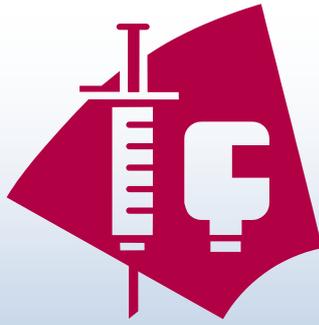




Diagnosis



Treatment



Care

Prescribed Minimum Benefits and Reproductive Health

In this issue of CMScript, our e-newsletter dedicated to prescribed minimum benefits (PMBs), we discuss reproductive health with a specific focus on infertility and premature labour. Are these conditions covered by PMBs and if so, what exactly should be funded?

Infertility

What is infertility?

Infertility is defined as the inability of a couple to fall pregnant despite having frequent, unprotected sex. Primary infertility describes couples who are unable to conceive for at least a year; secondary infertility refers to couples who have been pregnant at least once but have subsequently been unable to have more children. Recurring miscarriages are included in the condition.

What are the symptoms of infertility?

The main symptom of infertility is the inability to become pregnant.

If you decide to undergo testing and possible treatment for infertility, remember that it will take commitment from both partners.

What causes infertility?

Infertility may be caused by various factors in one or both partners. General health, lifestyle, and exposure to



certain environmental factors may also contribute towards the inability to conceive. Causes can also include menstrual problems in women and hormonal problems in men.

Infertility testing

If you decide to undergo testing and possible treatment for infertility, remember that it will take commitment from both partners. It will also involve questions about your sexual habits, and uncomfortable tests and procedures that can last several months. And after subjecting yourselves to all of this, there is unfortunately still no guarantee that you will fall pregnant.

Infertility testing and treatment is extremely expensive and for most couples the main concern is whether they can afford it. If you belong to a medical scheme, it is important to know if and how infertility is covered by the prescribed minimum benefits or PMBs.

PMBs include the diagnosis, treatment and care of infertility but the medical and surgical management that is guaranteed for members of medical schemes is limited to certain procedures and interventions. These include:

1. **Hysterosalpingogram.** This test evaluates the condition of your uterus and fallopian tubes to determine the presence of physical problems like possible blockages of the fallopian tubes.

2. **Blood tests to test for the presence of the following:**

a. Day 3 FSH/LH. FSH stands for “follicle-stimulating hormone” and LH stands for “Luteinizing hormone”. Both are released by a gland in the brain. In women, FSH stimulates the production of eggs and a hormone called oestradiol during the first half of the menstrual cycle and LH triggers ovulation. Their presence is measured by a blood test on the third day of a woman’s menstrual cycle.

b. Oestradiol. Oestradiol, which is the predominant estrogen (the sex hormone in women), acts as a growth hormone for tissue of the reproductive organs.

c. Thyroid function (TSH). TSH stands for Thyroid Stimulating Hormone. Thyroid dysfunction may cause problems such as anovulation (no ovulation, or no release of an egg) and menstrual irregularities.

d. Prolactin. This hormone is secreted by the pituitary gland in the brain. Prolactin stimulates lactation (milk production). A high level of prolactin can delay puberty, interfere with ovulation, and decrease libido in men. Low prolactin levels can cause menstrual disorders and lead to inadequate lactation.

e. Rubella. The German measles virus can cause severe abnormalities in babies if the mother contracts it during pregnancy.

f. HIV. Women with HIV may find it more difficult to fall pregnant. HIV-infected women experience reduced pregnancy rates and higher rates of miscarriages. HIV/AIDS may induce sterility, increase foetal mortality, and decrease the production of sperm, all contributing to a reduced fertility.

g. VDRL. This is the abbreviation of the laboratory test for syphilis. Syphilis is one of the leading sexually transmitted diseases that cause infertility.

h. Chlamydia is a sexually transmitted disease that often leads to reduced fertility.

i. Day 21 Progesterone. Progesterone is a female hormone produced mainly by the placenta in the ovary. It is measured on the 21st day of a woman’s cycle. Progesterone prepares the lining of the uterus (womb) to receive and sustain the fertilized egg and so makes pregnancy possible.

3. **Laparoscopy.** This surgical procedure is used to determine whether any physical problems are present, e.g. scar tissue, tumours, and other abnormalities in the uterus, fallopian tubes, and ovaries.

4. **Hysteroscopy** is a surgical procedure in which a scope instrument is inserted through the vagina and cervix into the cavity of the uterus to determine if there are any physical problems inside the uterus.

5. **Surgery (uterus and tubal)** covers rectifying any physical problems, including blocked fallopian tubes and the removal of growths.

6. **Ovulation defects and deficiencies** can be addressed through “chemical” treatment like medication to induce ovulation.

7. **Semen analysis** (volume; count; mobility; morphology). The Mixed Agglutination Reaction or MAR-test is used to check for anti-sperm antibodies. Sperm analysis checks the volume of semen, count of sperm in the semen, the movement and structure of the sperm, and also whether antibodies are present in the semen.

8. Basic **counselling** and advice on sexual behaviour, temperature charts etc.

9. **Treatment of local infections.**

Premature Labour



What causes premature labour?

Despite the enormous amount of research done, the causes of premature labour are still poorly understood and as such science does not yet know how to prevent it. The risk factors include, but are not limited to, previous preterm delivery, teenage pregnancy, sexually transmitted infections, recurrent urinary tract infections, and stressors such as physically exerting work and not getting enough rest.

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What is premature labour?

Labour usually begins within two weeks before or after the estimated date of delivery. Labour after 37 weeks of conception is considered safe, but anything before 37 weeks is considered premature labour.

Premature labour can result in premature delivery. There is usually little risk to the mother but the implications for the baby can be enormous. Premature labour can result in a premature infant – an infant who has not yet reached that level of foetal development which allows for self-sustained life outside the womb. Several crucial organs, e.g. the lungs, need to mature between the 34th and 37th week of gestation; a baby that is born prematurely is denied the chance of developing fully. This is what makes premature labour such a serious condition.

What are the symptoms of premature labour?

Any one or several of the following can indicate the onset of premature labour: sustained contractions, pelvic pressure that feels like the baby is pushing down, a mucoid or bloody vaginal discharge, fluid leaking from the vagina (signalling rupture of membranes), low back pain, an upset stomach and/or diarrhoea.

Discuss the symptoms related to premature labour with a healthcare provider so that you know exactly which steps to take should you experience them.

What is management?

The treatment of premature labour involves accelerating the maturation of the foetus, preventing preterm delivery by stopping the labour and ensuring the pregnancy continues until delivery is safer, or delivering the infant in instances when delivery is inevitable.

Both pregnancy and the medical management of low-weight neonates with respiratory difficulties are covered under the PMB regulations.

Medical schemes are allowed to employ managed care tools such as protocols and formularies founded on evidence-based principles and taking into account cost-effectiveness and affordability. The protocols will guide the management of premature labour, preterm delivery and low birth weight neonates with or without respiratory difficulties, and should be freely available to your doctor.

Remember that even if you have already obtained pre-authorisation for the delivery of your baby, you still need to contact your scheme within 48 hours after the emergency situation (premature labour) to ensure that they provide pre-authorisation for other treatment that may be needed.

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