnancies. However, they are expected to signpost to another professional or organisations that can support the woman in making an informed and personal decision about the next steps. Servicewomen do not have to present to their medical centre and advice can be accessed outside of the military (see Chapter 9: Further information).

If, after counselling, the woman makes an informed decision to terminate a pregnancy then this can be confidentially arranged by the external organisation. If the woman chooses to continue with the pregnancy, introductory advice on being pregnant within the military is available in Chapter 6: Becoming a parent.

Any information provided is confidential and is not shared with anyone else without the express permission of the woman. Whilst the woman will be asked about who their medical provider is, to enable ongoing support, the woman does not have to provide this information and this will not affect the care provided. However, involving the support of their military GP (in confidence) will enable discussion on the military aspects of any decision. This includes considering any short-term work limitations that may be needed to ensure a speedy recovery to full fitness.



Abortion

An abortion or “termination of pregnancy” is when a pregnancy is ended to prevent the birth of a live child. The pregnancy is ended, either by taking pills (medical abortion) or by surgery (surgical abortion). It is legal for this to occur within the UK up to 24 weeks from the date of the woman’s last menstrual period. In overseas locations the deployed medical support will ensure the servicewoman accesses appropriate confidential care, including impartial counselling.

Abortions in the early weeks of pregnancy are simpler, with lower risk of medical complications and less time needed for recovery. However, it may take some time for a woman to come to a decision she is happy with. The earlier she seeks advice the more time she will have to decide and the more options she will have available.

A woman deciding to terminate an unplanned pregnancy can be provided confidential support without disclosing any details to anybody outside of the immediate medical support team. From a legal perspective the father does not have to be legally informed or give any permissions. Some men would want to be involved in the decision and support their partner, but it is up to the woman whether or not to inform them.

How a woman feels physically and mentally following an abortion will differ between individuals. Women who have been able to think carefully about their decision to have an abortion usually do not regret it, but they also will not forget it. It is normal that a range of different emotions will be felt that may require ongoing support. Confidential post-abortion counselling is available to any woman who needs it and having a safe abortion will not limit a woman’s ability to get pregnant in the future.

Stopping Contraception

After the menopause

If a woman needs contraception, she is advised to use it until after her menopause. If she is under 50 years old, she should keep using contraception until 2 years after her last period. If she is over 50 years old, she should use contraception for one year after her last period.

No longer required pre-menopause

Packets of tablets, patches and rings can just be stopped or removed. It is recommended this is discussed with a healthcare professional first, to ensure there is no risk of unintended pregnancy. A small medical procedure is required to remove intrauterine devices and implants. There may be some bleeding irregularity as the natural menstrual cycle of the woman begins again (if pre-menopausal).

To try to conceive

It is advised that women start Folic Acid and Vitamin D supplements at least 3 months before they try to get pregnant. These can be started whilst still using contraception. Once contraception is stopped or removed then a woman's fertility typically returns to its normal level quite quickly.

To start alternative contraception

Switching between contraceptives requires medical advice to ensure there is no risk of an unintended pregnancy occurring before the new contraceptive becomes effective.

Sexual health

Contraception is a key part of sexual health and avoiding unplanned pregnancies, but there are other areas of sexual health relevant to all women. Being sexually healthy is about a person having emotional, mental and social wellbeing related to their sexuality. It is not just about avoiding disease or dysfunction, but all sex should be safe sex. Sexual health is a normal part of being an adult, whatever gender or sexuality a person identifies as, and should be approached in a positive and respectful way.

However an individual achieves pleasure from sexual acts and intimacy, they should be able to experience this without any fear, guilt or shame. Where other people are involved, this must be with their full consent. This means individuals must agree to take part by choice, having been able to freely make that choice and not when under the influence of any drugs or alcohol that may prevent them understanding the choice they are making. Without consent, any kind of sexual activity is sexual violence.

Sexually transmitted infections (STIs)

Sexually Transmitted Infections are common in both men and women. A sexually transmitted infection can be passed from one individual to another through any intimate sexual contact. This includes vaginal, anal and oral sex and sexual contact using sex toys. Engaging in sexual activity overseas may increase the risk of sexually transmitted infections because some types are more common.

The risk of developing and passing on sexually transmitted infection can be reduced by using barrier contraception (condoms for vaginal and anal sex and oral sex performed on men, and dental dams for oral sex performed on women). It is recommended that barrier methods are always used, in addition to other contraception which is more effective at preventing pregnancy. This is needed until both partners have been screened for sexually transmitted infections and remain only sexually active within that partnership.

Sexually active adults should undertake regular screening, as no barrier method is 100% effective at preventing sexually transmitted infections. Whilst condoms are the best way of preventing getting or passing on a sexually transmitted infection during penetrative sex, they do not protect against them all. Condoms with the CE or BSI kitemark on its packaging have been tested to a high standard. These are the only ones that should be relied on as a contraceptive and to prevent sexually transmitted infections.

Many sexually transmitted infections can go unnoticed. If they remain undetected and untreated they can lead to illness and disease that may cause long term problems, including fertility issues. Having a sexually transmitted infection once does not offer any protection – the same infection can be caught again. Having a regular check-up is the only way to ensure all possible infections are found and treated early.

STI testing

Someone should be tested for sexually transmitted infections if they:

- Participate in any vaginal, oral or anal sex or have sexual contact with other people (including through sex toys) without condoms or dams.
- Are in a new long-term sexual relationship and wish to stop using barrier methods like condoms or dams.
- Have been told by a sexual partner (current or previous) that they may have been infected with a sexually transmitted infection.
- Experience any symptoms that could be a sexually transmitted infection, which could include:
    - Unusual discharge from the vagina or anus.
    - Pain when passing urine.
    - Itching around vulva, vagina or anus.
    - Lumps or growth around the vulva, vagina or anus.
    - Rashes all over the body.
    - Unusual vaginal bleeding.

There is no single test to look for sexually transmitted infections. To undergo a complete screen, samples of blood, urine and swabs of places like the vagina and mouth are needed. The swabs can sometimes be done by the individual themselves and posted for testing. Medical centres can offer some aspects of testing and some tests are usually offered during a cervical screening appointment.

Sexually transmitted infection testing and treatment is sometimes limited in deployed locations but confidential advice can be obtained from the deployed healthcare professionals. It is important to remember that the earlier a sexually transmitted infection is treated the better.

Within the UK, Integrated Contraception and Sexual Health (iCASH) Clinics, also known as sexual health or Genito Urinary Medicine (GUM) clinics, offer comprehensive and free testing for sexually transmitted infections. They can also offer contraceptive advice. It is often not necessary to pre-book an appointment. The clinic records a name and contact details but any name can be given. However, it is essential to provide correct contact details so that test results can be shared and treatment prescribed if needed.

The results of sexually transmitted infection checks are kept confidential and not shared with military medical centres unless the individual asks for this. There is no limit to how many times an individual attends a clinic but a minimum of 12 weeks between appointments is usually recommended, unless specifically advised otherwise.

Please see the further information section for details about accessing these services.

Chapter 6:
Becoming a parent

Introduction

Conception is a multi-step process by which a woman becomes pregnant. This needs a sperm to meet with and fertilise an egg from the woman's ovaries. This creates an embryo which must then implant into the lining of the uterus, to develop into a foetus.

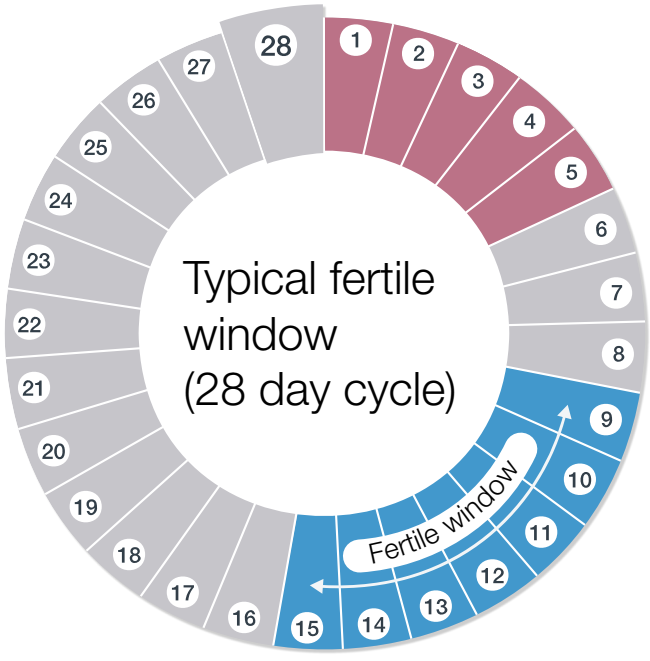
Conception

Fertility

Fertility describes the natural ability of humans to conceive. Unprotected sexual intercourse between a man and woman is the process by which natural conception is achieved.

For women, their 'fertile window' relates to the time during their menstrual cycle when they are most likely to become pregnant if unprotected sexual intercourse (or insemination, when sperm is artificially introduced into the woman) takes place. This is typically around days 9 to 15 if a woman has a 28-day menstrual cycle (see Chapter 3: Menstrual health for more detail on menstrual cycles). Fertility naturally declines with age and steeply declines in women from 35 years of age.

Around 84 out of 100 heterosexual couples will fall pregnant in a year with regular (every 2-3 days), unprotected sexual intercourse including during the fertile window. Service personnel can spend long periods of time away or separated from their partner. This may create domestic pressures for couples wishing to fall pregnant.



Infertility

Heterosexual couples who do not achieve a pregnancy within the first 12 months of regular unprotected sexual intercourse can be referred by a medical professional for investigation and potential support. Around 1 in 7 couples will fall into this category, referred to as infertility. This can be due to various factors affecting either or both partners.

Investigations can be started earlier than the first 12 months of regular unprotected sexual intercourse if either partner has medical conditions known to reduce fertility, or the woman is aged over 35 (when fertility naturally steeply declines).

A couple should consult their GP who will arrange some simple investigations before referring them to an assisted conception service in the UK. If one partner is not entitled to military medical care then they will need to see their civilian GP to arrange their relevant investigations. In these circumstances the findings will need to be shared with the GP of the woman intending to carry the pregnancy, who will then make the referral. For the man these investigations include a physical examination and providing a semen sample. For the woman this will involve a physical examination, a chlamydia test and blood tests.

Advice will also be provided about how to increase the likelihood of getting pregnant, as well as advice about taking folic acid and making healthy lifestyle choices.

These include:

- avoiding alcohol.
- not smoking.
- maintaining a healthy weight.

Dietary advice on what foods can harm a developing baby will also be provided.

Assisted conception

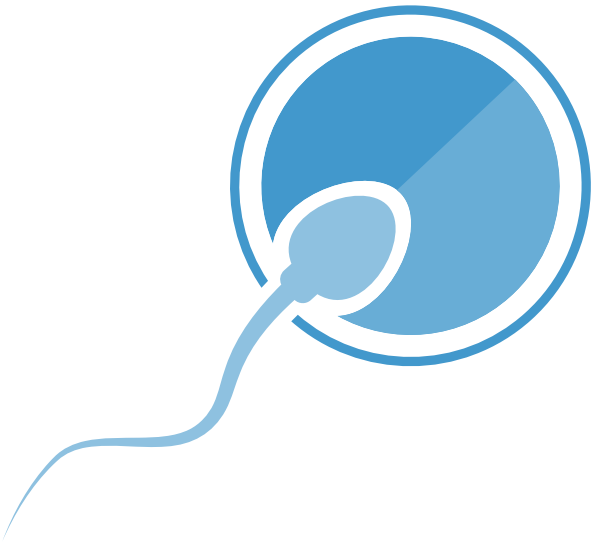
Assisted conception enables pregnancy to occur outside of unprotected sexual intercourse. This is done by scientifically combining sperm and eggs from the parents, or donors, to create an embryo. This is then implanted into the woman's uterus. It is available to heterosexual or same-sex couples and individuals choosing to be solo parents. Some assisted conception services are available at no cost to individuals. In other cases, a military medical centre can provide parts of the private treatment at no cost to the individual, reducing the overall personal contribution.

Assisted conception services are available throughout the UK but they vary between geographical regions. JSP 661 provides details to ensure that service personnel are not disadvantaged by where the military employs them.

Service personnel can get up to 3 years geographic stability in the UK to access assisted conception services, but to enable this, service personnel must inform Career management authorities and the chain of command.

The 2 main assisted conception options are:

- Intrauterine insemination (IUI). Sometimes referred to as artificial insemination, this is where sperm is directly inserted into the woman's uterus to fertilise the egg.
- In-vitro fertilisation (IVF). This is where an egg is removed from the woman's ovaries or provided by a donor and is fertilised with sperm outside of a woman's body. Selected embryo(s) are then placed back into a woman's uterus in a simple medical procedure.



Fertility preservation

Cryo-preservation can be used to preserve fertility. This involves freezing and storing eggs, sperm, or embryos to use in a person's future fertility treatment. In rare cases, this can involve freezing and storing ovarian or testicular tissue.

Both men and women may wish to preserve their fertility for a number of reasons including:

- To allow treatment of a medical condition which may affect future fertility, such as some cancer treatments.
- To delay parenthood until a date when they are ready to start a family and natural fertility may have reduced.
- To preserve tissue ahead of a deployment where there is risk of trauma which may affect future fertility procedure.

Servicewomen considering preserving eggs should be aware that the process is complicated and takes considerably more time than freezing sperm; this should be taken into account if planning for potential deployments or postings.

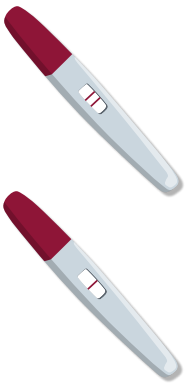
Testing for pregnancy

Urine pregnancy tests can be bought from supermarkets and pharmacies for home use, or are available at all medical centres. Pregnancy tests detect a hormone called Human Chorionic Gonadotrophin (hCG). Before the first day of a woman's expected period, hCG levels are too low for detection. Taking a pregnancy test before the first day of a woman's expected period will not give reliable results. However, a positive test is unlikely to be incorrect.

A woman should consider taking a pregnancy test after her next period is due if:

- Unprotected intercourse has taken place.
- A period is late, lighter or shorter than normal.
- Emergency contraception has been needed during the previous cycle.
- Symptoms of pregnancy are being experienced:
    - swelling or tenderness in the breasts.
    - sensitive nipples.
    - passing urine more than usual.
    - feeling sick or being sick.
    - tiredness and feeling irritable.
    - mood changes.
    - appetite changes (going off certain foods or food cravings).
    - stomach cramps, period-like pains or feeling bloated.

A woman should take a pregnancy test as soon as possible if she has had sexual intercourse and experiences one or more of the symptoms above. Some features of the military workplace can potentially harm a pregnant woman or their unborn child. Knowing early can help minimise these risks and gives servicewomen more time to think about their options.



Pregnancy test results are positive if the woman is pregnant.

Pregnancy test results are negative if the woman is not pregnant or the test was taken too early.

If a servicewoman is worried about becoming pregnant and pregnancy is not intended, contraception choices should be considered to reduce the risk of future unplanned pregnancy.

If a test result is POSITIVE then a woman has 3 potential choices:

- Continue the pregnancy and become a parent.
- End the pregnancy with abortion. (See the abortion section within Chapter 5: Contraception and sexual health).
- Continue the pregnancy and choose adoption (this is not covered within this handbook).

Once pregnancy is confirmed, it is important that medical advice is sought as soon as possible, to access appropriate care and informed advice. It is normal for women to have very mixed feelings about being pregnant, but especially if the pregnancy is unplanned.

Pregnancy within the Armed Forces

A pregnant servicewoman experiences significant physical, physiological and psychological change. This experience is different for every woman and every pregnancy. The most obvious changes are the shape and size of the woman as the baby grows, but the hormonal changes taking place affect every system within the body.

Human pregnancies typically last 40 weeks, from the start of the last menstrual period to birth. This is known as the gestation period and is split into 3 phases, referred to as trimesters.

During the first trimester (12-13 weeks) the body structure and organs develop. Most birth defects occur in this phase. Changes in hormone levels can cause symptoms of nausea (sickness), fatigue, sore breasts and increased urination. During this stage the risk of the pregnancy spontaneously terminating is highest. The woman will then experience a miscarriage.

The first scan typically takes place between 12-15 weeks of pregnancy but may occur sooner if there are any medical concerns. Many women choose to not share the news of their pregnancy until this scan has confirmed there are no obvious problems with the pregnancy.

A servicewoman may not initially want to inform her chain of command of her pregnancy. This could be for many personal reasons, including being undecided about whether to proceed with the pregnancy. Legally, she only has to notify the chain of command 15 weeks before her Expected Week of Childbirth (EWC) when she is 25 weeks pregnant; at this stage it is likely the pregnancy will be obvious.

For up to 25 weeks of pregnancy the servicewoman may choose not to tell her chain of command that she is pregnant, but this will prevent them from being able to offer her the full range of available support. Some features of the military workplace can potentially harm a mother or their unborn child. The chain of command must ensure these risks have been properly assessed and are reduced to as low as reasonably practicable - the most important considerations are the health and wellbeing of the servicewoman and her unborn baby.

A pregnant servicewoman will be given temporary medical restrictions which will protect her from any workplace activities that could harm her or the developing baby. These will not reveal she is pregnant and should be put in place as soon as she finds out she is pregnant. This approach protects the woman's right to privacy and still allows the chain of command to meet its obligation to protect the woman and developing baby. If a servicewoman discovers she is pregnant while on deployed operations she will need to inform her medical provider immediately. Normally she will be returned to her unit location as soon as possible. This will usually involve aeromedical transfer of the pregnant woman. The chain of command will be involved in arranging this, but the underlying medical reason is not revealed without explicit consent from the servicewoman.

When a woman is ready to inform her employer of her pregnancy, and at no later than 25 weeks pregnant, she will be formally downgraded to a medical grade that identifies she is pregnant. The temporary medical restrictions which protect her from workplace activities that could harm her or the developing baby will be extended. This downgrading and restrictions will normally remain in place until she returns from maternity leave. This will be explained to the servicewoman by her medical officer, and she will need to provide her consent.

The chain of command will become aware of a servicewoman's pregnancy either through the change in medical grade or through communication with the servicewoman directly. The chain of command must then conduct a risk assessment of the servicewoman's workplace and work. This must ensure none of the duties she is carrying out present a risk to her or her unborn child. Each Service provides policy guides to support the management of the servicewoman during her pregnancy and encourage constructive conversations around planning for maternity and returning to work afterwards. See the Defence guidance in Chapter 9: Further information.

Physical training while pregnant

Pregnant servicewomen are encouraged to continue physical training with their peers where it is reasonable and safe to do so. They are exempt from military fitness tests and their temporary medical restrictions and subsequent downgrading will cover this. This is because pregnant servicewomen are advised not to work at maximum effort. They should also avoid any contact activities which might 'bump the bump'. Many physical training instructors are now trained in pre and post-natal care and can provide support and further guidance on how to train safely.

Attendance on courses during pregnancy

Medical advice must be obtained in writing before a pregnant servicewoman is permitted to commence or continue a training course. The decision whether or not to allow a pregnant servicewoman to commence or continue a training course will need to consider the physical demands of the course and health and safety regulations. The regulations relating to the health and safety of pregnant servicewomen take priority over all other considerations.

Time off for prenatal care appointments

Following notification of pregnancy, a servicewoman must be allowed to attend all appointments for prenatal care recommended by a registered medical practitioner, midwife or health visitor. Prenatal care can include attendance at relaxation and parent-craft classes. A servicewoman should expect to be asked to produce written proof of appointments.

Accommodation

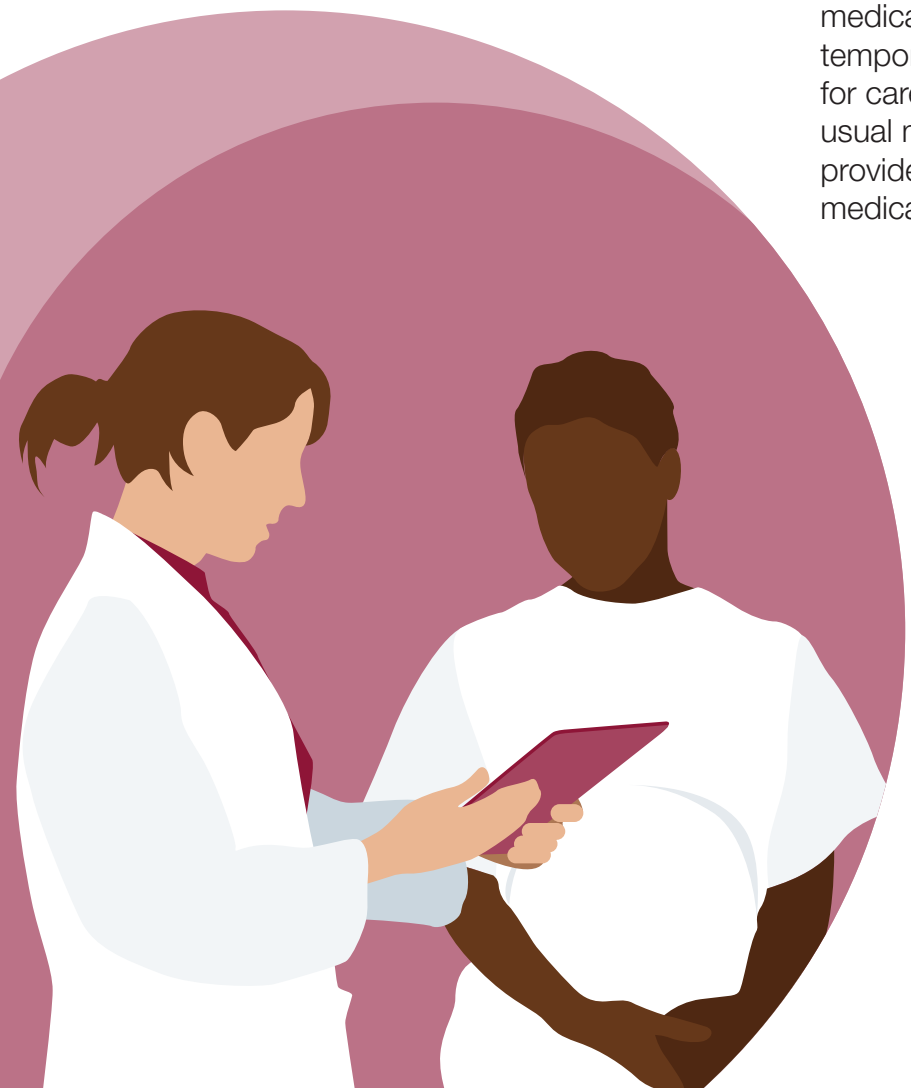
An unmarried servicewoman is entitled to Service Family Accommodation (SFA) up to 3 months before her estimated delivery date (EDD) but she may choose to stay in Single Living Accommodation (SLA). The servicewoman will pay SFA charges (abated for single occupancy) from the date of occupation and will be responsible for all utility bills.

Uniform

Pregnant women can wear maternity uniform to accommodate their changing physical shape but may need to get their stores to order this in for them. Civilian attire should also be permitted for social events.

Overseas service

Within the UK, maternity care, including prenatal care is of a very high standard. This cannot be guaranteed in all the parts of the world where service personnel operate. Isolated locations, or those with reduced levels of medical support (like the Falkland Islands, Kenya and Nepal) will be unable to provide the best care for mother and baby. Pregnant women based overseas may therefore be assigned back to the UK.



Military social life

Pregnant servicewomen are not restricted from attending mess and formal social events but they should not be made to attend. When event planning, an inclusive dress code and allowing comfort breaks should be considered. Safe menu choices and non-alcoholic drink options should be readily available for pregnant women.

Medical care

Military medical centres have access to midwives who can care for pregnant servicewomen. In some cases this may be arranged through a local GP surgery. If servicewomen do not live near a military medical centre they can register as a temporary resident with a civilian GP surgery for care during their maternity leave. Their usual military medical centre will continue to provide occupational advice and return to work medicals.

Pregnancy loss

Unfortunately, pregnancies do not always end in the birth of a live child. This can be because of a miscarriage or stillbirth. A miscarriage is when a pregnancy spontaneously terminates before 24 weeks gestation. A stillbirth describes any pregnancy loss after 24 weeks gestation. If the baby is born alive but dies shortly afterwards this is known as a neonatal death.

A loss at any stage of pregnancy will affect different people in different ways and can be very difficult. Support from the chain of command for servicewomen and their partners can make a positive difference during this time.

A servicewoman experiencing a stillbirth is entitled to full maternity leave and pay. In the event of a miscarriage, normal sick leave provisions apply.

Miscarriage

In the UK, one pregnancy in four ends in miscarriage. A miscarriage may affect a servicewoman or her partner in several different ways, including the following:

- Difficulty sleeping.
- Finding it hard to concentrate or feel motivated.
- Struggling with social interaction.
- Experiencing mood swings.
- Feeling tearful / irritable.
- Finding it difficult to manage their mental health.

Once the chain of command becomes aware of a miscarriage, it is important they acknowledge it and offer support. They should be aware that the servicewoman or partner may wish to keep the information private and under no circumstances should it be shared with colleagues without their consent.

Many women will need time off to recover both physically and emotionally. Sickness absence after a miscarriage should be managed in liaison with medical advisors. Servicewomen and their partners who have experienced a miscarriage may need time off in the future to attend appointments related to their loss.

Pregnancy-related mental health

Mental health conditions are common during pregnancy and the first year after birth. During this time 10-20% of the women will suffer with mental health issues. The risk of mental ill-health during pregnancy and following childbirth is higher in women with a history of any mental health condition.

Servicewomen are potentially subject to extra stresses, for example:

- Servicewomen can easily become isolated when restricted in their normal work and when away from the workplace during maternity leave.

- Military life can distance them from family support networks and separate them from their partner if a dual-serving couple.

- Servicewomen may also struggle with their identity changing to become a mother and contemplating returning to full-time work. This might be influenced by the need for robust childcare which accommodates unpredictable military working patterns and possible future deployments, separating them from their child.

Good communication with their chain of command throughout pregnancy, maternity leave and on return to work will help servicewomen feel supported. This should be tailored to the servicewoman's individual needs and agreed prior to her starting maternity leave.

Servicewomen should be encouraged to seek help for any mental health symptoms from a medical officer, their health visitor or midwife. They can also self-refer to their Department for Community Mental Health (DCMH) when pregnant or in the first 12 months after a live or stillbirth. All treatment will be confidential.

The following signs and symptoms may indicate a servicewoman is experiencing poor mental health and would benefit from additional support:

Signs of mental ill-health

- Isolation or withdrawal (lone activities, not leaving the house, not attending groups).
- Bickering with partner and family.
- Short temper with excessive reactions to things other people see as minor.
- Feeling overwhelmed and unable to cope.
- Self-harming: cutting/hitting/picking.
- Neglecting personal hygiene and grooming.
- Eating excessively or not eating enough.
- Obsessive behaviours towards self (excessive hand washing, checking) or to baby (constant checking).

Symptoms of mental ill-health

- Persistent feelings of sadness and low mood.
- Feeling distant and cut off from friends and loved ones.
- Lack of enjoyment and loss of interest in the wider world.
- Lack of energy and feeling tired all the time.
- Trouble falling asleep at night.
- Feeling like they have not bonded with their baby.
- Problems concentrating and making decisions.
- Frightening thoughts, for example about harming their baby.
- Feeling on edge or anxious.

If servicewomen recognise any of these signs or symptoms in themselves it is recommended they seek help from a healthcare professional as soon as possible. The chain of command or colleagues should also seek advice from healthcare professionals if they recognise these symptoms in someone else.

Returning to work after pregnancy

A servicewoman must take a minimum of 2 weeks leave after giving birth but is entitled to up to 6 months maternity leave on full pay. She may then take additional leave on reduced pay. She may also share her leave entitlement with her partner.

The point at which a servicewoman returns to work will affect her risk of injury and the level of physical limitations needed. Before returning to work she must undergo a mandatory medical assessment, during which she will be advised about a gradual return to all physical exercise. This considers the many hormonal and physical changes that occur to a woman's body during pregnancy, childbirth and whilst breastfeeding as well as psychological impacts.

New mothers, on their return to work, will usually have some employment restrictions. These vary between the Services but ensure that all servicewomen are given adequate time to undertake physical reconditioning for the full scope of their employment. This also allows servicewomen to adjust to the work environment as a new mother. Once the servicewoman returns to work she will be expected to fulfil all duties that are compatible with any health and safety or medical grading restrictions. The chain of command should provide adequate time for the servicewoman to regain physical fitness or trade familiarisation.

In addition to the medical assessment, all servicewomen should be interviewed by their chain of command before returning to work. This should discuss their individual welfare needs, childcare arrangements, opportunities for flexible working, courses and career management, plus any other issues the chain of command or servicewoman may wish to discuss.

Breastfeeding

On return to work a servicewoman may wish to continue breastfeeding by expressing milk during working hours. Defence supports servicewomen choosing to breastfeed, but there may be occasions where the nature of the military environment can make it impractical. The chain of command must conduct a risk assessment of the workplace to ensure breastfeeding can be done safely and the servicewoman is supported as much as possible.

Physical training and rehabilitation

The hormonal effects of pregnancy on the body places servicewomen at increased risk of musculoskeletal injury. Throughout pregnancy ligaments become more relaxed to accommodate foetal growth and allow childbirth.

Calcium is also lost from the skeleton to support foetal growth and breastmilk production, which causes temporarily reduced bone mineral density (making the bones potentially weaker). Childbirth is also an acute physical trauma on a woman's body and rehabilitation is key to ensure servicewomen return to full occupational fitness and effectiveness.

After childbirth women may develop specific medical problems. These include:

- weakened pelvic floor.
- urinary or faecal incontinence.
- prolapse of the pelvic organs.
- separation of the abdominal muscles (diastasis recti).
- complications of surgery.

In the UK military, there are a number of physiotherapists trained in women's health who can support women in their rehabilitation after pregnancy.

Due to the increased musculoskeletal injury risk for all, servicewomen must be provided with a supervised reconditioning programme prior to re-joining mainstream physical training or undertaking military fitness testing after childbirth. Many physical training instructors are now trained in pre and postnatal physical training activity and are able to offer more bespoke advice to servicewomen during pregnancy and when returning to work after childbirth.

Chapter 7:
Health screening

Introduction

Health screening

Health screening aims to identify and treat health conditions early, to get a better outcome for the person. There are different screening tests to detect different health conditions. Screening results will not always tell somebody if they have a condition or not but may identify individuals as being at higher risk and that they would benefit from further investigations. Health screenings are not compulsory, however it is recommend that servicewomen attend when they are invited. Details on when to expect a screening invitation are outlined below.

There are several benefits of health screening. These include:

- Detecting a health problem early before symptoms occur may allow more effective treatment.
- Detecting an increased chance of a health problem. This can help people make better informed decisions.
- Reducing the chance of developing a condition or its complications.
- Some deaths from treatable conditions can be prevented.

There are some risks and limitations of screening to be aware of:

- Screening tests are not 100% accurate. False positives can occur: people will be told they are at increased risk and they are not. This may lead to some people having unnecessary further tests or treatment. False negatives can also occur: people will be falsely reassured and may ignore other warning signs.
- People can also be correctly identified as not being at increased risk but will still go on to develop the condition.
- Screening tests can lead to difficult decisions about whether or not to undergo further tests which may carry risk of harm.
- Finding out about potential future health problems can cause anxiety, may affect employment and the deployment status of a servicewoman.

Screening programmes currently offered by the NHS differ slightly for men and women. This is because some conditions affect women far more than men, like breast cancer, or some affect only women, like cervical cancer.

Cervical screening

The NHS Cervical Screening Programme screens women aged 25-64 for conditions which may lead to cervical cancer if left untreated.

A sample of cells is taken from the cervix and tested for the presence of Human Papilloma Virus (HPV). If HPV is present the cells are checked for abnormalities which could, with time, develop into cervical cancer.

Human Papilloma Virus (HPV) is very common and can affect anyone who has ever had intimate relations. It can remain in the body as an active infection or become dormant and undetectable for many years. Being newly diagnosed with HPV does not mean a partner has been unfaithful.

HPV can be transmitted between men and women, and women and women through:

- vaginal, oral or anal sex.
- any skin-to-skin contact of the genital area.
- sharing sex toys.

Many young people are now vaccinated against some, but not all, strains of HPV. This lowers their chances of developing cervical cancer. However, they still need cervical screening from the age of 25. Women under 25 do not need screening because cervical cancer is very rare in this age group and any abnormalities found may not actually need treatment.

Women should not put off cervical screening. It is one of the best ways they can protect themselves from developing cervical cancer. Early treatment gets better outcomes.

Cervical screening does not prevent all cases of cervical cancer. The following symptoms may not be due to cancer but a woman should see her doctor as soon as possible (and not wait until her next screening appointment) if she has:

- bleeding between periods, during or after sex, or after the menopause.
- unusual vaginal discharge.

Servicewomen screening programmes follow NHS England guidelines. This is regardless of where in the UK the servicewoman is serving. This means civilian friends and family may be called for screening on different timescales if they live in Wales, Scotland or Northern Ireland.

TIP:
Servicewomen should set reminders on their mobile device.

- A woman should know when she is due for screening - she can check this at any time with the medical centre.
- If a servicewoman does not receive an appointment when expected, she should contact the medical centre and ask why.
- If a servicewoman does not get her results back within 2 weeks she should contact the medical centre to ask why not.

Cervical screening timeline

A woman can expect to receive her first invitation to cervical screening up to 6 months before turning 25. Between the ages of 25 and 50, a woman will be invited for cervical screening every 3 years. At the age of 50, cervical screening invitations reduce to every 5 years until the age of 64. At the age of 65 or older, women will only be invited to cervical screening if any of their last 3 test results were abnormal.

Age	When women are invited
Under 25	Up to 6 months before turning 25
25 to 49	Every 3 years
50 to 64	Every 5 years
65 or older	Only if 1 of the last 3 tests was abnormal

Routine smear timetable:
(Could change if received treatment or smears postponed because of pregnancy)

Age: 25, 28, 31, 34, 37, 40, 43, 46, 49, 54, 59, 64
(Every 3 years to 49, then every 5 years to 64)

Routine breast timetable:

Age: 50, 53, 56, 59, 62, 65, 68, 71
(Every 3 years from 50)

Breast screening

Breast screening helps to detect breast cancer early, allowing treatment to start sooner. This makes it more likely to be successful and less destructive. Breast screening tests are referred to as mammograms. Mammograms are the most common screening tests used, but some women with an elevated cancer risk or dense breast tissue will have Magnetic Resonance Imaging (MRI).

A woman should receive her first invitation to breast screening at 50 years of age. This will be repeated every 3 years up to the age of 70. Every woman should have been called forward for breast screening by the age of 53 years. Any woman who has not been called forward for breast screening should get in touch with her local breast screening centre. This can be found using the NHS online tools but the medical centre can help if needed.

TIP:
Servicewomen should create a reminder in their diary or phone to ensure they make an appointment. It is important that a servicewoman's medical centre has up-to-date contact details. These will be used by the NHS to get in touch and arrange an appointment.

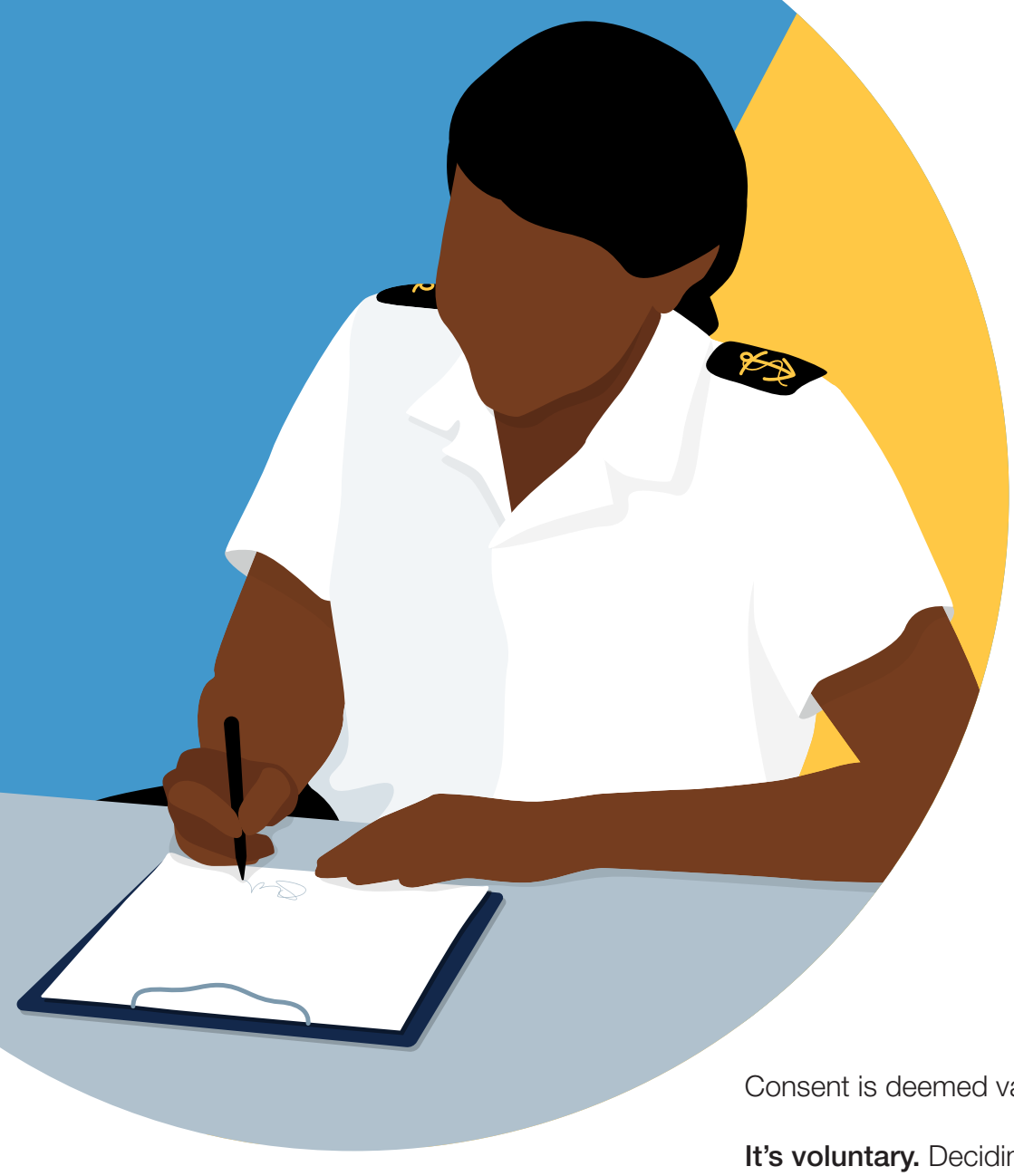
Some women may be at higher risk for breast cancer. This is usually because they carry a specific gene passed on through their family or because they have received certain medical treatments in the past. These women need to be referred for specialist surveillance, potentially from the age of 25 years.

A woman worried about a family history of breast cancer should discuss this with her GP, to understand if she needs specialist screening and from what age this should start.

It is rare for breast cancer to occur in young women but all women should still regularly check their breasts and report any abnormalities to their GP.

See Chapter 1: Body basics for more details on performing self-breast examinations.

Chapter 8:
Consent and confidentiality



Medical consent

A patient must give permission before receiving any form of medical treatment or investigation, which may be a physical examination or a test. This is known as consent and can be provided verbally, in writing or can be implied. For example, if a blood test is recommended a patient can say they agree to it (verbal), sign a form agreeing to it (written) or present their arm (implied) to have blood taken.

Consent is deemed valid if:

It's voluntary. Deciding to consent or not consent is made by the patient themself and must not be influenced by pressure from relatives, friends, chain of command or healthcare professionals.

It's informed. The patient is given all the information about what is involved, why it is recommended and what will happen afterwards. This information will include the benefits, the potential risks, likely follow-on options and what happens if it is not done.

The patient has capacity. This means that the patient has the ability to give consent. For example, they cannot be under the influence of alcohol or drugs, or so medically unwell that their ability to make the decision is affected.

A patient should know exactly what is going to be done to them and why. If a patient is unsure about anything, they should not hesitate to ask for more information or time to consider options. Healthcare practitioners do not mind explaining anything in more detail if a patient needs this.

If a patient is seriously unwell and unable to communicate, healthcare providers will decide how best to treat the patient without their consent. These decisions are not taken lightly and will be made in consultation with colleagues wherever possible. All healthcare providers know they must be prepared to outline and justify their actions if a patient is unable to consent.

Chaperones

A chaperone is an independent person (not a friend or relative of the patient) who is appropriately trained to witness and observe medical procedures performed by a healthcare professional.

A chaperone can provide additional comfort and support to the patient whilst ensuring a procedure is carried out appropriately and that the patient is treated with dignity, privacy and respect.

A chaperone can be requested by either the patient or the healthcare professional. All patients have the right to request a chaperone for any examination or procedure. This cannot be refused due to lack of availability of an appropriate individual, unless a delay would potentially harm the patient's health. A patient has the right to refuse the presence of a chaperone but the healthcare professional can also refuse to undertake the examination or procedure without one present.

The provision of a chaperone is good practice regardless of whether the patient and healthcare professional are the same gender, or whether the procedure is deemed intimate (by either the patient or healthcare professional).

The offer of the chaperone and any decision made should be recorded in the patient's medical records.

Privacy and confidentiality

All healthcare practitioners are obliged to keep personal medical information confidential. If they fail to do this they could lose their job and be unable to practise in the future. This is no different for military healthcare practitioners.

Healthcare practitioners will share information protected as medical-in-confidence with other healthcare providers, to enable patient treatment. They will also share very limited information, if justified, in the public interest where others are at risk. This may be because a patient has a highly contagious infection or because they are believed to be placing someone else at risk of significant harm.

In the military very limited information can be shared with the chain of command to say an individual is FIT or UNFIT to perform certain activities, where the safety of themselves or others may be at risk. In these circumstances the healthcare practitioner would not provide any information about the medical condition without the patient's consent, only advice about the employment.

The chain of command can request information about occupational health appointments like vaccinations, dental checks, screening audiometry or medical grading reviews. The information provided is limited to the date, time and location. Healthcare staff can only give out this information when it is known how this information is going to be used (eg published in routine orders) and if the use is justified (eg to access transport, to excuse patient from other activities).

Information will not be passed to the chain of command for appointments which are not occupationally focussed unless the patient gives explicit consent to do so. For example, non-occupational cervical screening appointments will not be disclosed. In these circumstances the patient will need to provide information to their chain of command, to secure time away from work to attend (eg date, time, duration including travel time). They will need to say that they are attending a medical appointment but they do not need to disclose any further medical details.

Chapter 9:
Further information

A list of further resources is provided below to support servicewomen in maintaining good health. Some of these resources are not defence specific and are available to all, whilst others provide information about defence specific policies which will need to be accessed through the defence intranet.

Useful resources

- Abortion: British Pregnancy Advisory Service
- Breast Check: NHS
- Chlamydia Screening: NHS
- Contraception and Sexual Health Services: iCaSH
- Contraception: Contraception Choices
- Emergency Contraception: NHS
- Endometriosis: Endometriosis UK
- Endometriosis: NHS
- Female Genital Mutilation: NHS
- Fertility Treatments: Human Fertilisation and Embryology Authority
- Menopause: Balance
- Menopause: The Well HQ
- Periods: NHS
- Pregnancy: British Pregnancy Advisory Service
- Pregnancy: NHS

- Pregnant Employee's Rights: GOV.UK
- Promoting Menstrual Wellbeing: Royal College of Nursing
- Sexual Health: British Association for Sexual Health and HIV
- Sports Bra Fitting Guide: boobydoo
- Urinary Incontinence: NHS
- Urinary Tract Infections (UTIs): NHS
- Vaginal Thrush: NHS

Defence guidance

- After Pregnancy Physical Training Guidelines
- Ante-natal Patient Information: Women's Health Rehab
- Assisted Conception Services and Fertility Preservation: 2021DIN01-020:
- Breast Health Issues: incidence of breast health issues and the efficacy of a sports bra fit and issue service in British Army Recruits
- Breastfeeding Policy: 2022DIN01-076
- Injury Prevention and Health Optimisation during Pregnancy and Maternity: 2020DIN01-130
- Introduction of Sanitary Hygiene Box for Emergency Use only when on Ops and Exercises
- Maternity in the Royal Navy: Parenting Pack
- New and Expectant Mothers: JSP 375 Vol 1 Chapter 20
- Physical training during pregnancy: ABN 051/2021
- Post-natal Patient Information: Women's Health Rehab
- Pregnancy and After Childbirth: Chief Medical Officer's Physical Activity Guidelines
- Pregnancy and Maternity in the British Army
- Pregnancy in the RAF: A Guide for Line Managers
- Pregnancy in the RAF: A Guide for Servicewomen
- Supply of Emergency Sanitary Products Provision for Service Personnel: 2021DIN01-098
- Tri-Service Regulations for Leave and Other Types of Absence: JSP 760

Chapter 10: Quick guide to servicewomen's health considerations

Commanders' considerations

Optimising hygiene and maintaining the personal health of all service personnel contributes to success on operations and combat effectiveness. As a commander or line manager you set and maintain the standard. Lead by example.

The basics

- Women's bodies and hygiene requirements are basic human needs – periods are normal.
- Enabling women to address their basic hygiene needs is an issue for commanders and male colleagues, not just a woman's issue.
- Do not ignore discussing the subject because you feel uncomfortable but always be respectful.
- Use the correct language – do not use euphemisms or slang words.
- When planning always "think servicewomen".

Uniform/clothing

- Wherever possible, allow people to choose the most appropriate uniform to complete their work tasks effectively. Servicewomen may be managing periods, pregnancy or menopause. Their bodies might require an alternative uniform to allow them to be comfortable and their best at work.
- Laundry. Access to laundry and washing facilities should be considered to support underwear cleaning on long deployments.

Privacy

- Establish a privacy area where a servicewoman can maintain their personal hygiene. This can be as simple as a screened area or access to a vehicle to enable showering.
- It is the commander's discretion on what level of privacy / screening can be provided and this will depend on the environment. Rarely will the tactical situation prevent using a privacy area (training or deployment).
- Communicate to all levels the availability of support and facilities. It needn't be much but ensure personnel know where to get support.
- The availability will normalise situations and remove stigmas. This measure will ensure commanders and units are prepared, regardless of use.

Urinary health

- Urinating in operational environments is more difficult for women and can carry additional health and safety considerations.
- Access to toilets is required throughout the day – think coverage and availability – it isn't always about the number of available loos but the location and access.
- Appropriate facilities and aids must be provided to women to ensure they can safely and discretely pass urine.
- The Urinary Support Device (USD) should be available for servicewomen. They will need to practise with the device before being in a challenging environment. Use of the USD must remain a choice for women and not be forced upon them.
- Promote a culture where hydration and urination are vital and ensure privacy and dignity are demonstrated around toilet facilities.

Menstrual health - period products

- Commanders should highlight the requirement for servicewomen to include personal sanitary and medical products in their kit before deployment.
- Servicewomen typically want to provide their own period products for personal use but they may experience unexpected or unscheduled bleeds. Include a menstrual support box (MSB) in your admin support for all exercises and deployments.
- Ensure the MSB is in an easily accessible location and women know how and where to access it. Recognise that approaching a person to ask for the MSB could block its use.

Menopause

- Every servicewoman's experience of the menopause will be different. Some may be affected earlier because of medical conditions but be aware that women over 45 are likely to be affected by the menopause. They may not mention it, and may not recognise the symptoms themselves, but the menopause could affect them mentally and/or physically. Sometimes the symptoms may be temporary or fluctuate, but they could affect decision making or how they feel.
- Medical support is available for women experiencing menopausal symptoms, but they should be allowed to make informed treatment choices without coercion.
- A new clothing issue is available for those experiencing the menopause. The additional uniform scaling will support women undergoing physical change or who wish to have a different clothing fit.
- Partners and work colleagues may also be affected.
- Be aware and be supportive.

Contraception and sexual health

- In a healthy sexual relationship, contraception should be openly discussed between partners; it is not solely a woman's responsibility.
- Different contraceptive options are available to support women wanting to prevent pregnancy, reduce the risk of sexually transmitted infections and/or suppress menstrual bleeds.
- Many hormonal contraceptive options can affect women's bleeding patterns and cause unpredictable bleeding; they may need menstrual supplies at short notice. Ensure the menstrual supplies box is always available and that women know how and where to access it.
- Servicewomen may need to continue using contraception throughout deployments and should be enabled to access this.
- Women who unexpectedly find themselves pregnant may choose to discuss this with you or not. Respect their confidentiality and their right to make the right choice for them. Do not be judgemental.
- Promote good sexual health by having posters visible around the unit about contraceptive choices and sexually transmitted infections with details of services locally available to your unit.
- Sexual activity must always be consensual between all parties. Any non-consensual sexual activity is sexual violence. This must be appropriately investigated if it is reported to you.

Becoming a parent

- Service personnel can frequently spend long periods of time away or separated from their partner. This may create domestic pressures for couples wishing to fall pregnant.
- The MOD has an assisted conception policy that supports employment restrictions to enable consistent access to services. This requires your cooperation as the chain of command when a service person engages with these services.
- Time off for medical appointments should be provided. You may ask about the time and date of the appointment and any travel time required to support attendance without needing to know the nature of the appointment.
- Some features of the military workplace can potentially harm a mother or their unborn child. It is important to make informed decisions to support and protect the servicewoman. During pregnancy, their body will undergo various physical and psychological changes.
- Pregnancy can occur at any point in a servicewoman's career and may be planned, unplanned, or achieved using assisted conception.
- Once a pregnancy has been declared, the individual will be given a temporary medical grading which may prevent them from doing certain activities; you must account for this in your planning. Pregnancy, or trying for a pregnancy, can be an emotionally challenging time for all involved. Although there is no legal requirement for you to be made aware until 25 weeks of pregnancy, if an individual does discuss their fertility journey/circumstances with you it is essential you are able to signpost to relevant support networks and offer compassion and understanding as a leader.
- Pregnant servicewomen are excused from all military fitness testing, but exercising during pregnancy is usually safe. They are recommended to get advice from your Physical Training Instructors and avoid potential contact sports and maximum effort activities.
- Different scaling and sizing of uniforms are available for issue to pregnant women at the various stages of pregnancy. Not all personnel will be aware of the policy. Sometimes discretion is required within the chain of command as a servicewoman may be concerned about others knowing – for example: consider if the clothing store team need to know the detail. A nominated unit PoC can be helpful to alleviate concerns and deal with potential sensitivities.
- Risk assessments (RA) must be conducted for personnel during and after pregnancy. You must conduct a RA and hold a meeting with the individual to discuss their individual welfare needs, childcare arrangements, opportunities for flexible working/service, courses, and career management.
- On returning to work after pregnancy an individual will require a medical appointment and may be referred to specialist care e.g. physiotherapy. They will also need to start on a supervised level 2 reconditioning programme before rejoining routine physical training or fitness testing to ensure they can regain fitness safely and effectively.

- JSP 375 Volume 1 Chapter 20 provide details about new and expectant mothers.
- Sadly, pregnancies do not always result in the birth of a live child and can end naturally at any stage - this is more common in the first 12 weeks. The emotional impact of pregnancy loss can be significant, and the servicewoman's body will already have significantly physically changed too. Support is available to help their recovery.
- Mental health conditions during pregnancy and the first year after childbirth are common; seeking professional and social support is recommended.

Servicewomen's considerations

Urinary health

- Drinking around 2 litres per day can be a helpful guide to help you stay hydrated but individual requirements will vary.
- Passing urine is an essential and normal body function that should occur 5 to 7 times a day, including once at night. Passing straw-coloured urine is ideal.
- Dehydration has many negative health and performance implications, and care should be taken to actively stay hydrated, despite this increasing the need to pass urine.
- In the operational environment, it can be more challenging to pass urine, but options such as the USD can help facilitate urinating in challenging environments. It is helpful to practise using these at home first.
- The pelvic floor is a collection of muscles and ligaments which work to hold the internal organs in the right place. A weak pelvic floor can cause issues with incontinence and prolapse. These conditions are common but are not normal and may need medical attention. Pelvic floor, or kegel, exercises can help to strengthen the pelvic floor and are recommended to prevent future problems arising.

Menstrual health

- Periods are a normal, regular and healthy occurrence for women. Periods can be a key indicator of your overall health. Knowing what is normal for you will help you identify when you may need some medical advice.
- Some military environments and situations can affect the length of period cycles or the heaviness of bleeding. Periods can often become unpredictable when the body is under high levels of physical and emotional stress. Monitor yourself to understand how you are affected and highlight any concerns.
- There are many different ways of managing the bleed produced by your period. Different environments within the military may require you to adjust what you usually do. Plan ahead, consider all the environments you may be working in and consider using a "pick and mix" approach to period products. Try to practice with your chosen method(s) within a simpler environment than a deployed or exercise location.
- Using contraception to reduce or stop your periods requires medication provided by medical staff and bleeding patterns can be irregular to start with. If you are going to start or change something, try doing it during a time and in a location where unexpected bleeding will not be too difficult to manage.
- If you have an unexpected bleed and not enough personal supplies, the menstrual support box (MSB) provides you with a range of period products, cleaning items and replacement underwear to enable you to manage it and get back to what you were doing.
- Wash hands before and after handling periods products.
- You can choose between internal and external products which collect or absorb period blood. The period product you choose may differ on the day of your period and the environment you are operating in.
- You can use a combination of period products if you have a heavy or unpredictable flow.
- Tampons should be changed every 4 hours or immediately before and after sleep to prevent the risk of Toxic Shock Syndrome.

Menopause

- The menopause is a natural event which all women will experience and is defined as having occurred when you have not had a period for 12 months. It indicates hormone levels have decreased and usually happens between the ages of 45 and 55 years.
- The symptoms of menopause vary greatly from person to person. You may transition through the menopause and quickly adapt with minimal support, or your symptoms may be challenging, significantly impact the quality of your life and those around you and need medical treatment.

- Common menopause symptoms include hot flushes, difficulty sleeping, changes in sex drive, mood changes, palpitations, problems with memory and concentration, joint stiffness and vaginal dryness. Seek help and support if these symptoms are affecting your work or personal life.
- Hormone Replacement Therapy is a common option for managing menopausal symptoms but there are others. You are encouraged to speak to your healthcare practitioner to explore what treatment options would work best for you, whether further health checks are needed and assess whether workplace adjustments are necessary.

Contraception and sexual health

- In a healthy sexual relationship, contraception should be openly discussed between partners; it is not solely a woman's responsibility.
- Different contraceptive options are available to support women in preventing pregnancy, reducing the risk of sexually transmitted infections and suppressing menstrual bleeds.
- Servicewomen should carefully consider the available contraceptive options and discuss their advantages and disadvantages with a healthcare provider to ensure they choose the most appropriate method for them.
- Servicewomen should carefully consider the available contraceptive options and discuss their advantages and disadvantages with a healthcare provider to ensure they choose the most appropriate method for them.
- In the event of unplanned pregnancy, the sooner advice is sought, the more time a woman will have to consider the options available to her.
- Women should consider having a sexually transmitted infection screen if they have had intimate sexual relations without using barrier methods, have been told they may have been exposed to an infection by a sexual partner, or are showing signs or symptoms of infection.

Becoming a parent

- Should you and your partner have trouble conceiving within the first 12 months of trying, medical advice should be sought. If assisted conception is needed this is supported by MOD policy.
- Servicewomen considering preserving eggs should be aware that the process is complicated and takes considerably more time than freezing sperm; this should be considered when planning for potential deployments or postings.
- Take folic acid, reduce smoking, limit your alcohol intake and maintain a healthy bodyweight if you are thinking about becoming pregnant.

- If you could be pregnant or are experiencing any symptoms that could be pregnancy, it is recommended you take a pregnancy test at the earliest opportunity. Some features of the military workplace can potentially harm a mother or their unborn child, so it is important to know early and make sensible decisions that can be supported by your chain of command.
- You are not legally required to notify your employer about the pregnancy until 25 weeks of pregnancy, but you should seek medical advice as soon as possible to discuss your options and remove yourself from any activities that could be dangerous for the baby or you. This can be done without identifying you are pregnant.
- During pregnancy, your body will undergo various physical, physiological, and psychological changes.
- You are excused from all military fitness testing but it is safe to exercise during pregnancy. You are recommended to get advice from your physical training instructors and avoid potential contact sports and maximum effort activities.
- Sadly, pregnancies do not always result in the birth of a live child and can end naturally at any stage. This is more common in the first 12 weeks. The emotional impact of pregnancy loss can be significant, and your body will have physically changed too. Support is available to help your recovery.
- Mental health conditions during pregnancy and the first year after childbirth are common; seeking professional and social support is recommended.
- Returning to work is a supported activity to reintroduce you to your military workplace effectively. Formal discussion and risk assessments with your line manager, review by your medical staff and provision of a supervised reconditioning program ensure you safely return to military activity.