

training manual

For The Providers of Youth
Friendly Services

FAMILY PLANNING AND REPRODUCTIVE HEALTH



In July 2011, FHI became FHI 360.



FHI 360 is a nonprofit human development organization dedicated to improving lives in lasting ways by advancing integrated, locally driven solutions. Our staff includes experts in health, education, nutrition, environment, economic development, civil society, gender, youth, research and technology – creating a unique mix of capabilities to address today's interrelated development challenges. FHI 360 serves more than 60 countries, all 50 U.S. states and all U.S. territories.

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Acknowledgement

Family Health International (FHI) and The United Nations Population Fund (UNFPA) are proud to present the Training Manual for Family Planning and Reproductive Health that aims to build the capacity of providers of youth-friendly services in Egypt.

This comprehensive training manual includes facilitator guidelines, training slides and a CD-Rom of the PowerPoint slides.

This activity is a fully collaborative effort between UNFPA and FHI in their efforts to enhance family planning and reproductive health services at the youth-friendly clinics.

Thanks are due to the Egyptian Family Planning Association (EFPA) for their support in the development of this manual.

Special gratitude is due to the facilitators who will use this manual in their work with service providers. We hope our efforts will assist them to have an immediate and long-lasting impact on the reproductive health and well-being of youth worldwide.

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
COCs	Combined Oral Contraceptives
ECPs	Emergency Contraceptive Pills
EFPA	Egyptian Family Planning Association
FHI	Family Health International
FGM	Female Genital Mutilation
FP	Family Planning
HIV	Human Immunodeficiency Virus
IPPF	International Planned Parenthood Federation
IUD	Intra Uterine Device
POPs	Progestin Only Pills
RH	Reproductive Health
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
UN	United Nations
UNFPA	United Nations Population Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
YFS	Youth Friendly Services
YFCs	Youth Friendly Clinics

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Introduction

Youth represent a large, significant and growing demographic in Egypt. With generally low contraceptive use rates and knowledge about reproductive health, youth represent a relatively high proportion of the country's unmet reproductive health needs. Promoting comprehensive youth friendly services is essential in assisting youth to make responsible sexual and reproductive decisions and empowering them to enforce these decisions.

Young People as an Age Group

- 1 Adolescents: 10 – 19 years
- 2 Youth: 15-25 years
- 3 Young people: 10 – 24 years

The meaning of "adolescence" -the period between 10 and 19 years of age- is understood in different ways in different cultural contexts. Almost universally, however, it is seen as a time of transition between childhood and adulthood, a period of physical and psychological changes associated with puberty, and of preparation for the roles, privileges and responsibilities of adulthood.

The nature and experience of adolescence vary tremendously by sex, marital status, class, region and cultural context. As a group, however, adolescents are generally recognized to have sexual and reproductive health needs that differ from those of adults, and which are still poorly understood in much of the world.

Adolescents and young people are at the beginning of their sexual and reproductive lives and they are also the next generation of parents. How they undergo preparation for this journey has tremendous implications for their own lives as well as for national reproductive health outcomes, including fertility, safe motherhood and sexually transmitted infections (STIs), particularly HIV/AIDS.

Internationally, unmet need for family planning among adolescents is twice as high as among the adult population, despite undeniable risks: young women aged 15 to 19 are twice as likely as women in their twenties to die in childbirth, and of the 14 million teenagers who give birth each year world wide, many face serious pregnancy-related illnesses and at least 5 million undergo unsafe abortion.

Purpose of this Training Manual

This training manual is designed to assist in developing the capacity of the providers of youth friendly services (YFS) in providing family planning (FP) and reproductive health (RH) services and information to youth through a training workshop.

YFS providers should be able to respond to the needs of young people, remove their fears, respect their concerns and provide the services within an environment that suit their preferences.

The training content and methodology of this manual will enable YFS providers to

respond to the frequently asked questions by young people such as; body changes that occur at puberty, reproductive physiology and anatomy, virginity, the sexual response cycle in human beings, female genital mutilation, premarital counseling ,pre and post natal care in addition to family planning. This training manual will be used to conduct a training workshop for physicians working in youth friendly clinics (YFCs).

The training workshop goal, objectives, and expected outcomes are:

Goal:

To improve the quality of sexual and reproductive health (SRH) services provided in the youth friendly clinics.

The Overall Objectives Are to:

1. Improve the family planning and reproductive health knowledge and skills of service providers
2. Strengthen the capacity of service providers in providing SRH information to youth

Expected Outcomes:

By the end of the training workshop, participants will be able to:

1. Explain the concept and components of YFS within the context of SRH
2. Describe the different parts and functions of the female and male genital organs
3. Explain the physiology of the female and male genital organs
4. Identify the appropriate family planning methods for youth according to their needs
5. Provide SRH information and services to youth according to their needs

Facilitator's Guidelines

This training manual contains guidance for the facilitators to conduct each session in the form of session plans including: session title, objectives, allocated time , training methodology, materials, power point presentations and selected handouts. It is recommended that the facilitators will use interactive techniques to stimulate group thinking and active participation through a variety of training methods including brain storming, asking questions, group work and role-plays, which are included in this training manual. A set of power point slides are included for each session and will be given to the participants for self-learning.

It is recommended that the organizers of this training workshop will ensure the availability of reference materials for reading during the workshop especially, "Family Planning A Global Handbook for Providers". It is also recommended that computers with internet access will be available during the session of "Providing SRH information to Youth" so that the participants will practice accessing selected web sites such as WHO, FHI, IPPF, UNFPA, Engender health and Pathfinder International for getting SRH information.

This training workshop is designed to be implemented in four days but it could be adapted to a longer or shorter duration according to the needs, background and number of participants. The manual contains samples of Workshop Agenda (training schedule), Pre-Post Tests and Evaluation Forms.

Session One

Welcome and Introduction to the Workshop

Session 1: Welcome and Introduction to the Workshop

Allocated Time: (120 minutes)

Session Objectives:

By the end of this session, participants will be able to:

1. Describe the workshop goal, objectives, expected outcomes and agenda
2. Identify their expectations from the training workshop
3. Establish ground rules and group norms for the training workshop
4. List the names of facilitators and the participants
5. Answer the pre-test questionnaire

Materials:

- Flipchart and Markers
- Overhead Projector and set of transparencies OR Data Show and Power Point Presentations on a CD **Presentation 1**
- Training agenda
- Name tags
- Index cards
- Adequate number of the pre-test copies

Methodology:

Step 1- Welcome (10 minutes)

- Host organizational staff welcomes participants as they arrive at the training room
- Ask each participant to sit in his/her designated space where his/her name tag has been placed
- Welcome the participants into the training room and introduce yourself and all facilitators to the trainees

Step 2 - Introduction to the Workshop and the Participants (60 minutes)

- Distribute the pretest and ask participants to respond (20 minutes)
- Present the goal, objectives, expected outcomes, evaluation methodologies, and the agenda of the training workshop to the participants (10 minutes)
- Explore the participants' training expectations and personal goals (15 minutes)
- Establish ground rules and group norms with participants and write it on a flipchart (15 minutes)

Appreciative Interview/Icebreaker (50 minutes)

Give each one of the participants an index card and a marker and instruct them as follows:

- On the index card, participants should write down three of their own physical characteristics that are easily noticeable. Participants should not write their names
- Completed index cards will be given to the trainer
- Each participant is given a completed index card (but not his/her own)
- At this point, each participant carries out two activities: 1) S/he locates the person described on the index card; 2) S/he interviews the located participant and is in turn interviewed by him/her
- The interviewer then records the following information on the index card of the interviewed person
 1. Name
 2. Place of work
 3. Two expectations of the workshop
 4. Two thoughts regarding YFS

Handouts

1. Workshop agenda
2. Workshop goal, objectives, and expected outcomes

Family Planning and Reproductive Health Training for the Providers of Youth Friendly Services



Goal

To improve the quality of sexual and reproductive health (SRH) services provided in the youth friendly clinics (YFCs)



Objectives

The overall objectives are to:

- Improve the family planning (FP) and reproductive health (RH) knowledge and skills of service providers
- Strengthen the capacity of service providers in providing SRH information and services to youth



Expected Outcomes

By the end of the training workshop, participants will be able to:

- Explain the concept and components of YFS within the context of SRH
- Describe the different parts and functions of the female and male genital organs
- Explain the basic knowledge of the physiology of the female and male reproductive organs



Expected Outcomes *(cont.)*

By the end of the training workshop, participants will be able to:

- Identify the appropriate FP methods for youth according to their needs
- Provide SRH information and services to youth according to their needs



Training Methods

- Working Groups
- Brainstorming
- Role Play
- Lectures with discussions
- Demonstration and re-demonstration



Session **t**wo

Youth Friendly Services

Session 2: Youth Friendly Services

Allocated Time: 180 minutes

Session Objectives:

By the end of this session, participants will be able to:-

1. Explain the concepts of Youth Friendly Services (YFS)
2. Explain characteristics of Youth Friendly Clinics (YFCs)
3. Identify the characteristics and qualifications of the providers of YFS
4. List strategies for implementing YFS

Materials:

- Flipchart and Markers
- Overhead Projector and set of transparencies OR Data Show and Power Point Presentations on a CD **Presentation 2**
- Handout "Youth Friendly Services"

Methodology:

Step 1- Introduction to Youth Friendly Services (60 minutes)

1. Write the following on a flipchart
 - 1 *What are the issues that must be addressed in youth friendly services?*
 - 2 *What are the needed providers' technical competencies?*
2. Ask the participants to think about the listed questions
3. Divide the participants into two groups and instruct each group to go to a specific part of the room
4. Distribute a sheet of flipchart paper and marker to each group
5. Ask each group to answer one question
6. Give the working groups 20 minutes to discuss the question and to write the answer on the flipchart
7. Each group will then have 10 minutes to present what they have written on the flipchart
8. After each group presents, ask the participants to add their thoughts and suggestions

Step 2- Characteristics of Youth Friendly Services (40 minutes)

1. Ask the participants about the characteristics of YFS
2. Write their responses on the flipchart
3. Present the 11 characteristics of Youth Friendly Services and refer to their thoughts on the flipchart when it is applicable.

Step 3 – Self-Assessment (60 minutes)

1. Divide the participants into two groups and instruct each group to go to a specific part of the room
2. Distribute a sheet of flipchart paper and marker to each group

3. Groups will then do self-assessment regarding what they are doing in their YFCs to identify gaps and suggest actions/recommendations for improvement - Group (1) work on the services and group (2) work on service providers
4. Give the working groups 20 minutes to discuss and write on the flipchart
5. Each group will then have 10 minutes to present what they have written on the flipchart
6. After each group presents, ask the participants to add their thoughts and suggestions

Step 4 – Wrap up/Presentation (20 minutes)

The facilitator will wrap up this session by using the power point presentation

Handouts

1. YFS Handouts
2. Printout of the power point presentation

Handouts: Youth Friendly Services (YFS)

Youth friendly services represent an approach, which brings together the qualities that young people demand, with the high standards that have to be achieved in the best public services. Such services are **accessible, acceptable and appropriate** for young people. They are in the **right place, at the right time, at the right price** (free where necessary) and delivered in the **right style** to be acceptable to young people. They are **equitable** because they are inclusive and **do not discriminate** against any sector of this young clientele on grounds of gender, ethnicity, religion, disability, social status or any other reason. Indeed, they reach out to those who are most vulnerable and those who lack services.

The YFS are **comprehensive** in that they deliver an essential package of services to the whole target group. They are **effective** because trained and motivated health care providers who are technically competent and who know how to communicate with young people without being patronizing or judgmental deliver them. These providers are backed up by youth friendly support staff and have access to equipment, supplies and basic services. They also maintain a system of quality improvement so that staff are supported and re-motivated to keep up their high standards.

Finally, the Youth Friendly Services are **efficient** so that they do not waste money, and they record enough information to be able to monitor and improve performance. The gold standard for Youth Friendly Services is that they are effective, safe and affordable; they meet the individual needs of young people who return when they need to and recommend these services to friends.

Making services youth friendly is not primarily about setting up separate dedicated services, although the style of some facilities may change. The greatest benefit comes from improving generic health services in local communities and the competences of health care providers to deal effectively with youth.

Service Providers Technical Competencies

Doctors and nurses need good knowledge of normal adolescent development and the skills to diagnose and treat common conditions, such as anemia or menstrual disorders in girls, and to recognize signs of sexual or physical abuse. They need access to the correct drugs and supplies to treat common conditions and prevent health problems. They should know where to refer young people for specialized physical or psychological treatment. Such referrals may be to people or services outside the health system for counseling or social support.

Strategies for Implementing Youth Friendly Services

1. Service provider must see the person (the client) not the problem

Technical competence must be accompanied by respect and sensitivity to draw the young person and discover underlying problems that may not be the immediate cause of a visit. By focusing on the person, rather than the symptom, providers can discover underlying concerns.

Technical skills and a sympathetic professional approach should be combined with a non-judgmental approach. Health care providers do not need to abandon their own belief systems or values, but they do need to understand a situation from a youth's point of view and not to allow their own views to dominate the interaction.

1. Training and staff support

Technically competent and empathetic staff need a system of ongoing support. A youth friendly approach should include repeated training sessions to refresh the skills of current staff as well as developing new skills for new staff. Training and peer-review sessions should cover everyone from doctors (who may believe they need no further training) to receptionist and support staff (who may be surprised that they are part of the team) as they may be the first person an adolescent meets at a health facility. If they are unfriendly, or judgmental he/she may never return.

Management and supervision should be aimed at creating a supportive environment and at developing systems to maintain and improve quality. Health care providers should be involved in developing protocols and guidelines, covering key quality issues. They should also develop self-assessment and peer review mechanisms, which create a culture of openness. Monitoring systems should encourage young people to provide feedback on the services.

2. Making the services physically acceptable

Services need to be provided in places that young people can reach and at times feasible to them. This may involve holding special clinics in youth centers, or other places where young people go. Clinical staff can take shifts to be available in late duty hours and weekends, when young people are not at school, college or working.

Physical surroundings and clinic infrastructure are important. Many places have no special youth centre, but still provide a welcoming health facility. A busy city hospital with limited budget can create a 'YFS corner', by putting up a partition thus ensuring privacy, or by using a rear door where they can enter without being stigmatized. Some clinics give young people numbers when they arrive so that they can be called to see the doctor without having their names called out. Young people themselves may help to decide on a creative name that will be welcoming but not stigmatizing. Care must be given to the paintings, posters on the walls, cleanliness and availability of chairs in the waiting area. Additionally health promoting materials should be existing in the waiting area to be read or viewed by youth while waiting.

3. Confidentiality and privacy

Youth need to be assured of privacy and confidentiality during consultation and afterwards. Young people should not be expected to undress or be examined where people can see them. Those waiting outside should not be able to hear a doctor giving a diagnosis. Additionally, patients must be assured that the medical records will not be left on view and that receptionists will not gossip.

In most countries, there is legal obligation for doctors to report sexual assault and road traffic accident and there are also legal restrictions on treatment of young people below a certain age without parental consent. These and other legal constraints need to be explained as the only exceptions to a strict policy of confidentiality. This policy itself can be jointly developed with young people and health care providers so that everyone understands and feels comfortable with the ground rules. The confidentiality policy, including exceptions, needs to be explained to all young people and parents or guardians and to be clearly understood by referral agencies.

4. Services that are acceptable to the local communities

Simply, making services ‘youth friendly’ will not increase utilization, unless young people feel that it is acceptable to be seen using these services. Community support for the service must be sought. It should be made clear to the community members why youth friendly services are important and why these should include sexual and reproductive health and confidential counseling. Local meetings may be held for parents, and community and religious leaders should be approached for support. Services may even be located in community settings. There are many examples of services being delivered in schools, community centers or on the street.

5. Involving youth

Services of high quality are those that closely involve youth in their planning and monitoring. The involvement of youth guarantees their right to have their views heard and also increases the confidence that other young people have in those services. Also, through involvement of young people, service providers can be confident that they are providing services in the right place, at the right time and in the right style.

Characteristics of YFS

YFS need to be accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient. These characteristics are based on the WHO Global Consultation in 2001 and discussions at a WHO Expert Advisory Group in Geneva in 2002. They require:

1. Youth friendly policies that:

- Fulfil the rights of youth as outlined in the United Nations (UN) Convention on the Rights of the Child and other instruments and declarations
- Take into account the special needs of different sectors of the population, including vulnerable and under-served groups
- Do not restrict the provision of YFS on grounds of gender, disability, ethnic origin, religion or (unless strictly appropriate) age

- Pay special attention to gender factors
 - Guarantee privacy and confidentiality and promote autonomy so that youth can consent to their own treatment and care
 - Ensure that services are either free or affordable by youth
- 2. Youth friendly procedures to facilitate:**
- Easy and confidential registration of youth, and retrieval and storage of records
 - Short waiting times and (where necessary) swift referral
 - Consultation with or without an appointment
- 3. YFS providers who:**
- Are technically competent in adolescent specific areas
 - Offer health promotion, prevention, treatment and care relevant to each client's maturation and social circumstances
 - Have interpersonal and communication skills
 - Are motivated and supported
 - Are non-judgmental, considerate, easy to relate to and trustworthy
 - Devote adequate time to clients or patients
 - Act for the best interests of their clients
 - Treat all clients with equal care and respect
 - Provide information and support to enable each client to make the right free choices for his or her unique needs
- 4. Youth friendly support staff who are:**
- Understanding, considerate and treat each client with equal care and respect
 - Competent, motivated and well supported
- 5. Youth friendly health facilities that:**
- Provide a safe environment at a convenient location with an appealing ambience
 - Have convenient working hours
 - Offer privacy and avoid stigma
 - Provide information and education material
- 6. Youth involvement, so that they are:**
- Well informed about the services and their rights
 - Encouraged to respect the rights of others
 - Involved in service assessment and provision
- 7. Community involvement and dialogue to:**
- Promote the value of health services
 - Encourage parental and community support

8. Community based outreach and peer-to-peer services to increase coverage and accessibility

9. Appropriate and comprehensive services that:

- Address each client's physical, social and psychological health and development needs
- Provide a comprehensive package of health care and referral to other relevant services
- Avoid unnecessary procedures

10. Effective youth health services that:

- Are guided by evidence-based protocols and guidelines
- Have equipment, supplies and basic services necessary to deliver the comprehensive SRH package
- Have a process of quality improvement to create and maintain a culture of staff support.

11. Efficient youth services which have:

- A management information system including information on the cost of resources
- A system to make use of this information

Youth Friendly Services



Youth Friendly Services (YFS)

- What is it?
- Characteristics of YFS
- Characteristics of the providers and facilities
- Strategies for Implementing YFS



Definition

YFS represent an approach which brings together the qualities that young people demand, with the high standards that have to be achieved in the best public services.

YFS are:

- Accessible, acceptable and appropriate for youth
- In the right place, at the right time and at the right price
- Comprehensive because they deliver an essential package of services



Definition *(cont.)*

- Equitable and do not discriminate against any sector of youth on grounds of gender, ethnicity, religion, disability, social status or any other reason
- Reach out to those who are most vulnerable and those who lack services
- Effective because they are delivered by trained and motivated health care providers



Characteristics of Service Providers

- Well trained
- Demonstrate respect and concern for young people
- Knowledgeable of normal adolescent development
- Have the skills to diagnose and treat common conditions
- Have access to the correct drugs and supplies
- Know where to refer youth
- Respect the confidentiality and privacy



Strategies for Implementing YFS

- Service provider must see the person (the client) not the problem
- Training and staff support
- Making the service facilities acceptable
- Confidentiality and Privacy
- Services that are acceptable to the local communities
- Involving youth



Characteristics of YFS

1. Youth friendly policies that:

- Fulfil the rights
- Address the special needs of different sectors of the population
- Avoid discrimination
- Pay special attention to gender factors
- Guarantee privacy and confidentiality
- Ensure affordability to young people



Characteristics of YFS *(cont.)*

2. Youth friendly procedures to facilitate:

- Easy and confidential registration of clients, retrieval and storage of records
- Short waiting time and (where necessary) swift referral
- Consultation with or without an appointment

Characteristics of YFS *(cont.)*

3. Youth friendly health care providers who are:

- Technically competent
- Have interpersonal and communication skills
- Motivated and supported
- Non-judgmental
- Devote adequate time to clients or patients
- Provide information and support to enable adolescent's voluntary and informed choices



Characteristics of YFS *(cont.)*

4. Youth friendly support staff who are:

- Understanding and considerate, treating all youth clients with equal care and respect
- Competent, motivated and well supported

5. Youth friendly health facilities that:

- Provide a safe environment at a convenient location
- Have convenient working hours
- Offer privacy and avoid stigma
- Provide information and education material



Characteristics of YFS *(cont.)*

- 6. Youth involvement in planning, implementing and evaluating YFS so that they become:**
- Well informed about the services and their rights
 - Encouraged to respect the rights of others
 - Involved in service assessment and provision

Characteristics of YFS *(cont.)*

7. Community involvement and dialogue to:

- Promote the value of SRH for youth
- Encourage parental and community support

8. Community based outreach and peer-to-peer services to increase coverage and accessibility



Characteristics of YFS *(cont.)*

9. Appropriate and comprehensive services that:

- Address each youth's physical, social and psychological health and development needs
- Provide a comprehensive package of SRH care and referral to other relevant services
- Do not carry out unnecessary procedures (i.e. doing unnecessary pelvic exam)



Characteristics of YFS *(cont.)*

10. Effective SRH services that are:

- Guided by evidence-based protocols
- Having equipment and supplies necessary to deliver the essential SRH package
- Having a process of quality improvement



Characteristics of YFS *(cont.)*

11. Efficient SRH services which have:

- Accurate data
- Monitoring and Evaluation System



Session Three

Anatomy of the Female and Male
Genital Organs

Session 3: Anatomy of the Female and Male Genital Organs

Allocated Time: 120 minutes

By the end of this session, participants will be able to:

1. List the different parts of the external and internal genital organs of female and male
2. Describe the functions of the different parts of the female and male genital organs

Materials:

- Flipchart and Markers
- Overhead Projector and set of transparencies OR Data Show and Power Point Presentations on a CD

Presentation 3

Methodology:

Exercise 1. (45 minutes)

1. Distribute the diagram of female external and internal genital organs and ask the participants to write down the names of the different parts
2. Ask two volunteers to present what they wrote for the external and internal organs to their colleagues
3. The facilitator will manage the discussion among the group and present the correct slides

Exercise 2. (30 minutes)

1. Distribute the diagram of male external and internal genital organs and ask the participants to write down the names of the different parts
2. Ask a volunteer to present what he/she wrote for the external and internal organs to his colleagues
3. The facilitator will manage the discussion among the group and present the correct slides

Exercise 3. (45 minutes)

1. Ask the participants to draw the female and male genital organs on flipcharts using their own drawing skills and inform them that the most appropriate drawings will be used by service providers to explain the reproductive anatomy to youth clients
2. Ask two volunteers to play the role of a service provider and a youth client who needs information about genital organs

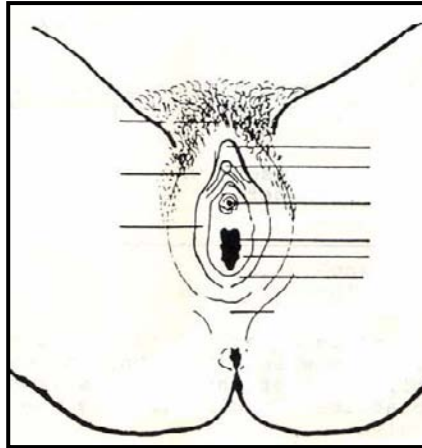
Handouts

Printout of the power point presentation

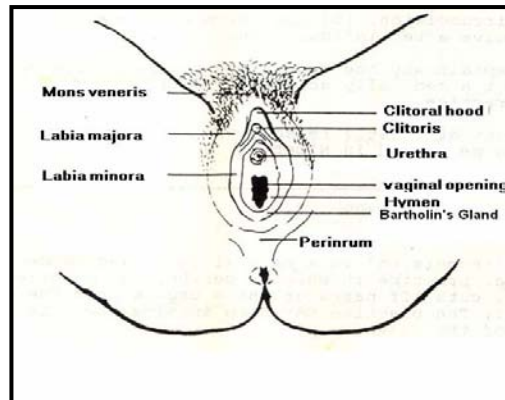
Anatomy of the Female and Male Genital Organs

Female External Genital Organs

Exercise 1

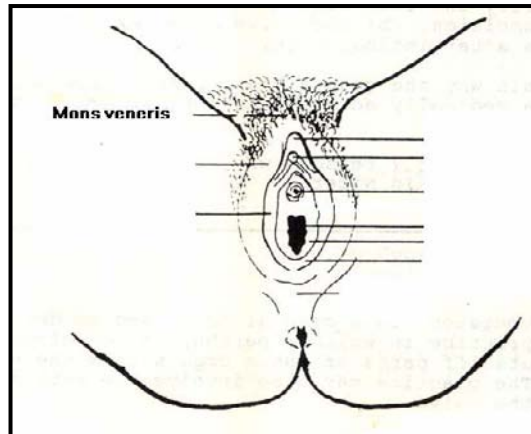


Female External Genital Organs *(cont.)*



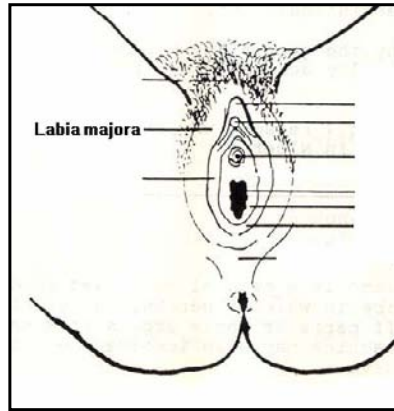
Female External Genital Organs *(cont.)*

A pad of fatty tissue over the pubic bone. This structure, which becomes covered with hair during puberty, protects the internal sexual and reproductive organs.



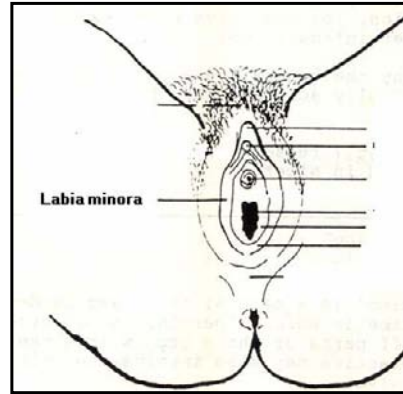
Female External Genital Organs *(cont.)*

Two spongy folds of skin - one on either side of the vaginal opening covering and protecting the genital structures.



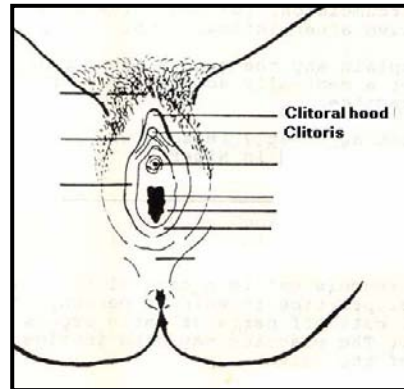
Female External Genital Organs *(cont.)*

Two erectile folds of skin between the labia majora that extend from the clitoris on both sides of the urethral and vaginal openings.



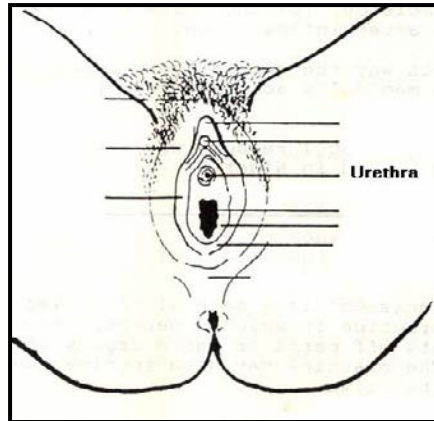
Female External Genital Organs *(cont.)*

An erectile, hooded organ at the upper joining of the labia that contains a high concentration of nerve endings and is very sensitive to stimulation.



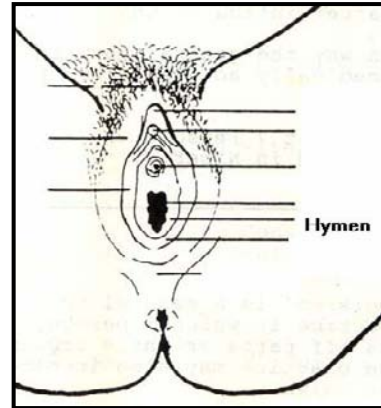
Female External Genital Organs *(cont.)*

The external opening of the urinary tract.



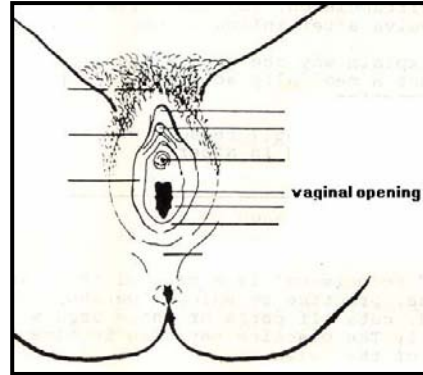
Female External Genital Organs *(cont.)*

A thin membrane that surrounds the opening to a young woman's vagina.



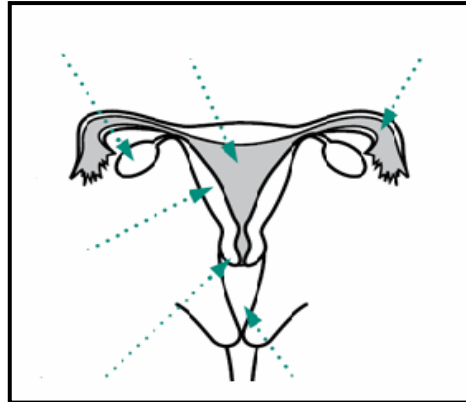
Female External Genital Organs *(cont.)*

The external opening of the
genital tract.

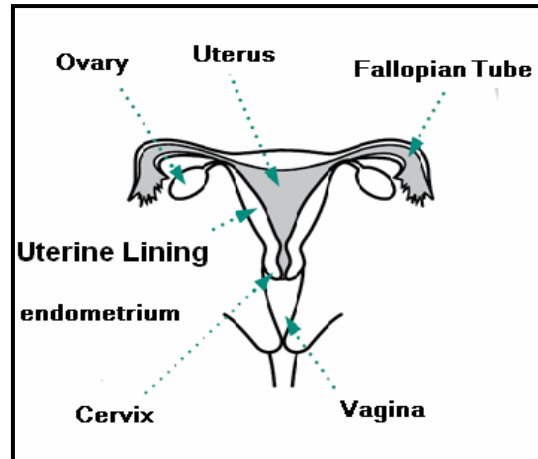


Internal Female Genitals

Exercise 2

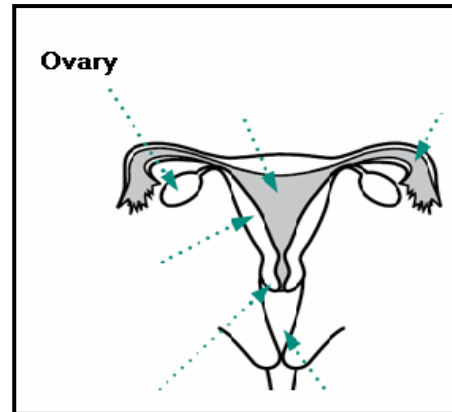


Internal Female Genitals *(cont.)*



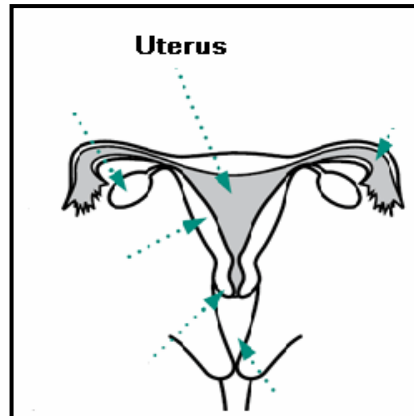
Internal Female Genitals *(cont.)*

Where ova develop and one is released every month.



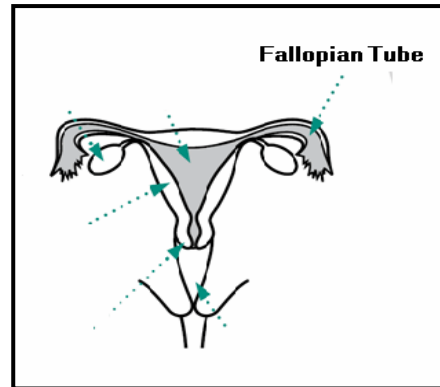
Internal Female Genitals (cont.)

Where the fertilized ovum grows and develops into a fetus.



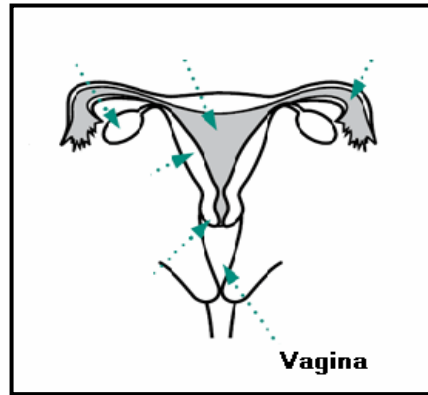
Internal Female Genitals *(cont.)*

- An ovum travels along one of these tubes once a month, starting from the ovary
- Fertilization of the ovum (when sperm meets the ovum) occurs in the outer third of the tube



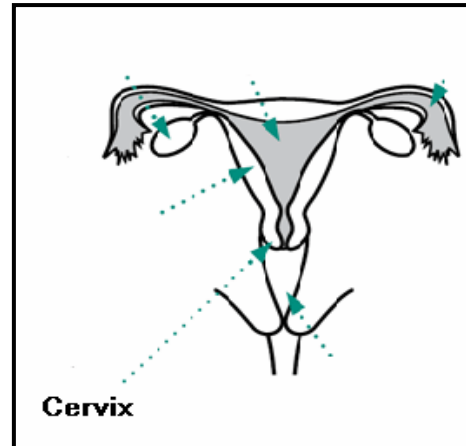
Internal Female Genitals (cont.)

Join the outer sexual organs with the uterus.



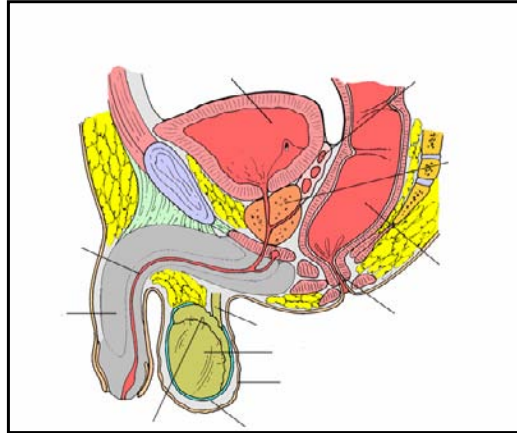
Internal Female Genitals (cont.)

- The lower portion of the uterus which extends into upper vagina
- Produces mucus

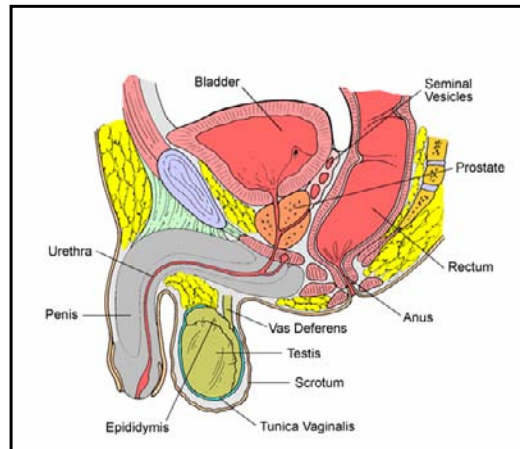


External and Internal Male Genitals

Exercise 1

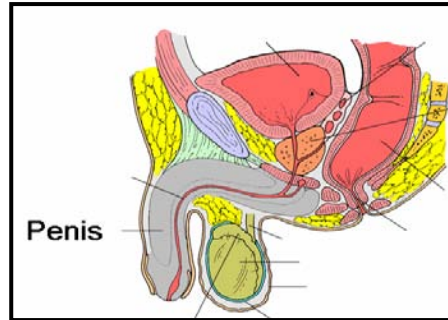


External and Internal Male Genitals (cont.)



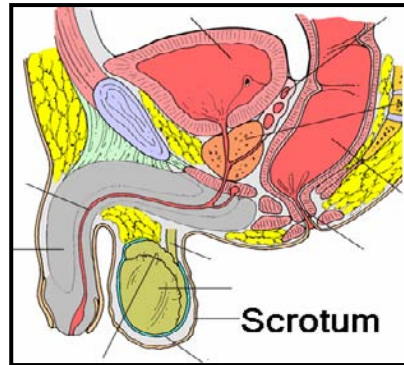
External and Internal Male Genitals (cont.)

- Cylindrical structure with the capacity to be flaccid or erect
- Very sensitive to stimulation
- Glans penis is the most highly innervated part
- Penetrates the vagina during sex
- Provides passage for both urine and semen



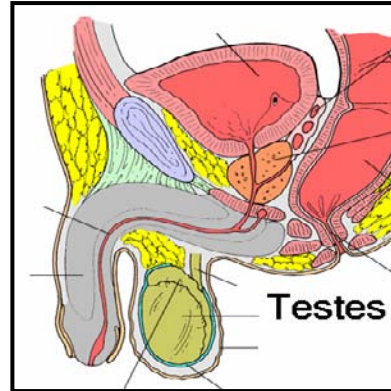
External and Internal Male Genitals (cont.)

- A pouch of skin hanging directly under the penis and contains the testes
- Protects the testes and maintains the temperature necessary for the production of sperms



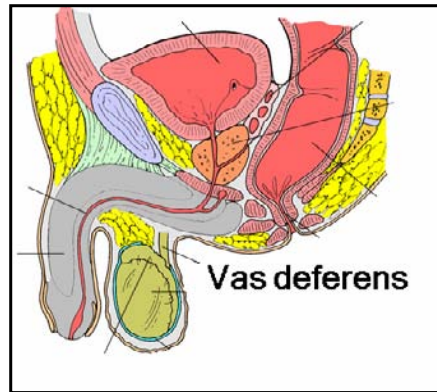
External and Internal Male Genitals (cont.)

- Paired, oval-shaped organs located in the scrotum
- Produce sperms and male sex hormone (**testosterone**)
- Highly innervated and sensitive to touch and pressure



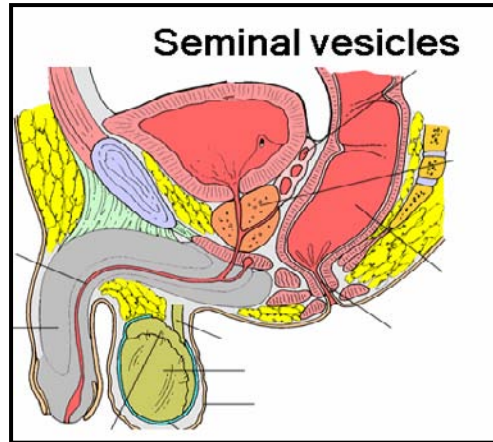
External and Internal Male Genitals (cont.)

Paired tubes that carry the mature sperms from the epididymis to the urethra.



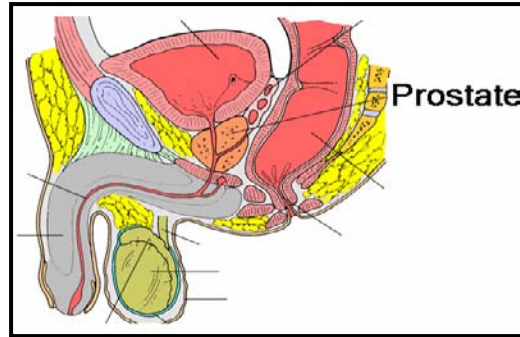
External and Internal Male Genitals (cont.)

A pair of glandular sacs that secrete about 60% of the fluid that makes up the semen in which sperms are transported.



External and Internal Male Genitals (cont.)

- Glandular structure that secretes some of the fluid that makes up the semen
- The alkaline quality of the fluid neutralizes the acidic environment of the male and female reproductive tracts



Session **F**our

Physiology of the Female and
Male Reproductive Organs

Session 4: Physiology of the Female and Male Reproductive Organs

Allocated Time: 180 minutes

By the end of this session, participants will be able to:

1. Describe the different phases of the menstrual cycle
2. Explain the processes of ovulation, conception and implantation
3. List the symptoms and signs of pregnancy
4. Explain the physiological functions of the male sex organs
5. Identify the risk of diseases and infections in relation to anatomy and physiology

Materials:

- Flipchart and Markers
- Overhead Projector and set of transparencies OR Data Show and Power Point Presentations on a CD **Presentation 4**
- Handout "Reproductive Physiology"

Methodology:

Role play 1. (120 minutes)

1. Classify participant into FIVE groups and each group will select one participant to play the role of a service provider and one to play the role of a youth client
2. The five selected service providers will read the handouts of female reproductive physiology to get prepared to respond to the questions of their clients (20 minutes)
3. Each one of the selected youth clients will be assigned to ask one of the following questions:
 - a. How menstruation occurs?
 - b. How ovulation occurs?
 - c. How conception occurs?
 - d. How implantation occurs?
 - e. What are the functions of the female sex hormones?
4. Each group will conduct their role play followed by discussion in 20 minutes

Discussions (20 minutes)

1. The facilitator will ask the participants the following questions:-
 - a. *What are the symptoms and signs of pregnancy?*
 - b. *What are the risks of diseases and infections in relation to the female anatomy and physiology*

Power point presentation (40 minutes)

The facilitator will wrap up this session using the power point presentation

Handouts

1. Reproductive Physiology Handouts
2. Printout of the power point presentation

Handouts: Reproductive Physiology

Female Reproductive Physiology

Female reproductive physiology is more complex than male reproductive physiology due to the cyclical nature of the reproductive system.

1. Ovaries:

- a. Produce **ova** (eggs)
- b. Produce estrogen and progesterone (in follicular cells) responsible for reproductive development of primary and secondary sex characteristics; sex drive; preparation of uterus for implantation and maintaining it during pregnancy and preparation of mammary glands for milk production by stimulating duct formation.

2. Fallopian tubes

- a. Receive **ova** upon ovulation
- b. Transport ova to uterus
- c. Site of fertilization

3. Uterus: Site of implantation of fertilized ovum and houses developing fetus

4. Vagina: Receives penis during copulation and serves as birth canal

Menstrual Cycle

- Cycle that repeats at approximately one-month interval
- **Menstruation:** Periodic shedding of the inner layer of the uterus (**endometrium**) which is accompanied by bleeding
- Average menstrual cycle length is about 28 days; range 25 - 30 days in the majority of women
- The cycle length can be influenced by stress, body composition, pregnancy, nursing, etc.

Phases of Menstrual Cycle

The phases of the menstrual cycle correspond to the ovarian cycle and the accompanying hormonal changes. They are 3 phases:

1. The **menstrual and recovery phase:** corresponds to the first three days of the ovarian cycle when the hormones are at their lowest levels and the primordial follicles are being stimulated to develop. The endometrium consists of the basal layer of endometrial stroma, the basal parts of the glands and the basal stumps of blood vessels. Following shedding of the epithelium (because of ischemia), the surface epithelium is regenerated from the epithelium lining the basal parts of the glands.

2. The **estrogen or proliferative phase**: increasing levels of estrogen secreted by the granulosa cells of the secondary follicle stimulates proliferation of the endometrium. The proliferative endometrium consists of:
 - a. Columnar epithelium
 - b. Tubular glands
 - c. Cellular endometrial stroma
 - d. Proliferating blood vessels
3. The **progesterone or secretory phase**: Following ovulation, secretion of progesterone by the corpus luteum stimulates the endometrium to become secretory, oedematous and vascular. The secretory endometrium is characterized by:
 - a. Distended and secretory glands that have a serrated outline
 - b. An oedematous stroma containing extracellular fluid
 - c. Large, tortuous blood vessels

The endometrium at this stage has all the necessary characteristics to receive a developing embryo.

If fertilization occurs:

1. The oocyte undergoes division
2. The resulting zygote develops into a conceptus
3. Implantation occurs 5-6 days after fertilization

Following implantation, the conceptus secretes Human Chorionic Gonadotrophin (HCG), which is very similar to LH and has similar effects. This causes the corpus luteum to continue to proliferate and to secrete increasing levels of progesterone so that the secretory endometrium is maintained.

If fertilization does not occur:

The secondary oocyte degenerates, HCG is not produced, the level of progesterone falls causing constriction of the endometrial blood vessels and ischemia of the endometrium, which is therefore not maintained and menstruation occurs.

Ovulation

The ovulation process is important if subsequent fertilization is to take place. This is a delicately timed phenomenon dependent on hormonal interactions involving a variety of endocrine glands.

Conception

In a fertile cycle, coitus around the time of ovulation will result in rapid entry of sperm through cervical mucus to the upper genital tract. Spermatozoa have been demonstrated in the fallopian tubes 5 minutes after ejaculation (although most sperm take considerably longer) and they can survive in the female genital tract for 5 days or more.

Fertilization

Usually occurs within few hours of ovulation, in the outer third of the fallopian tube. After fertilization occurs, the ovum remains in the fallopian tube for about 72 hours. During this time, the fertilized ovum starts to divide in the lumen of the fallopian tube, resulting in a ball of cells called the morula.

Implantation

By day three after fertilization the morula (or developing embryo) reaches the uterine cavity. It takes another 2-3 days to start implanting and approximately another 3 days to implant successfully. On average, it takes 6 days after ovulation for the developing embryo to start implantation. Once the embryo is in the uterine cavity, the cells surrounding it start to produce HCG, which is detectable in maternal blood from the 8th or 9th day after ovulation. Completion of implantation is regarded as the point of conception. Many fertilized ova (about 50%) do not implant and are lost during the next menstrual flow. HCG maintains the corpus luteum, with continuing secretion of both progesterone and estrogen until the placenta takes over this function later in the pregnancy.

Diagnosis of Pregnancy

Most women suspect pregnancy before seeking confirmation. However, it is sometimes necessary to differentiate pregnancy from other causes of uterine enlargement and/or amenorrhea. The signs and symptoms of pregnancy are as follows:

- Cessation of menses (amenorrhea)
- Breast changes
- Vaginal discoloration
- Skin pigmentation
- Morning sickness
- Perception of fetal movements (quickening)
- Urinary frequency
- Fatigue

Male Reproductive Physiology

Testes: Produce sperms and testosterone

Epididymis: Location of sperm maturation for motility and fertility, concentration and storage between ejaculations

Vas Deferens: Stores and transports sperm

Seminal Vesicles: Produce seminal fluid and secrete fructose to provide energy to sperms

Prostate: Contributes alkaline secretions to seminal fluid, which neutralize the acidic vaginal secretions

Penis: Copulation and urination

Scrotum: Houses testes and provides temperature lower than the body for sperm maturation

Endocrine Regulation of Testicular Function:

Hypothalamus	Anterior Pituitary	Testes
GnRH	LH & FSH	Testosterone

Risk of Diseases and Infections

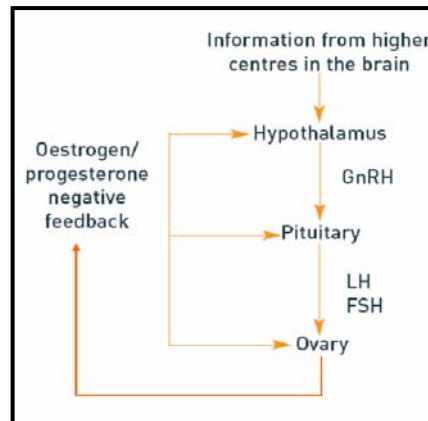
It is important to recognize that women are more vulnerable to diseases of the genital tract than men for some anatomical, physiological and histological causes:

- The lining of the vagina is a mucous membrane which is more permeable than the skin of the penis
- Women have more surface area through which infection can occur
- Lack of lubrication during intercourse and changes in the cervix during the menstrual cycle facilitate transmission of infection to women.
- Pre-pubertal girls and adolescents are particularly vulnerable, because their vaginal and cervical tissues may be less mature and more readily penetrated by organisms (e.g., Chlamydia and gonococci)
- Postmenopausal women are more vulnerable than younger women to get small abrasions in the vagina during sexual activity because of thinning and dryness of the tissues
- Women who have an STI (mostly asymptomatic unlike men) are more likely to get or transmit another STIs, including HIV/AIDS
- Other biological risks include the use of vaginal douches, which increase the risk of pelvic inflammatory disease

Reproductive Physiology



Endocrine Regulation of Ovarian Functions



Female Reproductive Physiology

Ovaries:

- Produce **ova** (eggs)
- Produce sex hormones (estrogen and progesterone) responsible for:
 - a. Reproductive development of primary and secondary sex characteristics
 - b. Sex drive
 - c. Preparing uterus for implantation and maintaining it during pregnancy
 - d. Preparing mammary gland for milk production by stimulating duct formation



Female Reproductive Physiology *(cont.)*

Uterus:

Site of implantation of fertilized ovum and houses developing fetus

Fallopian tubes:

- Receive **secondary oocyte** upon ovulation
- Transport ova to uterus
- Site of fertilization

Vagina:

Receives penis during copulation and serves as birth canal



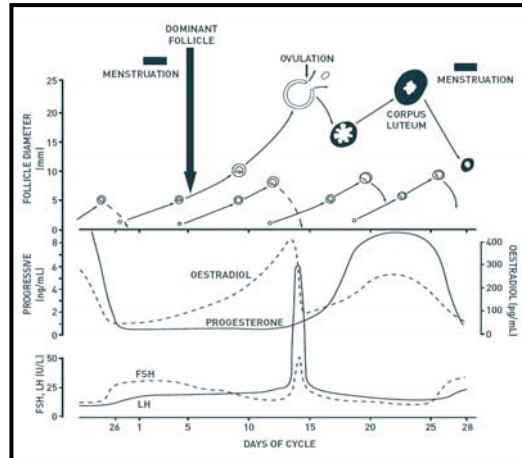
Menstrual Cycle

Menstruation:

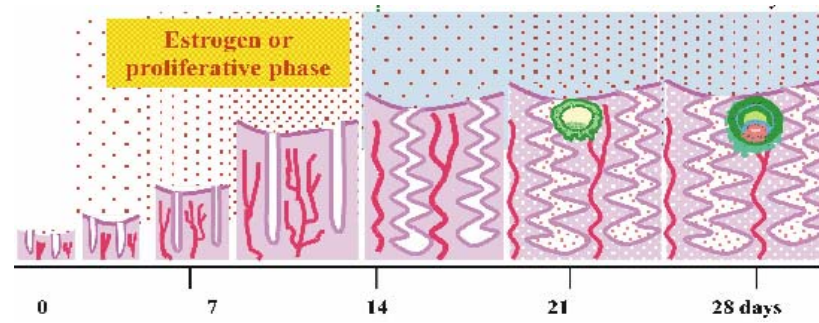
- Periodic shedding of the inner layer of the uterus (**endometrium**) which is accompanied by bleeding
- Average menstrual cycle length - about 28 days (range 25 - 30 days) in the majority of women



Ovarian Cycle

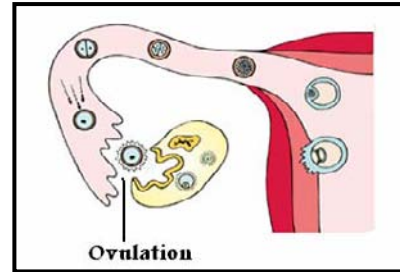


Endometrial Cycle



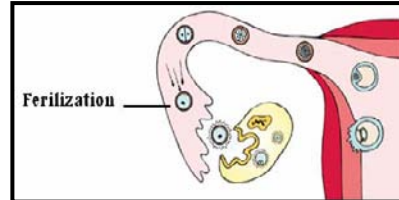
Ovulation

- Is important if subsequent fertilization is to take place
- A delicately timed phenomenon dependent on hormonal interactions and involving a variety of endocrine glands



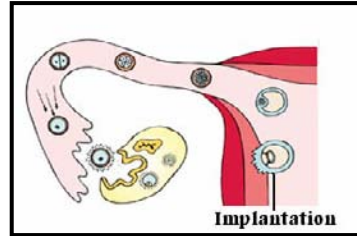
Fertilization

- Following ovulation, the ovum is picked up by the fimbria of the fallopian tube
- The ovum remains viable for about 18 to 24 hour
- Fertilization occurs when the ovum meets a viable sperm



Implantation

- The fertilized ovum enters the uterine cavity
- The trophoblast cells burrow into the endometrium and implantation occurs

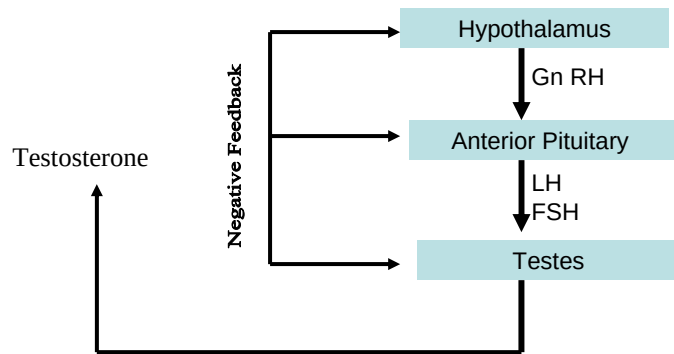


Diagnosis of Pregnancy

The signs and symptoms of pregnancy are :

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- Breast changes
- Vaginal discoloration
- Skin pigmentation
- Morning sickness
- Perception of fetal movements (quickening)
- Urinary frequency
- Fatigue

Endocrine Regulation of Testicular Functions



Male Reproductive Physiology

Penis:

Copulation and urination

Testes:

Produce sperms and testosterone

Epididymis:

Location of sperms maturation, concentration and storage between ejaculations

Vas Deferens:

Stores and transports sperms



Male Reproductive Physiology

Seminal Vesicles:

Produce seminal fluid and secrete fructose to provide energy to sperms

Prostate:

Contributes alkaline secretions to seminal fluid which neutralize acidic vaginal secretions

Scrotum:

Houses testes and provides lower temperature for sperm maturation



Risk of Diseases and Infections

Women are more vulnerable because:

- The lining of the vagina is a mucous membrane and more permeable than the outside of the penis
- More surface area through which infection can occur
- Changes in the cervix during the menstrual cycle
- Use of vaginal douches, which increase the risk of inflammatory disease



Session Five

Family Planning Methods and Counseling

Session 5: Family Planning Methods and Counseling

Allocated time: (300 minutes)

By the end of this session, participants will be able to,

- 1- Define the main components of SRH counseling
- 2- List the different categories of family planning (FP) methods
- 3- Practice utilization of the WHO eligibility criteria for using the different FP methods
- 4- Identify the appropriate FP methods for youth/young people
- 5- Describe the emergency contraceptive methods
- 6- Demonstrate putting on the male condom on penile model

Materials:

- Flipchart and Markers
- Overhead Projector and set of transparencies OR Data Show and Power Point Presentations on a CD **Presentation 5**
- Family Planning A Global Handbook for Providers
- Pelvic model and IUD insertion instrument
- Penile model and male condom

Methodology

Role play 2 (40 minutes)

- The trainer will ask for (3) pairs of volunteers from the participants to play the role of (3) youth clients asking for contraceptive advice and (3) service providers giving the advice regarding the use of three different FP methods (combined oral contraceptive pills (COCs) - male condom – emergency contraception)
- The participants will observe the (3) role-plays, take notes and get involved in an interactive discussion (10 minutes for each)
- The facilitator will moderate the discussion around the (3) role-plays focusing on the following points: (10 minutes)
 - a. Fears and concerns of the youth clients
 - b. Communication skills of the service providers
 - c. The ability of the providers to convey the accurate information
 - d. Satisfaction of the clients

Group work 1 (60 minutes)

- The facilitator will ask the participants to be divided into (5) groups
- Each group will prepare a short presentation on flip chart after reading the handouts of SRH counseling (20 minutes)
- Each group will have (5 minutes) to present and the facilitator will wrap up in (15 minutes)

The (5) topics of the presentations are:

1. What is counseling?
2. How will counseling help the clients?
3. What are the tasks that are addressed in SRH counseling?
4. Who can do counseling?
5. Contraceptive counseling

Discussion (20 minutes)

The facilitator will:

- Ask the participants to list the different FP methods
- Write down the methods on the flipchart
- Then ask the participants to categorize them (hormonal, mechanical etc...)

Group work 2 (80 minutes)

The facilitator will distribute (Family Planning A Global Handbook for Providers) to all participants and ask them to be divided into 5 groups and each group will read one of the following sections (30 minutes)

Group 1. Hormonal contraception

Group 2. Intra Uterine Device

Group 3. Local barriers

Group 4. Natural methods

Group 5. Emergency contraception and surgical methods

The facilitator will then ask each group a set of questions to be answered by the different members of the group in an interactive way and allow the rest of the groups to participate in the discussion and write the answers on the flip chart

Questions for group 1: (10 minutes)

1. What are the hormonal methods?
2. What is the mode of action of each method?
3. How to use each method?
4. what are the advantages?
5. What are the common side effects?

Questions for group 2: (10 minutes)

1. How do IUDs prevent pregnancy?
2. What are the main counseling points for using this method?
3. Explain the insertion procedures on a pelvic model

Questions for Group 3: (10 minutes)

1. Demonstrate using a male condom to a client using the penile model
2. Explain the advantages of male and female condoms
3. Explain the mechanisms of action of a local spermicide and how to use it
4. What is the diaphragm?

Questions for group 4: (10 minutes)

- 1 Explain the withdrawal method using your own drawings
- 2 What is the lactational amenorrhea method and what are the counseling points for using it?
- 3 Explain the safe period (fertility awareness method)

Questions for group 5: (10 minutes)

- 1 Explain the emergency contraception (EC)
- 2 What are the different methods of EC and their effectiveness?
- 3 What are the main counseling points?

Group Work 3 (40 minutes)

The facilitator will explain to the participants how to use the Medical Eligibility Criteria tables for contraceptive use to check if a certain client can or cannot use a certain FP method, and then he will present the following cases and ask them to check the tables to identify the category for each case

- 1- A breast-feeding client for 3 months and she wants to start COCs
- 2- A nulliparous woman who wants to use an IUD
- 3- A woman with ovarian cancer who wants to take a progestin only injectable
- 4- A woman with undiagnosed breast mass who wants to use implanon
- 5- A woman with endometriosis who wants to use IUD
- 6- A young woman with an STI (not HIV) who wants to take a monthly injectable
- 7- A woman with blood pressure 140/90 who wants to use a combined vaginal ring
- 8- A young woman with history of DVT who wants to use COCs
- 9- A young woman who had a first trimester abortion one week ago and wants to use Depoprovera
- 10- A young woman with varicose veins who wants to use COCs

Wrap up/Presentation (60 minutes)

The facilitator will wrap up using power point presentation

Handouts

1. Counseling handouts
2. Printout of the power point presentation

Handouts: Counseling

What Is Counseling?

Counseling is a face-to-face process of communication by which one person helps another individual, couple, family or group to identify his/her or their needs and make appropriate decisions and choices.

Counseling is a structured conversation between two or more people that assists one or more of the participants to work through particular issues that she or he faces with regard to SRH needs and contraception, to explore their feelings and to find ways to deal with them. Counselors encourage people to recognize and develop their own coping capacity, so they can deal more effectively with issues of concern.

Counseling not only helps people with their immediate needs, but also helps them to recognize and draw upon their own resources, which they can use for future problems they may encounter. Counseling is about creating new perspectives and change. The change may be an internal change (helping them to feel differently about a situation); a change in their behavior (e.g. practicing safer sex) or a change in their environment.

Counseling Aims to Help People to:

- Understand their situation more clearly
- Identify a range of options for improving that situation
- Make choices, including contraceptive choices, which fit their values, characteristics, feelings and needs
- Make their own decisions and act upon them
- Cope better with problems
- Develop life skills such as being able to talk about sex with a partner
- Provide support for others while preserving their own strength

Counseling in Sexual and Reproductive Health Settings

In SRH settings, counseling can be used for a variety of tasks, which include:

- To decide whether or not she, he or they need and want to use a method of contraception
- To make an informed, free choice of a contraceptive method
- To learn about the method of choice
- To use the method of choice properly
- To overcome anxieties and make adequate decisions if problems occur
- To help with concerns about STIs and/or HIV infection
- To prepare couples for parenthood
- To make informed decisions about breast-feeding
- To help women decide whether or not to terminate pregnancy
- To discuss any issues around sexuality and sexual relations, infertility, menopause and other sexual and reproductive health issues

Effective counseling is particularly important in helping people with concerns about SRH because many people feel unable to talk with relatives or friends about these concerns. They may even feel unable to talk to their partners about contraceptives, safer sex or a diagnosis of STI. These situations can be complex and clients need time to discuss them through and make an appropriate decision.

Trained counselors are trusted by the community and can reach a wider group of clients with unmet needs, including young people, men and those not at risk of pregnancy. Counselors have many opportunities to counsel clients on SRH issues including FP. By expanding FP counseling to SRH counseling, the client is looked at in a holistic way. This is more helpful to the clients in terms of FP and their sexual life as it makes them feel that the counselor cares about them as people rather than contraceptive users thus the use of the existing facilities is maximized.

Who Can Do the Counseling?

In many clinical settings, there may not be a formal counselor, however, several clinic staff such as nurses, health educators, receptionists, doctors and community workers could be trained to provide counseling. People who are motivated to counsel are more likely to make empathetic and proficient counselors. Managers should motivate and support providers, community workers or volunteers to be involved in counseling process. All staff members and community workers who provide counseling on a regular or occasional basis should be provided with appropriate training on counseling and communication skills.

To Be a Counselor One Needs:

- To have knowledge of:
 - a. Relevant SRH issues
 - b. All available resources for SRH matters in their locality, including HIV prevention, support and/or care for victims of gender-based violence. (Counselors might draw a map of all the resources in their district and use it to refer clients as appropriate)
 - c. Trends and changes in SRH needs
- To be motivated and committed
- To have counseling skills including:
 - a. Active listening
 - b. Non-verbal communication
 - c. Paraphrasing
 - d. Asking questions
 - e. Reflecting feelings
 - f. Providing information
- To have the right attitudes, including:
 - a. Being non-judgmental
 - b. Not imposing one's own values on clients
 - c. Being warm and approachable
 - d. Being empathetic

- e. Having respect for clients
 - Being committed to the client's well-being
 - Being willing to learn continuously and from one's own mistakes
 - Knowing oneself
 - Having knowledge of life and of people with different cultures and ways of life

Environment

- It is important to make clients feel at ease, safe and confident
- Create a safe environment for counseling including the physical environment
- Ensure that counseling is done in private and is confidential so that every client feels comfortable to discuss risk factors, including sexual behavior
- Provide a space where accompanying children can play with supervision while the mother is counseled
- Make sure that the room is arranged in such a way that it facilitates communication between the client and the counselor
- Use visual aids to facilitate discussions, such as flip charts, anatomical and contraceptive posters or pelvic models
- The counselor's approach and attitude is crucial; the counselor can make the clients feel safe and confident by treating them in a warm and respectful way and communicating with them in a language and terminology they understand
- The appearance and approach of the counselor should be such that clients do not feel overpowered and feel secure enough to open up
- Whenever possible and practical, counsel the client and the partner and/or the family when appropriate

Counseling Session

- As soon as you meet client, give him/her your full attention
- Greet him/her politely and introduce yourself (name and title)
- Explain that any information they share with you is confidential
- Ask the client what the reason is for his/her visit and how you may help them
- Listen attentively and demonstrate this through positive body language and non-verbal communication
- Give the client enough time to express her or his ideas and to make their own decision; value silence while the client thinks deeply or copes with her or his emotions
- Be aware of possible or known cultural differences between you and your client and ask for a fuller explanation if you do not understand or need to know more
- Good interpersonal communication requires appropriate eye contact; however, this may not always be culturally acceptable
- Do not write and listen at the same time; give your full attention to listening and then make notes with the client's permission if you need to
- Encourage the client to speak or continue speaking by words such as "I see", "go on" etc; these small signs are vital to show that you are interested and pleased that the client is expressing her/himself
- Assist the clients to talk about their needs and encourage them to ask any question

- to help them with their SRH needs
- Explain to them that you are asking questions to help them with their needs
- Help the clients to focus on issues where they can actively do some positive change, rather than being overwhelmed by the whole issue or problem
- Help the clients to identify others that they can rely on and receive help from
- Try to answer your client's questions honestly, accurately and fully, however difficult they are; giving false reassurance does not help the client to end worrying
- Involve new clients in the process of completing any required forms accurately and completely; for returning clients, involve them in updating their records
- If counseling is taking place in a clinic, as opposed to the client's home or other place in the community, explain the steps of the clinic visit, including who they will see, what examinations and tests will be performed and the reasons they are necessary, how long the visit will take and whether any payment is necessary
- Refer the client to a range of services as needed
- Provide ongoing support but avoid dependency and help clients to develop their own coping skills

The Link Between Education/Information and Counseling

Counseling is part of the information and education process. Giving information and education before the counseling can save some time in individual counseling but the counselor still needs to check that the client understands the basic facts in relation to her or his own life. Time in waiting areas should be used to educate clients on RH/FP, STIs/HIV/AIDS prevention and other SRH issues. Clients should learn about FP, safer sex, STIs, HIV/AIDS and other SRH issues through other education activities, including posters and pamphlets (in appropriate languages) placed in waiting areas; films or videos; and by taking part in group discussions.

During *individual counseling*, learning is enhanced by clients receiving information tailored to their specific needs.

In *group information-giving*, the provider (or a video or printed pamphlet) gives the basic facts about an issue (e.g., FP, safer sex, STIs, HIV/AIDS transmission routes, potential advantages and disadvantages of having an HIV test and the process of counseling and testing). The provider or video needs to give the information in a clear and interesting way that relates to people's lives. Questions and discussions should be encouraged and the group should be warned that confidentiality cannot be guaranteed and it is safest to talk about issues in a general way rather than disclose personal information. This can happen later in the individual counseling session. The ideal size for the group depends on the venue and the time available; between ten and twenty people gives opportunities for discussion.

In certain settings with cultural norms around SRH matters, *group counseling* may be preferred. In-group counseling, the counselor guides a process of rapport building, exploration of the issues around prevention, options for risk reduction and other SRH information. The group is smaller (may be up to ten people) and made up of people who will feel comfortable to talk together (e.g., single-sex groups of a similar age and status, couples or families).

They may share their feelings and experiences but with the understanding that confidentiality is not guaranteed. The group can share successful strategies for safer sex, support, encourage each other, and leave the session with more understanding of their options, their own feelings and values.

Contraceptive Counseling

1. Choice of method

Clients should make their own decision on which contraceptive method is appropriate for them. The counselor should help each client to match her or his FP needs and preferences to a safe and appropriate method. If the client is visiting the clinic to start using a method of contraception, ask the client if s/he has a particular method of contraception in mind.

If the client is considering a particular method:

- Try to determine by discussion and review of the client's medical and social history if the method is appropriate for the characteristics, needs and circumstances of the client
- If the method is appropriate, determine if the client knows about other contraceptive options and make sure that s/he is firm about her/his choice
- If the method is not appropriate (e.g., if she is breast-feeding, is less than 6 months postpartum and wants to use COCs; or if a barrier is unlikely to be used properly when an unwanted pregnancy would be a high risk), explain the disadvantages of using such a method and inform the client about other more appropriate contraceptive options
- If, after discussing all the contraceptive options, the client chooses the originally preferred method, this method can be provided if the benefits outweigh the risks and there are no absolute contraindications
- If the client has a relative contraindication and the method is provided, advise her of the warning signs relevant to her condition; the participation of a senior staff in the screening and counseling process may be required

If the client is not considering a particular method:

- Ask the client which methods of family planning s/he knows about this gives an opportunity to determine the client's level of knowledge as well as an opportunity to correct any misinformation
- Briefly describe each method to the client. Provide additional information on the method in which the client is interested. Show the methods to the client and let her/him examine them. Make sure information on all the following is included:
 - a. How the method works
 - b. Effectiveness of the method
 - c. Medical contraindications
 - d. Possible side effects
 - e. Advantages
 - f. Disadvantages
- Encourage questions

- Discuss advantages and disadvantages of the various methods in relation to the characteristics and needs of the client (e.g., current family situation, ability to remember to take a pill every day, partners' cooperation, frequency of sexual intercourse, number of partners)
- Advise the client that except for barrier methods no other method provides protection against STIs and that the condom is the only method demonstrated to protect against HIV
- Determine if the client is ready to make her/his decision by specifically asking "What method have you decided to use?"
- After listening to all the contraceptive options available, the client may still be unable to decide and may ask you to recommend a method
- Through continuous education and counseling, the choices will become clearer and the client will eventually be able to make her/his decision
- In the meantime, suggest a method, which is best suited to the client's particular characteristics and needs. If this is done, explain the reason for recommending that method and make sure that the client has understood those reasons and agrees with the recommendation. If the client does not agree, recommend another method until the client is satisfied. If there is still some hesitation, give the client more time to consider before making her/his choice

Never try to impose a method against the will of the client

Special situations

- Some clients cannot use the method they choose for health reasons. When this occurs, explain to the clients what the contraindications are and help them choose another method
- If the client chooses a method, which you do not have in stock or do not offer, make a referral to a location where the method of choice may be obtained
- Help the client choose a method that can be used until her/his preferred method is available
- If the client chooses female or male sterilization, she or he will have to receive special counseling, since this is a permanent method and the client must sign a specific informed consent form

2. Explanation of how to use the method of choice

- The specific information that a client should receive about each method is stated in the chapters on each method in the distributed (Family Planning A Global Handbook for Providers). The following general areas must be covered when discussing the chosen contraceptive method:
 - a. How to use the method
 - b. Possible side effects
 - c. Management of side effects
 - d. Warning signs that indicate need for medical follow-up, and where to obtain this follow-up.
 - e. Re-supply information, if applicable
 - f. When the next follow-up visit should take place

- Ask clients what they have understood about each of the above points by asking them to repeat the instructions in their own words and if necessary, repeat the instructions, emphasizing the points, which the client has not understood well, correcting any misunderstanding and providing any missing information
- Provide each client with printed information on the chosen method in a language appropriate to his or her reading level and when serving illiterate clients, provide carefully designed pictorial materials as a support for the one-to-one counseling which are especially important for methods such as the pill and barriers that are dependent on correct use to be effective
- Explain when the client should return for routine follow-up and resupply and also, a return visit if the client:
 - a. Is experiencing any side effect
 - b. Has any question
 - c. Wishes to switch to a different method
 - d. Wants to stop using the method

3. Return for follow-up

Enabling a client to understand complete information about FP is not something that is usually accomplished in one visit; assisting clients to plan their families throughout their reproductive life is an ongoing process. Follow-up visits are an important opportunity to:

- Reinforce the decision clients have made to plan their family
- Discuss any problem they are having with their method of choice
- Answer any question they may have
- Explore changes in their current health status or life situation, which indicate a need to switch to another contraceptive method or stop using any method
- During a follow-up visit:
 - a. Briefly review the chart for the main details of the reproductive health history
 - b. Ask the client how s/he feels with the method and if there are questions
- If s/he is having any problem with the method, assess the nature of the problem and discuss possible solutions
- If the problem is a side effect, assess how severe it is and offer suggestions for managing it or refer the client for treatment
- If the client is not using the method any more, ask why not (it may be due to problems related to misunderstanding, side effects or supply)
- If the client still wishes to continue using a contraceptive, answer her/his questions and provide information that will enable her/him to continue with the contraceptive of choice
- If the client is still using the method, determine if it is being used correctly and instruct the client on the correct use of the method if necessary
- Ensure that the client receives re-supplies and an appropriate examination if necessary
- Assist the client in selecting another contraceptive method if the client is not satisfied with a method, if her/his situation has changed, or if the method is no longer safe
- If a client wishes to become pregnant, help her to stop her method and provide

information on the return of fertility with emphasizing the importance of antenatal care and where to obtain it

4. Problems using the method

- If a client seeks help because of problems with the method, it is important that service providers take care of the psychological needs of the client as well as the medical condition; comfort the client and give emotional support
- If the client is unhappy about the method being used, ask about the reasons and give reassurance about the method or advice about other contraceptive options
- If a client is having complications, which indicate that the method should be discontinued, give advice on other contraceptive options

5. Method failure

- If pregnancy has occurred, it is necessary to discuss it with the client (ideally with the couple) and to give her all the support and advice she may need
- Try to determine if the pregnancy is the result of method failure and identify, if possible, factors that may have contributed to it
- Providers should be sensitive and understanding of changing feelings and provide support as required
- The client should be supported and encouraged to return for further counseling if desired
 - a. *If the woman plans to continue the pregnancy:* Advise her on the importance of early antenatal care and nutritional counseling and where and how to obtain it; a referral should be provided if necessary
 - b. *If the woman does not wish to continue the pregnancy:* Counseling should be provided in accordance with local laws and regulations with explaining to the client the dangers of unsafe abortion

6. Integrating STIs and HIV/AIDS counseling

Counselors who are mainly involved in family planning may feel that STIs and HIV/AIDS counseling is an additional task that involves all kinds of problems that are difficult to resolve. They will need to understand the benefits of integrating STI/HIV counseling, be given a chance to express their concerns and to identify the support that they will need.

STIs, including HIV/AIDS are major problems, and clients should understand the risks and decide how to protect themselves. For each contraceptive method, providers should explain whether it protects or not against STIs/HIV and promote dual protection when appropriate.

7. Counseling for groups with special needs

Programs serving clients with special needs should ensure that providers of counseling are well trained in the needs of these groups and what specific approaches may be useful. Examples of such client groups include adolescents, as well as illiterate or low-literate populations.

Contraception



Contraception for Young People

- Young people can safely use many contraceptive methods
- Young women are often less tolerant of side effects than older women
- With counseling, young people will know what to expect and may be less likely to stop using the methods
- STIs risks and how to reduce it is an important part of counseling



Young Adults and Contraceptive Use

- Few married youth use contraceptives before first birth
- Common reasons for non-use of contraceptives among youth:
 - a. Lacked information about contraception
 - b. Lacked access to contraceptives
 - c. Youth may not use FP methods consistently and correctly



Barriers to Access Contraceptive Use

- **Lack of access to services or methods:**
 - a. Clinics not designed to be inviting to youth
 - b. Providers reluctant to serve youth
- **Youth may:**
 - a. Lack transportation to clinic or money for contraceptives or services
 - b. Be concerned about having pelvic exam



Psychological and Social Consequences of Unplanned Pregnancy for Youth

- Limited education
- Fewer career or job opportunities
- Heavy economic burden
- Depression, loss of self-confidence and lack of hope
- Consequences more severe for young women than men
- Children of young parents may face psychological, social and economic obstacles



Medical Risks of Pregnancy in Young Women

Under age 16:

Small pelvis



May result in:

Obstructed or
prolonged labor

First birth

Hypertensive



Disorders of

Pregnancy

Hemorrhage, eclampsia

Can be fatal for both mother and child



Contraceptive Options

- Hormonal Methods
- Mechanical Methods
- Barriers Methods
- Natural Methods
- Surgical Methods
- Emergency Contraception
- Postpartum/Postabortion Contraception



Hormonal Methods



Combined Oral Contraceptives (COCs)

- Are pills that contain low doses of 2 hormones (progestin and estrogen) like the natural hormones in woman's body
- Work by preventing ovulation



Advantages of Combined Oral Contraceptives

- Very safe and effective when used consistently and correctly
- Rapid return of fertility
- Use independent of sexual intercourse
- Can be stopped at any time without providers' help
- Don't interfere with sex
- Controlled by the woman



Advantages of Combined Oral Contraceptives *(cont.)*

- Non-contraceptive health benefits:
 - a. Improve dysmenorrhea
 - b. Decrease menstrual bleeding
 - c. Reduce symptoms of endometriosis and polycystic ovarian syndrome
 - d. Protect against endometrial and ovarian cancers

Combined Oral Contraceptives: Counseling

- Pills must be taken daily for 21 days followed by 7 days break
- Possible side effects include nausea or breakthrough bleeding
- Link pill-taking to a daily routine
- Missing pills risks pregnancy and makes side effects worse
- Encourage use of condoms for backup if pills not taken correctly or if at risk for STIs



Progestin - Only Pills (POPs)

- Contain very low dose of progestin, like the natural hormone progesterone in a woman's body (called minipills)
- Do not contain estrogen – can be used through breastfeeding and by women who cannot take estrogen
- To be taken as one pill every day without break



Advantages of Progestin - Only Pills

- Can be used while breastfeeding
- Can be stopped at any time without providers' help
- Don't interfere with sex
- Are controlled by the woman
- No estrogen related side effects
- Reduce the risk of ectopic pregnancy



Progestin - Only Pills: Counseling

- My cause changes in the bleeding patterns
- Must be taken every day
- Do not make women infertile
- Safe and suitable for nearly all women



Progestin Only Injectables

- Depoprovera -depot medroxyprogesterone acetate (DMPA)
- Norstarte -norethisterone enanthate (NET-EN)



Advantages of Progestin Only Injectables

- Very effective against pregnancy
- Protect against endometrial cancer
- No daily action required or supplies needed at home
- Use independent of sexual intercourse

However, clinic visit is required



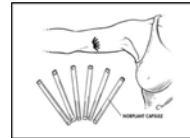
Progestin Only Injectables: Counseling

- Bleeding irregularities likely to occur
- Return for injections regularly (every 3 months for DMPA or every 2 months for NET-EN)
- Injection can be as much as 2 weeks early or late
- Return of fertility is often delayed
- Use condoms if at risk for STIs



Implants

- Are small flexible rods or capsules that release a progestin like the natural hormone progesterone
- Placed under the skin of the upper arm
- Require trained provider to insert and remove
- Appropriate for those wanting long-term method
- Safe during breast feeding
- Return of fertility immediate upon removal of implants
- Bleeding changes are common



Combined Injectables

- Contain 2 hormones (progestin and estrogen) like the natural hormones in the woman's body
- Highly effective method (3 pregnancies/100 women over the first year)
- Fertility returns after injections are stopped
- Work primarily by preventing ovulation
- Risk of pregnancy is greatest when a woman is late for an injection or misses an injection



Advantages of Combined Injectables

- Do not require daily action
- Can be stopped at any time
- Good for spacing
- Are private

Combined Injectables: Counseling

- Return on time (every 4 weeks)
- Injection can be as much as 7 days earlier or late
- Bleeding changes are common but not harmful



Combined Patch

- Small, thin square of flexible plastic patch put on the body
- Continuously releases 2 hormones (progestin and estrogen)
- A new patch is put every week for three weeks then no patch for the fourth week
- Work by preventing ovulation



Combined Patch: Counseling

- Replace each patch on time for greatest effectiveness
- Bleeding changes are common but not harmful



Combined Vaginal Ring

- A flexible ring placed in the vagina
- Continuously releases 2 hormones (progestin and estrogen)
- Kept in place for three weeks then removed for the fourth week
- During the fourth week the woman will have monthly bleeding
- Prevent ovulation



Combined Vaginal Ring: Counseling

- Kept in place all the time day and night for three weeks
- Start each new ring on time for greatest effectiveness
- Bleeding changes are common but not harmful



Mechanical Methods

Copper Intrauterine Device (Cu IUD)

- Very effective at pregnancy prevention
- Use independent of intercourse
- Quick return of fertility
- Requires clinic visit for insertion and removal
- No STIs protection



Advantages of Copper Intrauterine Device

- Long term pregnancy protection up to 12 years
- Safe and suitable for nearly all women
- Has no future costs after the IUD is inserted
- Dose not require the user to do any thing once the IUD is inserted



Copper Intrauterine Device: Eligibility

- Not usually recommended for young who have no children
- Not recommended for those with recent or current STIs
- Under age 20 and nulliparous women may have increased risk of expulsion

Copper Intrauterine Device: Counseling

- IUDs are not appropriate for those with high-risk behavior
- Important to check for signs of expulsion
- Long term pregnancy protection
- Very effective
- Bleeding changes are common
- Inserted by a trained provider



Barrier Methods



Barrier Methods

- Includes male and female condoms, spermicides, diaphragms and cervical caps
- Are most effective when used consistently and correctly
- Pregnancy rates in typical use range from 12 % for condoms to 21 % for spermicides
- Safe with no systemic effects



Advantages of Barrier Methods

- Male condom is the most effective method for STIs/HIV prevention
- Female condom is an alternative to male condom
- Most methods are accessible and available
- Good for infrequent sexual activity
- User-controlled
- Easily initiated and discontinued



Barrier Methods: Counseling

Successful use requires:

- Partner participation and negotiation skills
- High level of motivation, self-confidence and self-control

Key messages:

- Always keep barrier methods available to be used when needed
- Communication and shared responsibility are vital
- Consistent and correct use are key to effectiveness



Male Condom Use

- Check expiry date
- Check presence of air before opening
- Open package carefully
- Squeeze air at the tip of the condom
- Do not unroll before putting it on erected penis
- Hold rim of condom during withdrawal
- Dispose the used condom in a bin, not the toilet



Female Condom

- A thin, soft and transparent plastic sheath
- The woman places the closed end of the sheath high in her vagina before sex
- The large flexible ring around the open end of the sheath stays outside the vulva
- During sex, the man's penis goes inside the female condom
- As effective as the male condom
- Protects from STIs



Natural Methods

Lactational Amenorrhea Method (LAM)

- Temporary and effective method for breastfeeding women
- For LAM to be effective :
 - a. Breastfeeding must be exclusive, on demand and throughout day and night
 - b. The woman must be amenorrheic
 - c. Within the first six months postpartum
- LAM provides no protection against STIs



Fertility Awareness Methods

A woman knows how to tell when the fertile time of her menstrual cycle starts and ends. During the fertile time, couple avoids vaginal sex or use another method as condoms (called periodic abstinence).

Methods include:

- **Calendar based method (rhythm methods)** involves keeping track of days of menstrual cycle to identify the start and the end of the fertile time
- **Symptoms based method** depends on observing signs of fertility (cervical secretion – basal body temperature)



Fertility Awareness Methods: Counseling

- Requires partners' cooperation
- Woman must be aware of body changes
- No side effects or health risks
- Do not require procedures or supplies
- Can be used to identify fertile days for women who want to become pregnant
- Allow some couples to adhere to their religious or cultural norms about contraception



Periodic Abstinence and Withdrawal

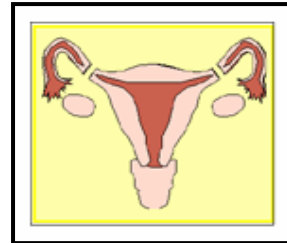
- Always available
- Can promote reproductive health awareness
- Training about fertility awareness is essential
- High pregnancy rates in typical use
- No STIs protection
- Require considerable motivation
- Periodic abstinence is difficult for young women with irregular menstrual cycles



Surgical Methods

Female Sterilization

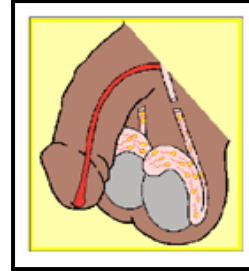
- No need to worry about contraception again
- Permanent
- No long term-side effects
- Involves physical examination and surgery
- Not an appropriate method for young adults



Female Sterilization

Vasectomy

- Permanent
- Involves safe and simple surgical procedure
- Couple must use condom or another contraceptive for three months after the vasectomy (three months delay in taking effect)
- Does not affect male sexual performance
- Not an appropriate method for young adults



Vasectomy

Emergency Contraception



Emergency Contraception (EC)

EC refers to the type of contraception that is used as an emergency procedure to prevent unintended pregnancy following unprotected act of sexual intercourse. EC is sometimes referred to as the (Morning After Pill or the Post Coital Contraception).

Indications of Emergency Contraception

- When no contraception is used
- Contraceptive failure
- Sexual assault/rape

Emergency Contraception: Counseling

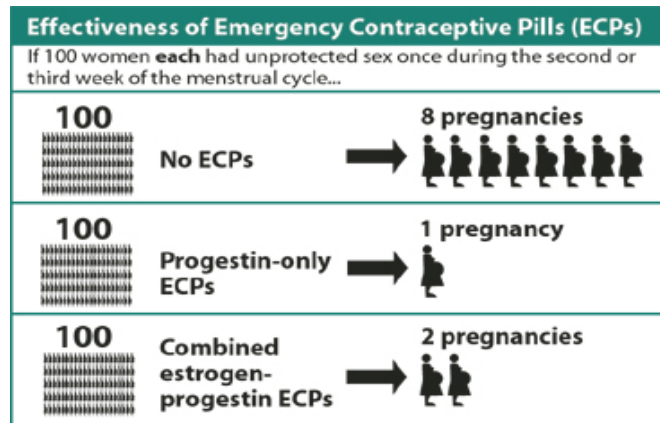
- EC pills help to prevent pregnancy when taken up to **FIVE** days after unprotected sex
- The sooner they are taken the better
- Don't disrupt an existing pregnancy
- Safe for all women
- Provide an opportunity to start using an ongoing FP method



Emergency Contraception Options

- Pills:
 - a. Dedicated products (pills containing levonorgestrel such as Postinor, Optinor, Norlevo)
 - b. POPs
 - c. COCs
- Copper IUDs:
 - can be inserted within 5 days of unprotected intercourse

Effectiveness of Emergency Contraception



Side Effects of Emergency Contraception

Changes in bleeding pattern including:

- Slight irregular bleeding for 1–2 days after taking ECPs
- Monthly bleeding that starts earlier or later than expected



Side Effects of Emergency Contraception *(cont.)*

In the week after taking ECPs:

- Nausea
- Abdominal pain
- Fatigue
- Headache
- Breast tenderness
- Dizziness
- Vomiting



Health Benefits and Risks of Emergency Contraception

Health Benefits:

Help protect against risks of pregnancy

Health Risks:

None



Postpartum/Postabortion Contraception



Postpartum Contraception Breastfeeding Women

Timing of Method Initiation for Breastfeeding Women

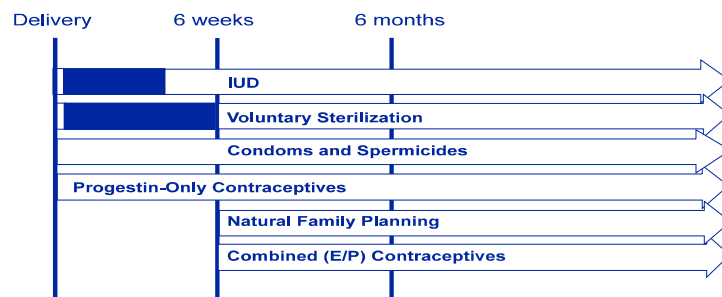


 Adapted from: FHI 1994.



Postpartum Contraception Non-Breastfeeding Women

Timing of Method Initiation for Nonbreastfeeding Women



 Adapted from: FHI 1994.



Post-abortion Contraception

All methods can be used after uncomplicated first trimester abortion

- COCs
- POPs
- Progestin only injectables
- Combined injectables
- Implants
- Spermicides
- Condoms
- IUDs



WHO Medical Eligibility Criteria for Starting Contraceptive Methods

Known medical conditions that might affect eligibility for the use of a contraceptive method are classified into four categories:

WHO 1	Can use the method. No restriction on use.
WHO 2	Can use the method. Advantages generally outweigh theoretical or proven risks. Category 2 conditions could be considered in choosing a method. If the client chooses the method, more than usual follow-up may be needed.
WHO 3	Should not use the method unless a doctor or nurse makes a clinical judgment that the client can safely use it. Theoretical or proven risks usually outweigh the advantages of the method. Method of last choice, for which regular monitoring will be needed.
WHO 4	Should not use the method. Condition represents an unacceptable health risk if method is used.



Simplified 2-Category System

WHO Category	With Clinical Judgment	With Limited Clinical Judgment
1	Use the method in any circumstances	Use the method
2	Generally use the method	Use the method
3	Use of the method not usually recommended unless other, more appropriate methods are not available or acceptable	Do not use the method
4	Method not to be used	Do not use the method

Session Six

Providing Sexual and Reproductive
Health information to Youth

Session 6: Providing Sexual and Reproductive Health Information to Youth

Allocated Time: 300 minutes

By the end of this session, the participants will be able to

- 1- Provide SRH information to youth
- 2- Respond to the frequently asked questions by youth regarding their SRH

Materials:

- Flipchart and Markers
- Overhead Projector and set of transparencies OR Data Show and Power Point Presentations on a CD **Presentation 6**
- Computers, printers, and internet access

Methodology

Exercise (20 minutes)

- The facilitator will distribute pieces of paper to the participants and asks each participant to write two of the frequently asked SRH questions by youth then to read what he/she wrote
- The facilitator will list down the questions on the flip chart and keeps it displayed in front of the participants during the whole day

Group work 4 (50 minutes)

- The participants will be classified into (3) groups
- Each group will answer one of the following questions and write the answer on a flip chart (20 minutes)
 - a. *Question1: Why youth need SRH information?*
 - b. *Question 2: Who can provide SRH information to youth?*
 - c. *Question 3: How to prepare service providers to be able to provide SRH information to Youth*
- The reporter of the group will present the answer (10 minutes each)

Power point presentation (10 minutes)

The facilitator will wrap up by a short power point presentation (10 minutes) about how to communicate with youth and respond to their needs for SRH information /counseling with messages to service providers when talking with youth about their SRH.

Group discussion (20 minutes)

- The facilitator will lead a discussion about sexual development of boys and girls from the age of 10 to 24 as one of the most important sections of the SRH information that concerns young people
- The facilitator will distribute the handout of this subject and discuss it with the participants

Group work and role-plays (90 minutes)

- The participants will be divided into (5) groups, each group will select one of the frequently asked SRH questions by youth from the displayed list and search for the appropriate SRH information in the distributed book or through the internet by accessing the different related sites such as: FHI - UNFPA - IPPF - Engender health - Pathfinder International (30 minutes).
- Each group will report back through a role-play between a youth client and a service provider (10 minutes each).
- The facilitator will moderate the discussion, encourage feed back from the group and wrap up in 10 minutes

Power point presentation (50 minutes)

The facilitator will address important SRH issues that concerns young people through a short presentation including:-

- Female genital mutilation (FGM)
- Virginitiy
- Sexual response cycle in human beings
- Abstinence
- Youth and STIs/HIV
- Pre and postnatal care
- Premarital package
- Youth and unsafe abortion

Handouts

1. Handouts: Sexual Development, Abstinence, Youth and STIs/HIV, Youth and unsafe abortion, FGM, Sexual Response Cycle
2. Print out of the power point presentation

Closing Session (60 minutes)

- Feedback and final evaluation of the workshop
- Post-test
- Closing remarks
- Certificates distribution and group photo

Handouts: Sexual Development, Abstinence, Youth and STIs/HIV, Youth and unsafe abortion, FGM, Sexual Response Cycle

Sexual Development

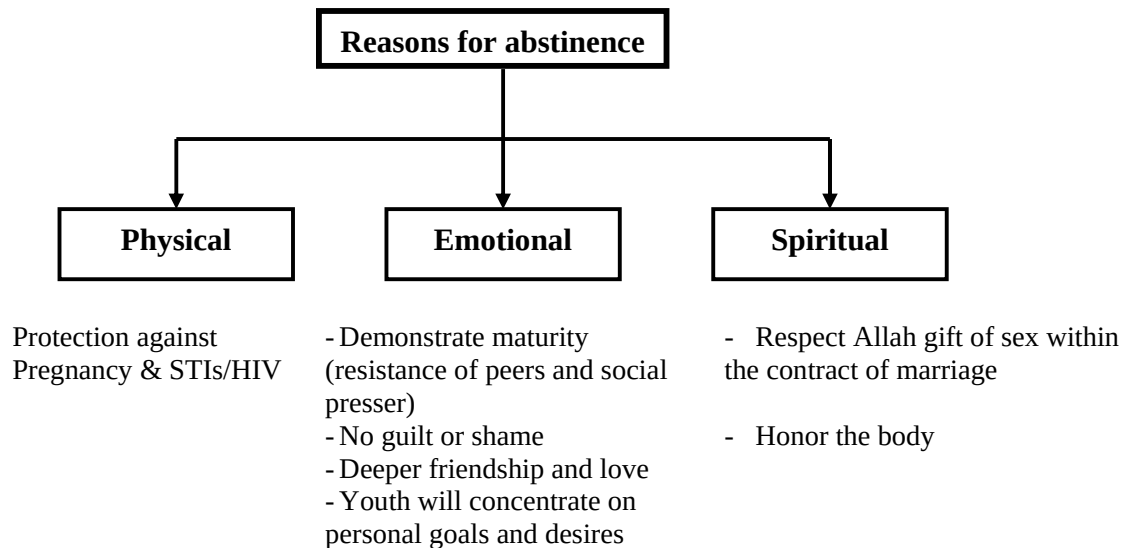
- **Physical changes for boys ages 10 to 14**
 - 1 Growth spurts occur
 - 2 Muscles enlarge
 - 3 Voice deepens
 - 4 Acne develops
 - 5 Sperms mature, wet dreams begin
- **Emotional changes for boys ages 10 to 14**
 1. Values and beliefs primarily determined by family
 2. Experience mood swings, behavior driven by feelings
 3. Confused about emotional and physical changes
 4. Begin to have sexual feelings and curiosities
 5. Begin to seek acceptance by peers through competition and achievement
- **Physical changes for boys ages 15 to 19**
 1. Development continues
 2. Genitals enlarge
 3. Hair grows around genitals, under arms and on chest
- **Emotional changes for boys ages 15 to 19**
 1. Challenge rules and test limits
 2. Feelings contribute to behavior but do not control it, can analyze potential consequences
 3. Compare own development to peers, become concerned with self-image
 4. May have a girlfriend and want to experiment or act on sexual desire
 5. Peers influence leisure activities, appearance, substance use, and initial sexual behaviors
- **Physical changes for boys ages 20 to 24**

Development finishes
- **Emotional changes for boys ages 20 to 24**
 1. Develop more serious relationships, may commit and marry
 2. Understand consequences of behaviors
 3. Struggle with adult roles and responsibilities, modern versus traditional values
 4. Can make own decisions, peers have less influence
 5. Cope with the competing demands of school, family, spouse, community, livelihood, and self

- **Physical changes for girls ages 10 to 14**
 1. Grow taller, bigger (often before boys)
 2. Breasts begin to enlarge
 3. Hips widen
 4. Acne develops
 5. Hair grows around genitals and under arms
 6. Ovaries mature, menstruation begins, able to become pregnant
- **Emotional changes for girls ages 10 to 14**
 1. Values and beliefs primarily determined by family
 2. Experience mood swings, behavior driven by feelings
 3. Confused about emotional changes, preoccupied with physical appearance
 4. Self-esteem determined by others
 5. Seek acceptance by fostering relationships with peers
- **Physical changes for girls ages 15 to 19**
 1. Development continues
 2. Breasts enlarge, hips widen, hair grows around genitals and under arms
- **Emotional changes for girls ages 15 to 19**
 1. Compare their development to peers, determine self-image
 2. May challenge rules and test limits of gender norms, desire more control over life
 3. Increased interest in sex, aware of own sexuality
 4. Desire to be loved may influence decision-making in sexual relationships
 5. Peers influence leisure activities, appearance, substance use, and initial sexual behaviors
- **Physical changes for girls ages 20 to 24**
Development finishes
- **Emotional changes for girls ages 20 to 24**
 1. Develop more stable relationships and marry
 2. Understand consequences of behaviors and prepare for parenthood
 3. Clearer about self in relation to others, including spouse
 4. Cope with the competing demands of school, family, spouse, community, livelihood, and self
 5. Able to recognize and seek help when needed

Abstinence

Young people have to understand healthy relationships to be better prepared to resist infatuation and to make an informed decision when choosing a partner for marriage



Youth and STIs/HIV

- Young people are at risk of STIs/HIV because of the risky behavior
- Young people who show symptoms of STIs, or have had unprotected sex should visit a clinic for testing and treatment
- STIs can put young people at greater risk for:
 - a. HIV transmission
 - b. Infertility or sterility
- HIV transmission through blood, semen, vaginal fluids, and breast milk
- Sexual transmission of HIV can be prevented by:
 - a. Abstinence
 - b. Being faithful
 - c. Condom use

Youth and Unsafe Abortion

- Young married women who are not using FP methods are at risk of unplanned pregnancy.
- This often leads them to seek unsafe clandestine abortion
- Consequences of unsafe abortion including injuries, hemorrhage, and infections may lead to permanent morbidity like infertility or loss of life (mortality)

Prevention:

Providing SRH information and services to youth

Female Genital Mutilation (FGM)

1. What is female genital mutilation?

Female genital mutilation (FGM), often referred to as 'female circumcision', comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons. There are different types of female genital mutilation known to be practiced today. They include:

- **Type I:**

Excision of the prepuce, with or without excision of part or the entire clitoris

- **Type II:**

Excision of the clitoris with partial or total excision of the labia minora

- **Type III:**

Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).

The most common type of female genital mutilation is excision of the clitoris and the labia minora, accounting for up to 80% of all cases; the most extreme form is infibulation, which constitutes about 15% of all procedures.

2. Health consequences of FGM

The immediate and long-term health consequences of female genital mutilation vary according to the type and severity of the procedure performed.

- **Immediate complications** include severe pain, shock, hemorrhage, urine retention, ulceration of the genital region and injury to adjacent tissue. Hemorrhage and infection can cause death.

Recently, concern has arisen about possible transmission of the human immunodeficiency virus (HIV) due to the use of one instrument in multiple operations, but this has not been the subject of detailed research.

- **Long-term consequences** include cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, dyspareunia (painful sexual intercourse), sexual dysfunction and difficult childbirth.
- **Psychosexual and psychological health:** Genital mutilation may leave a lasting mark on the life and mind of the woman subjected to it in the form of feelings of incompleteness, anxiety and depression.

3. Who performs FGM, at what age and for what reasons?

- FGM is usually performed by a traditional practitioner using crude instruments and without anesthetic. WHO opposed medicalization of all the types of female genital mutilation.
- The age at which FGM is performed varies from area to area ranging from infants few days old to female children and adolescents and occasionally mature women.

4. The reasons given by families for having FGM performed include:

- Psychosexual reasons: reduction or elimination of the sensitive tissue of the outer genitalia particularly the clitoris in order to attenuate sexual desire of the female, maintaining chastity and virginity before marriage and fidelity during marriage and increasing male sexual pleasure
- Sociological reasons: identification with the cultural heritage, development of girls into womanhood, social integration and the maintenance of social cohesion
- Hygienic and aesthetic reasons: the external female genitals are considered dirty and unsightly and are to be removed to promote hygiene and provide aesthetic appeal
- Myths: enhancement of fertility and promotion of child survival
- Religious reasons: Some Muslim communities believe FGM is demanded by the Islamic faith. The practice, however, predates Islam.

5. Current WHO activities related to FGM

- Advocacy and policy development
- Research and development
 - a. Generate knowledge
 - b. Test interventions to promote the elimination of FGM
- Development of training materials for integrating the prevention of FGM and training of health care providers

Sexual Response Cycle in the Male

1. Excitation Phase:

▪ Genital changes :

a. External genital organs:

- The excitation phase occurs within 10-30 seconds of the initiation of sexual stimulation which may be psychological through imagination or emotions or physical through tactile stimulation during the foreplay
- The most important change during this phase is the onset of penile erection
- Penile erection (from the Latin Word *Lumescere* that means swelling) is an increase in the length and the circumference (girth) of the penis as a result of increased blood volume inside it
- Rigidity of the penis during erection results from an increased blood pressure of the cavernous spaces

b. Internal genital organs:

The testes start to show enlargement due to congestion and elevation due to contraction of the cremasteric muscle

▪ Extra-genital changes:

- a. Autonomic changes: rise in the blood pressure, heart rate and respiratory rate
- b. Somatic changes: semi-spastic contractions of the facial, intercostals and abdominal muscles

2. Plateau phase:

▪ Genital changes :

a. External genital organs:

- The plateau phase follows the excitation phase and continues for about (30 seconds to 3 minutes)
- There is accentuation of the physiological responses that happened in the excitation phase: the penile erection becomes more rigid in addition to an increase in the size of the glans and the diameter of the penile shaft
- The scrotum shows smoothing of the skin and flattening (Masters et al., 1992).

b. Internal genital organs:

- There is accentuation of the responses of the excitation phase: the testes show more enlargement in volume by about 50%, elevation as well as rotation so that they rest on the perineum by their posterior surface
- There may be few drops of mucoid secretions of Cowper's glands that are termed pro-semen

▪ Extra-genital changes:

There is accentuation of the changes that happened in the excitation phase as follows:

- a. Autonomic changes: more increase in blood pressure, heart rate, respiratory rate and there may be sex flush on the skin (occurs in about

25% of the males) which is maculopapular rash on the abdomen that spreads to the chest, face, arms and the thighs and is more marked in fair persons

- b. Somatic changes: generalized myotonia in addition to semispastic contractions of the facial, intercostals and abdominal muscles (Masters et al., 1992)

3. Orgasm Phase:

If effective sexual stimulation continues late in the plateau phase, the person reaches a peak where the body suddenly discharges its accumulated sexual tension; that is termed orgasm. It lasts only for few seconds, thus it is the shortest phase of the sexual response cycle (Masters et al., 1992).

Orgasm is a cerebral event of intense pleasurable sensation that occurs simultaneously with the genital event of ejaculation.

4. Resolution Phase :

The duration of this phase is variable: If orgasm occurred, it is about (10-15 minutes) with sense of well being and if orgasm did not occur, it is about (10-15 hours) with sense of exhaustion, depression and pelvic pain. Despite the variable duration, there is reversal of all the genital and the extra-genital changes that happened during the previous phases (see before).

The most important and characteristic feature of the resolution phase in the males is the refractory period which is the period of time after male orgasm during which further sexual excitation and/or orgasms are impossible. It may last from few minutes to few hours or even days. This refractory period is increased in the following two conditions:

- 1. Increased age of the individual
- 2. Increased number of repeated ejaculations within a period of time

Sexual Response Cycle in the Female

1. Excitation Phase:

▪ Genital changes:

- a. External genital organs:

The excitation phase occurs within 10-30 seconds of the initiation of sexual stimulation, which may be psychological or physical. The females differ from the males in that they are stimulated more by the psychological factors rather than the physical factors i.e. a woman may be sexually responsive to a specific male whereas a man may be able to be responsive to a wide range of sexually attractive females (Kaplan , 1974). The basic physiological event is the vaso-congestion. Accordingly, the clitoris undergoes enlargement in the diameter by two-folds rather than the length. The labia minora becomes swollen with flattening and separation of the labia majora.

b. Internal genital organs:

The first and the most important sign of excitation in the female is the appearance of vaginal transudate within 10-30 seconds of sexual stimulation. It is produced by vasocongestion in the walls of the vagina leading to transudation of this clear mucoid fluid. Its main function is to facilitate the process of penile intromission without difficulty. It has to be noted that this is not a vaginal secretion because there are no secretory glands in the vagina.

- **Extra-genital changes:**

They are same as the males

2. Plateau phase:

- **Genital changes :**

a. External genital organs:

The clitoris undergoes more congestion but it is retracted against the pubic bone. This may give a false impression to the husband of absence of excitement, which is not true. This retraction helps to protect the very sensitive clitoris at this stage from direct stimulation. The clitoris undergoes indirect stimulation either by being pressed upon as a part of the vulva by the pubic bone of the husband or by the traction on it by the clitoral hood, which is the fused upper part of the labia minora. The in and out thrusting movements of the penis lead to traction on the labia minora that are transmitted to the clitoris through the clitoral hood, leading to its stimulation. The labia majora become more widely separated. The labia minora become more enlarged to the double or triple of their size. The most important change is the change of color of the labia minora. They become pink to bright red in color in the females who have never been pregnant and deep red in the females who have been pregnant.

b. Internal genital organs:

The upper two-thirds of the vagina show dilation or ballooning. This is associated with elevation of the uterus in a process termed as “tenting” The lower third of the vagina shows narrowing of the lumen by about 30% that result from vasocongestion of the vaginal wall. This is termed as the “orgasmic platform” that helps to “grip” the penis during coitus, so the penile size is not important in the female sexual stimulation (Masters et al., 1992).

- **Extra-genital changes:**

They are same as the males. However, sex flush is more common as it occurs in 50-75% of women

3. Orgasm phase:

It is astonishing to know that until the mid-twentieth century many people including some medical authorities believed that women were not capable of orgasm. Sex was seen for centuries as something the man did to the woman for his own satisfaction and the woman did it for the man as one of her wifely duties ?!! The females were told the following dictum. “You can’t have any physical sexual release and even if you can you shouldn’t!! (Masters et al., 1992).

What a long, hard and pleasure-free journey of the females through the darkness of ignorance?

Physiologically, the orgasm in the female is characterized by (5-15) rhythmic contractions at 0.8 second intervals of the perineal, anal, uterine and the vaginal muscles (Kaplan, 1974). Subjectively, the orgasm in the female has been described as follows:

- The orgasm usually has its onset with a momentary cessation of the consciousness. This is followed immediately by an intense sensual awareness of the clitoris that radiates upward into the pelvis associated with a sense of bearing down or expelling
- Then, there is a sensation of warmth moving from the pelvis to the whole body
- There may be a sensation of the muscle contractions felt in the vagina and the pelvis described as “pelvic throbbing”
- It may be associated with involuntary vocalization a desire for closeness or after-play (Meyer et al., 1983)

4. Resolution phase :

This phase is characterized by the reversal of all the genital and the extra-genital changes that occurred in the previous 3 phases, so the genital and extra-genital organs return to their unaroused state.

The most important and characteristic feature in this phase in the females is the absence of the refractory period in between so long as there is continued psychological and/or physical stimulation (Kaplan, 1974).

If orgasm did not occur, this phase may be prolonged and is associated with pelvic pain and discomfort.

Effects of Aging on the Sexual Response Cycle

- **The male:** The excitation phase becomes more prolonged and more direct genital stimulation is required for the erection to occur. In addition, there is mild decrease in the rigidity of erection. The plateau phase may be shortened due to lesser control over the ejaculation. The orgasmic sensation becomes of lesser intensity, which may be related to reduced ejaculate volume. The resolution phase shows prolongation of the refractory period that may reach up to days or weeks.
- **The female:** The excitation and the plateau phases show less vaginal lubrication. This leads to painful intercourse (dyspareunia). This pain is accentuated by the atrophic mucosal changes and decreased expansion of the vagina.

Final Word:

It should be well known that sex is an intimate relationship rather than a mechanical act. Marital relations between civilized men and women are not only hard and strict anatomical and physiological facts.

Providing Sexual and Reproductive Health Information to Youth



How to Communicate with Youth



How to Communicate with Youth?

- Understand the question being asked
- Give a clear and simple answer
- Check for understanding of the answer
- Build confidence and trust



Messages for Service Providers

- Using appropriate language to talk openly and comfortably about SRH will help adults build confidence and trust when communicating with young people
- From age 10 to 24, girls and boys go through normal emotional and physical changes as they develop into adults
- Talking simply and accurately to youth as they go through physical and emotional changes will help them better understand their development and build self esteem



Female Genital Mutilation (FGM)

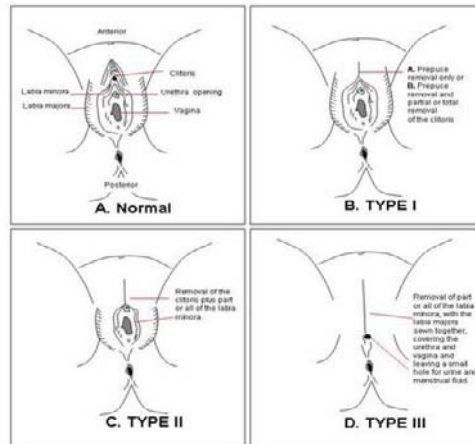


What is FGM?

FGM, often referred to as 'female circumcision', comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons.

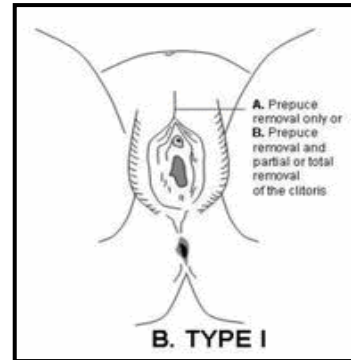


Different Types of FGM



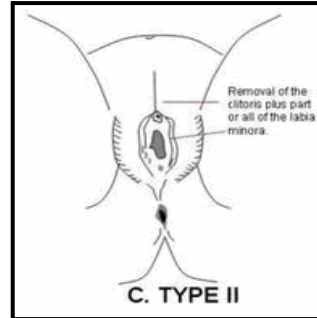
Type I

Excision of the prepuce,
with or without excision of
part or all of the clitoris



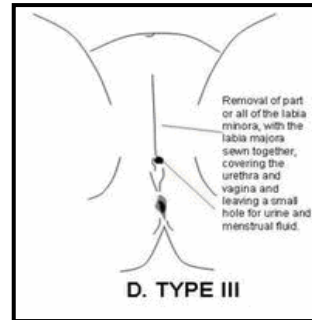
Type II

Excision of the clitoris
with partial or total
excision of the labia
minora



Type III

Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)



Health Consequences of FGM

Immediate complications include:

- Severe pain
- Shock
- Hemorrhage
- Urine retention
- Ulceration of the genital region and injury of adjacent tissue
- Possibility of transmission of the HIV

Hemorrhage and infection can cause death



Health Consequences of FGM *(cont.)*

Long-term consequences include:

- Cysts and abscesses
- Keloid scar formation
- Damage to the urethra resulting in urinary incontinence
- Dyspareunia (painful sexual intercourse) and sexual dysfunction
- Difficult childbirth



Health Consequences of FGM *(cont.)*

Psychosexual and psychological health:

- Genital mutilation may leave a lasting mark on the life and mind of the woman
- Later in life, women may suffer feelings of incompleteness, anxiety and depression



Who Performs FGM?

- Traditional practitioner with crude instruments and without anesthetic
- It may be performed in a health care facility by qualified health personnel (forbidden by law in Egypt)

WHO is opposed to medicalization of all the types of female genital mutilation



The Reasons Given by Families for Having FGM Performed

Psychosexual reasons:

- Attenuate sexual desire
- Maintain chastity and virginity before marriage
- Maintain fidelity during marriage
- Increase male sexual pleasure

Sociological reasons:

Development of girls into womanhood



The Reasons Given by Families for Having FGM Performed *(cont.)*

Hygiene and aesthetic reasons:

The external female genitalia are considered dirty

Myths:

Enhancement of fertility and promotion of child survival

Religious reasons:

Muslim communities practice FGM in the belief that it is demanded by the Islamic faith



Current WHO Activities Related to FGM

- Advocacy and policy development
- Research and development
 - a. Generate knowledge
 - b. Test interventions to promote the elimination of FGM
- Development of training materials for integrating the prevention of FGM and training of health care providers



VIRGINITY

Definition

- Specifically denoting absence of sexual experience
- Typically applied to women
- Also applied to men in many references

Virginity

- The status of virginity has historically been respected in various ways, particularly when there are traditional or religious views associating sexual activity to marriage only
- In Arab culture, the loss of virginity before marriage is a matter of deep shame and considered sin
- In certain cultures, female circumcision is performed at puberty to ensure chastity and maintain virginity until marriage



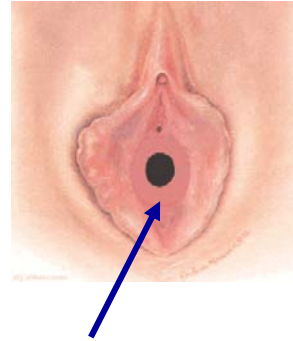
Virginity Versus Technical Virginity

- Many societies place high value on virginity before marriage, yet, premarital sexual activities that do not involve vaginal penetration occur
- This is considered by some people as technical virginity (no penetration)
- In many opinions, when an individual is engaged in non-penetrative sexual activity (oral or anal sex, mutual masturbation), he/she is no longer a virgin in any meaningful sense



Hymen

- A thin incomplete membrane surrounding the vaginal orifice with one or more openings of various shapes and sizes
- Varies considerably in elasticity, but is generally torn during the first coitus
- An intact hymen is a sign of virginity, but this is not reliable as in some cases coitus fails to cause a tear

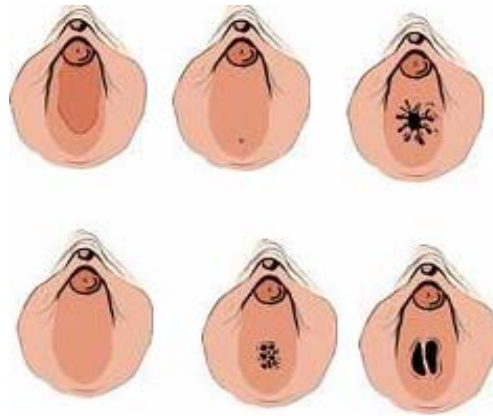


Hymen (cont.)

Childbirth causes much greater tearing of the hymen and only few tags remain called Carunculae Myrtiformes (CM)



Different Types of the Hymen



Hymen: Medico-legal

- An **intact** hymen is not a barrier to pregnancy
- Coitus is possible through an **intact** elastic hymen

This may be of medico-legal importance if after marriage, penetration of the penis during the first coitus results in no bleeding.

Once the Hymen is torn or cut it never heals again

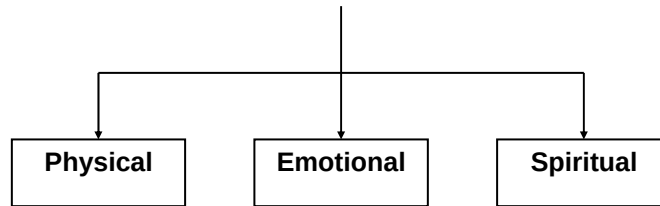
Abstinence



Abstinence

Young people have to understand healthy relationships to be better prepared to resist infatuation and make an informed decision when choosing a partner for marriage

Reasons for abstinence



Abstinence *(cont.)*

Physical	Emotional	Spiritual
▪ Protection against - Pregnancy - STIs/HIV	▪ Demonstrate maturity (resistance of peers and social pressure) ▪ No guilt or shame ▪ Deeper friendship and love ▪ Concentrate on personal goals and desires	▪ Respect Allah gift of sex within the contract of marriage ▪ Honor the body

Youth and STIs/HIV



Youth and STIs/HIV

- Young people are at risk of STIs/HIV because of their risky behavior
- Young people who show symptoms of STIs or had unprotected sex should visit a clinic for testing and treatment
- STIs can put young people at greater risk for:
 - a. HIV transmission
 - b. Infertility or sterility



Youth and STIs/HIV *(cont.)*

- HIV transmission occurs through blood, semen, vaginal fluids and breast milk
- Sexual transmission of HIV can be prevented by the **ABC** Approach
 - a. **A**bstinence
 - b. **B**eing faithful
 - c. **C**ondom use



Youth and Unsafe Abortion



Youth and Unsafe Abortion

- Young married women who are not using FP methods are at risk of unplanned pregnancy
- This often leads them to seek unsafe clandestine abortion
- Consequences of unsafe abortion include injuries, hemorrhage, and infections that may lead to permanent morbidity like infertility or loss of life (mortality)

Prevention: Providing SRH information and services to youth



Sexual Response Cycle in the Male and Female



Phases of the Sexual Response Cycle

- Excitation
- Plateau
- Orgasm
- Resolution

The Changes during Each Phase

- **Genital changes :**
 - a. External organs
 - b. Internal organs
- **Extragenital changes :**
 - a. Autonomic
 - b. Somatic

Premarital Package



Messages to the Premarital Couple

To assist in improving reproductive health, the service provider should tell the couple that:

- Men and women are equal partners
- Men and women are both entitled to receive proper information
- Men's support of women's reproductive health will result in healthy children and happier families



Components of the Premarital Package

- Advocating the premarital package
- Premarital counseling
- Premarital history taking and examination
- Premarital investigations
- Premarital immunization



Advocating the Premarital Package

Tell the couple about:

- The importance of premarital counseling and examination as a preventive measure
- The procedures of premarital examination
- The value of premarital counseling and examination in preventing:
 - a. Rh incompatibility
 - b. Hazards of German measles during pregnancy
 - c. STIs including AIDS



Premarital Counseling

- Help couples to discuss their thoughts and fears freely
- Discuss concerns raised by the couple
- Reassure the couple and alleviate all worries and concerns
- Explain the basic RH/FP issues to the couple:
 - a. Anatomical facts
 - b. Reproductive physiology
 - c. Suitable FP methods
 - d. Healthy timing and spacing of pregnancy



Premarital Counseling *(cont.)*

- Provide information about the wedding night:
 - a. Defloration does not require use of force
 - b. Defloration causes minimal pain and bleeding, therefore does not need precautions
 - c. The importance of foreplay
 - d. Lubricants can facilitate the first coitus
 - e. Narcotics (such as hashish) and alcohol have an adverse effect on sexual relations



Premarital History Taking

- Record the couple's history
- Ask the couple about:
 - a. Consanguinity or any familial disease
 - b. Diseases: diabetes, tuberculosis, hypertension, STIs, mumps in men etc.
 - c. Operations: laparotomy, varicocele, hydrocele, hernia
 - d. Menstrual history: menarche, regularity, duration, flow, dysmenorrhea and date of last menstruation
 - e. Immunization for rubella



Premarital Examination

General examination:

- Very short : may indicate Turner's syndrome or pituitary dwarfism (this condition can be associated with menstrual troubles or infertility)
- Very tall: may indicate gigantism (this condition can be associated with menstrual disturbances or infertility)
- Size of the breasts and condition of the nipples
- Abnormal obesity
- Hirsutism

Premarital Examination *(cont.)*

General examination:

- Cachexia (TB – chronic renal illness, etc.)
- Signs of anemia
- Skin lesions
- Heart disease
- Diabetes
- Hypertension



Premarital Examination *(cont.)*

Abdominal examination:

- Distribution of pubic hair
- Abdominal masses
- Scars

Examination of external genital organs:

- Genital ulcers, discharge, warts
- Labia minora, clitoris and evidence of FGC (in females)
- Varicocele, hypospadias or undescended testicles (in males)



Premarital Investigations

- Rh grouping
- Refer for other investigations (only if needed), such as:
 - a. VDRL for syphilis
 - b. ELISA for hepatitis or HIV
 - c. Semen analysis
 - d. Ultrasound and hormone assays for female

Premarital Immunization

- Unless the woman has been vaccinated against rubella, advise immunization against rubella at least three months before marriage
- Advise the couple to be vaccinated against Hepatitis



Referral

Refer the couple to a specialist for preconception advice in case of high risk i.e. family history of medical disorders (e.g., Down syndrome or other syndromes).

Antenatal Care



Definition of Antenatal Care (ANC)

ANC is a preventive obstetric health care program aimed at optimizing maternal / fetal outcome through regular monitoring of pregnancy.



Benefits of Antenatal Care

- Best possible health status for mother and fetus
- Early detection and timely referral of high-risk pregnancy
- Reduction of maternal and perinatal mortality and morbidity rates
- Education of the mother about:
 - a. Physiology of pregnancy
 - b. Nutrition
 - c. Alarming signs and symptoms
 - d. Infant care
 - e. Breastfeeding
 - f. Child spacing



Schedule of Antenatal Care Visits

- To 28th weeks gestation → every 4 weeks
- 28th - 36th weeks → every 2 weeks
- Thereafter → every week

The Initial ANC Visit

Booking Procedures and/or Registration

History taking:

- Personal history
- Complaint
- Menstrual history
- Obstetric history
- Family history
- Medical history
- Surgical history
- Family planning history
- Immunization history
- Breastfeeding history



The Initial ANC Visit *(cont.)*

Examination:

- General (varicose veins, oedema, back)
- Breast examination
- Skeletal or neurological abnormalities
- Chest and heart examination
- Abdominal inspection
 - a. Contour and size of abdomen
 - b. Scars of previous operations
 - c. Signs of pregnancy
 - d. Fetal movements



The Initial ANC Visit *(cont.)*

Abdominal palpation:

- Fundal level
- Fundal grip
- Umbilical grip
- Pelvic grip

Abdominal auscultation of fetal heart sounds (FHS):

- At 10 weeks, by Sonicaid
- At 20 weeks, by Pinard's fetal stethoscope



The Initial ANC Visit *(cont.)*

Laboratory investigations:

- Urine analysis
- Stool analysis
- Blood analysis:
 - a. Complete blood count
 - b. ABO grouping and Rh typing
- Oral glucose challenge test (for patients with risk factors for diabetes)

Pelvic ultrasound



The Initial ANC Visit *(cont.)*

Counsel for the place of delivery:

- Encourage the woman to deliver at a health facility
- Counsel her for safe home birth if desired by the woman and/or her family and not contraindicated (in case of high risk pregnancy)

Woman's health card:

Create a Woman's Health Card and fill in the data at each antenatal care visit



ANC Periodic Visits

- General examination
- Record any new complaint
- Urine examination
- Assessment of fetal well-being
- Ultrasound, if available (at 37 weeks)
- Assessment of fetal size, lie and presentation



Health Education for Pregnant Women

- Adequate nutrition
- Suitable clothing
- Dental care
- Breast care
- Sexual activity
- Adequate weight gain (10-12 kg)



Health Education for Pregnant Women *(cont.)*

- Baths
- Exercise
- Rest and Sleep
- Drugs
- Smoking
- Traveling regulations
- Tetanus Toxoid Immunization



Common Complaints of Pregnancy

- Nausea and vomiting
- Heartburn and hyperacidity
- Excessive salivation
- Constipation
- Hemorrhoids and varicose veins

Common Complaints of Pregnancy *(cont.)*

- Oedema
- Leg cramps
- Excessive odorless, colorless vaginal discharge not associated with burning sensation or pruritis vulvae
- Backache

Alarming Signs and Symptoms of Pregnancy

Pregnant women should be advised to seek **immediate medical care** if they experience any of the following symptoms or signs:

- *Vaginal bleeding*
- *Severe oedema*
- *Escape of fluid from vagina*
- *Abnormal gain or loss of weight*
- *Fever*

Alarming Signs and Symptoms of Pregnancy *(cont.)*

Pregnant women should be advised to seek **immediate medical care** if they experience any of the following symptoms or signs:

- *Decrease or cessation of fetal movements*
- *Severe headache*
- *Epigastric pain*
- *Blurred vision*

Postnatal Care



Definition of Postnatal Care (PNC)

- Postnatal period starts about two hours after the delivery of the placenta and continues for 42 days
- Skilled care and early identification of problems during PN period could reduce the incidence of death and disability

Needs of Women during the Postnatal Period

Information and/or counseling including:

- Care of the infant and breastfeeding
- Physical changes of their bodies, including signs of possible problems
- Self care, hygiene and healing
- Sexual life
- Contraception
- Nutrition



Needs of Women during the Postnatal Period *(cont.)*

Women may experience anxiety due to:

- Inadequacy
- Loss of marital intimacy
- Isolation and depression
- Constant responsibility for infant care and other family members

Thus emotional and psychological support are needed from the following:

- Health care providers
- Husband and family



Needs of Infants during the Postnatal Period

- Easy access to the mother
- Appropriate feeding
- Adequate temperature
- Safe environment
- Parental care
- Cleanliness

Needs of Infants during the Postnatal Period *(cont.)*

- Observation of physical status by a concerned caregiver
- Access to health care guidance and management of any potential complication
- Nurturing
- Cuddling
- Stimulation



Needs of Infants during the Postnatal Period *(cont.)*

- Protection from the following:
 - a. Diseases
 - b. Harmful practices
 - c. Abuse and/or violence
- Acceptance of the following:
 - a. Sex
 - b. Appearance
 - c. Size
- Recognition by the state (vital registration system)



Main Anatomic and Physiologic Changes during the Postnatal Period

Pelvic Organs

- Uterine involution
- Lochia flow as a result of cast off the decidua
 - a. Lochia rubra
 - b. Lochia serosa
 - c. Lochia alba



Main Anatomic and Physiologic Changes during the Postnatal Period *(cont.)*

Breasts

- Colostrum (during the first three days)
- Normal flow of milk (start at the third day and continue)



Main Anatomic and Physiologic Changes during the Postnatal Period *(cont.)*

Blood coagulation

On the third postpartum day, a rapid and dramatic increase in both number and adhesiveness of platelets together with an increase in fibrinogen and other clotting factors, put the woman at higher risk for thrombotic complications.



Major Maternal Health Challenges during the Postnatal Period

- Postpartum Hemorrhage: the major cause of maternal mortality
- Pre-eclampsia: the second direct cause of maternal mortality
- Puerperal Genital Tract Infection :still a major cause of maternal mortality in developing countries
- Thromboembolic Disease (TED)



Major Maternal Health Challenges during the Postnatal Period *(cont.)*

Complications of the urinary tract

- Retention of urine
- Incontinence
- Infection

Complaints about the Perineum and the Vulva

- Pain in the perineum and the vulva
- Perineal and/or labial tears or an episiotomy



Major Maternal Health Challenges during the Postnatal Period *(cont.)*

Breast Problems

- Engorgement of the breasts
- Mastitis
- Breast abscess develops in a minority of cases



Major Maternal Health Challenges during the Postnatal Period *(cont.)*

Psychological Problems

- Postpartum blues
- Postpartum depression
- Puerperal psychosis



Dangerous Maternal Symptoms during the Postnatal Period

Refer the mother to the health care facility if any of the following symptoms occurred:

- Vaginal bleeding
- Severe headache
- Blurring of vision
- Severe epigastric pain
- Convulsions
- Fever
- Chest pain or dyspnea
- Fainting



Dangerous Maternal Signs during the Postnatal Period

Refer the mother to the health care facility if any of the following signs were detected during postnatal home visits:

- Pulse > 100
- Blood pressure > 140/90 mmHg
- Temperature > 38°C
- Tender or hard breast
- Painful calf muscle
- Abdomen very tender when pressed (different from normal postnatal cramping of the uterus when breastfeeding)
- Malodorous vaginal discharge or infected perineal wound (episiotomy or tear)



Major Infant Health Challenges during the Postnatal Period

- Convulsions or continuous sleep
- Refusal of feeding for two successive times
- Delayed passage of stool or urine for more than 24 hours
- Diarrhea or excessive vomiting
- Fever or cold skin
- An umbilical stump that is red, oozing, draining pus or discharge



Major Infant Health Challenges during the Postnatal Period *(cont.)*

- An abnormal color
- Lethargy
- Rapid respiration
- Poor and weak sucking
- Poor color (blue body) and/or muscle tone
- Weak and/or constant painful cry
- Eye/eyes that are swollen, sticky with pus or discharge



Dangerous Infant Symptoms and Signs during the Postnatal Period

Refer the infant to the health care facility if any of the following signs were detected during postnatal home visits:

- Temperature $>38^{\circ}\text{C}$ or $< 36^{\circ}\text{C}$
- Respiratory rate $> 60/\text{minute}$
- Flaccid, not reactive infant
- Jaundice, cyanosis or pallor
- Difficulty in breathing manifested by nasal flaring and retraction of the chest wall during respiration
- Bloody or purulent discharge from the umbilical stump



Timing of Postnatal Care Visits

- First Visit (within 24 hours)
- Second Visit (day 4 after birth)
- Third Visit (day 7 after birth)
- Fourth Visit (clinic visit at day 40)

Appendices

Sample of Workshop Agenda

(Training Schedule)

Day one

09:00 to 11:00	11:00 to 11:30	11:30 to 02:30	02:30 to 03:30
Welcome and Introduction to the Workshop - Welcome (10 minutes) - Pre-test. (20 minutes) - Workshop description (10 minutes) - Participants' training expectations (15 minutes) - Establishment of ground rules and group norms (15 minutes) - Appreciative Interview/Icebreaker (50 minutes)	Coffee Break	Youth Friendly Services - Introduction to Youth Friendly Services (60 minutes) - Characteristics of Youth Friendly Services (40 minutes) - Self Assessment (60 minutes) - Wrap up and presentation (20 minutes)	Participants' feedback and evaluation of day one activities.

Day two

09:00 to 11:00	11:00 to 11:30	11:30 to 02:30	02:30 to 03:30
Anatomy of the Female and Male Genital Organs - Exercise 1: Female genital organs (45 minutes) - Exercise 2: Male genital organs (30 minutes) - Exercise 3: Skills related to the ability to draw female and male genital organs for the purpose of counseling (45 minutes)	Coffee Break	Physiology of the Female and Male Reproductive Organs - Role Play 1 (120 minutes): - How menstruation occurs? - How ovulation occurs? - How conception occurs? - How implantation occurs? - What are the functions of the female sex hormones? - Discussions (20 minutes) - Power point presentation (40 minutes)	Participants' feedback and evaluation of day two activities.

Day Three

09:00 to 11:00	11:00 to 11:30	11:30 to 02:30	02:30 to 03:30
Family Planning Methods and Counseling ■ Role Play 2: Family planning methods specific counseling (40 minutes) ■ Group work 1: (60 minutes) a. What is counseling? b. How counseling will help the clients? c. What are the tasks that are addressed in SRH counseling? d. Who can do counseling? e. Contraceptive counseling ■ Discussion: (20 minutes) listing the different categories of FP methods	Coffee Break	Family Planning Methods and Counseling (cont.) ■ Group work 2: Review of the FP methods from the "Family Planning A Global Handbook for Providers" (80 minutes) ■ Group work 3: WHO Medical Eligibility Criteria (40 minutes) ■ Presentation and discussion (60 minutes)	Participants' feedback and evaluation of day three activities.

Day Four

09:00 to 10:40	10:40 to 11:10	11:10 to 01:30	01:30 to 02:30
Providing SRH information to youth ■ Exercise: Brainstorming and listing the frequently asked SRH questions by youth (20 minutes) ■ Group work 4: (50 minutes) To answer three listed questions ■ Presentation (10 minutes) about how to communicate with youth ■ Discussion about "Sexual development in boys and girls" (20 minutes)	Coffee Break	Providing SRH information to youth (cont.) ■ Group work and role plays: Commonly asked questions by youth (90 minutes) ■ Power point presentation (50 minutes) a) FGM b) Virginity c) Abstinence d) Youth and STIs/HIV e) Youth and unsafe abortion f) Sexual response in female and male g) Premarital Package h) Pre and post natal care	Participants' feedback and evaluation of day four activities. Closing Session ■ Final workshop evaluation ■ Post-test ■ Closing remarks ■ Certificates ■ Group photo

Sample of Pre and post-Tests

Write true (T) or false (F) beside each sentence

	T	F
1. Young women can begin COCs without a pelvic exam.		
2. Young women who have not had children should not use COCs		
3. Young women who have varicose veins can take COCs		
4. Young women who are breastfeeding between 6 weeks and 6months postpartum should not take COCs		
5. Young women who are infected with HIV can safely use COCs		
6. POPs should be taken every day without break		
7. Bleeding changes with POPs are common but not harmful		
8. POPs are not safe for breastfeeding women		
9. Young women can start POPs immediately after first trimester abortion		
10. Emergency contraceptive pills (ECPs) help to prevent pregnancy when taken up to 5 days after unprotected sex		
11. ECPs work by disrupting an existing pregnancy		
12. ECPs work primarily by preventing or delaying ovulation		
13. Nausea, abdominal pain, fatigue and headache may occur after taking ECPs		
14. Bleeding changes are common and harmful with progestin only pills and injectables		
15. Depo-Provera is taken every 2 months and Noristerate is taken every 3 months		
16. Return of fertility is often delayed with progestin only injectables than with the other methods		
17. All progestin only injectables will cause changes in the mood or sex drive		
18. Depo-Provera protects against endometrial cancer		
19. Monthly injectables contain 2 hormones (estrogen and progesterone).		
20. Monthly injectables can be given as much as 7 days early or late.		
21. Combined patch is put on the body each week for 4 weeks (one patch every week)		
22. Combined vaginal ring is kept in the upper vagina for 3 weeks followed by a week with no ring in place.		

	T	F
23. Implanon is a single rod of progestin only subdermal implant effective for 2 years	☐	☐
24. TCu 380 A IUD is effective for ten years only	☐	☐
25. TCu 380 A is more likely to come out among women who have not had given birth	☐	☐
26. Male and female condoms can protect from STIs except HIV	☐	☐
27. Local spermicides are more effective in preventing pregnancy than female condom	☐	☐
28. The fertility awareness methods are not effective if the woman is having irregular cycles	☐	☐
29. All hormonal contraceptive methods can be started after uncomplicated first trimester abortion in young women	☐	☐
30. Fertility returns after 2 weeks of first trimester abortion	☐	☐

Check (✓) in front of the correct answer

31. The cervix is

- a. The lower portion of the uterus
- b. Produces mucus that affect sperm penetration
- c. Progestin only contraceptive methods work mainly on the cervix
- d. All of the above

32. The thin tube that carries sperms from the testicles to the seminal vesicles is called

- a. Prostate
- b. Vas deferens
- c. Urethra
- d. None of the above

33. The sensitive ball of tissue on the external female genital organ that creates sexual pleasure is

- a. Labia minora
- b. Clitoris
- c. Labia majora
- d. All of the above

34. The event that occurs between days 7 and 21 of the regular menstrual cycle often, around day 14 is called

- a. Fertilization
- b. Conception
- c. Ovulation
- d. None of the above

35. Fertilization usually occurs in

- a. The inner third of the fallopian tube
- b. The outer third of the fallopian tube
- c. The endometrium
- d. None of the above

36. Youth is a vulnerable group to STIs/HIV because

- a. They have different anatomy and physiology of their sex organs than older people
- b. They do not use contraceptive methods
- c. They may have risky behavior
- d. All of the above

37. Female genital mutilation (FGM)

- a. Protects the chastity and virginity of women
- b. May lead to sexual dysfunctions in women
- c. Not prohibited by the MOHP of Egypt
- d. All of the above

38. List 4 characteristics of youth friendly services

- 1.
- 2.
- 3.
- 4.

39. List 4 characteristics of youth friendly service providers

- 1.
- 2.
- 3.
- 4.

40. List 4 characteristics of youth friendly clinics

- 1.
- 2.
- 3.
- 4.

41. Mention 2 benefits of the antenatal care

1.
2.

42. Mention the four phases of the sexual response cycle in both males and females

1.
2.
3.
4.

Model Answer for the Pre and post-Tests

Write true (T) or false (F) in front of each sentence?

	T	F
1. Young women can begin COCs without a pelvic exam.	X	
2. Young women who have not had children should not use COCs		X
3. Young women who have varicose veins can take COCs	X	
4. Young women who are breastfeeding between 6 weeks and 6months postpartum should not take COCs	X	
5. Young women who are infected with HIV can safely use COCs	X	
6. POPs should be taken every day without break	X	
7. Bleeding changes with POPs are common but not harmful	X	
8. POPs are not safe for breastfeeding women		X
9. Young women can start POPs immediately after first trimester abortion	X	
10. Emergency contraceptive pills (ECPs) help to prevent pregnancy when taken up to 5 days after unprotected sex	X	
11. ECPs work by disrupting an existing pregnancy		X
12. ECPs work primarily by preventing or delaying ovulation	X	
13. Nausea, abdominal pain, fatigue and headache may occur after taking ECPs	X	
14. Bleeding changes are common and harmful with progestin only pills and injectables		X
15. Depo-Provera is taken every 2 months and Noristerate is taken every 3 months		X
16. Return of fertility is often delayed with progestin only injectables than with the other methods	X	
17. All progestin only injectables will cause changes in the mood or sex drive		X
18. Depo-Provera protects against endometrial cancer	X	
19. Monthly injectables contain 2 hormones (estrogen and progesterone).	X	
20. Monthly injectables can be given as much as 7 days early or late.	X	
21. Combined patch is put on the body each week for 4 weeks (one patch every week)		X
22. Combined vaginal ring is kept in the upper vagina for 3 weeks followed by a week with no ring in place.	X	

	T	F
23. Implanon is a single rod of progestin only subdermal implant effective for 2 years		X
24. TCu 380 A IUD is effective for ten years only		X
25. TCu 380 A is more likely to come out among women who have not had given birth	X	
26. Male and female condoms can protect from STIs except HIV		X
27. Local spermicides are more effective in preventing pregnancy than female condom		X
28. The fertility awareness methods are not effective if the woman is having irregular cycles	X	
29. All hormonal contraceptive methods can be started after uncomplicated first trimester abortion in young women	X	
30. Fertility returns after 2 weeks of first trimester abortion	X	

Check (✓) in front of the correct answer

31. The cervix is

- a. The lower portion of the uterus
- b. Produces mucus that affect sperm penetration
- c. Progestin only contraceptive methods work mainly on the cervix
- d. All of the above (✓)

32. The thin tube that carries sperms from the testicles to the seminal vesicles is called

- a. Prostate
- b. Vas deferens (✓)
- c. Urethra
- d. None of the above

33. The sensitive ball of tissue on the external female genital organ that creates sexual pleasure is

- a. Labia minora
- b. Clitoris (✓)
- c. Labia majora
- d. All of the above

34. The event that occurs between days 7 and 21 of the regular menstrual cycle often, around day 14 is called

- a. Fertilization
- b. Conception
- c. Ovulation (✓)
- d. None of the above

35. Fertilization usually occurs in

- a. The inner third of the fallopian tube
- b. The outer third of the fallopian tube (✓)
- c. The endometrium
- d. None of the above

36. Youth is a vulnerable group to STIs/HIV because

- a. They have a different anatomy and physiology of their sex organs than older people
- b. They do not use contraceptive methods
- c. They may have risky behavior (✓)
- d. All of the above

37. Female genital mutilation (FGM)

- a. Protects the chastity and virginity of women
- b. May lead to sexual dysfunctions in women (✓)
- c. Not prohibited by the MOHP of Egypt
- d. All of the above

38. List 4 characteristics of youth friendly services

- 1- Fulfil the rights of youth
- 2- Ensures confidentiality and privacy
- 3- Involves youth in planning and evaluating the service
- 4- Provide comprehensive package of SRH services

39. List 4 characteristics of youth friendly service providers

- 1- Technically competent
- 2- Have communication skills
- 3- Non judgemental and considerate
- 4- Motivated and supported

40. List 4 characteristics of youth friendly clinics

- 1- Convenient location
- 2- Offer privacy and avoid stigma
- 3- Provide information and education materials
- 4- Have convenient working hours

41. Mention 2 benefits of the antenatal care

- 1. Prevent conditions that may threaten the health of the fetus and or the mother
- 2. Help a woman approach pregnancy and child birth as positive experience

42. Mention the four phases of the sexual response cycle in both male and female

1. Excitation phase
2. Plateau phase
3. Orgasmic phase
4. Resolution phase

Final Workshop Evaluation

Training from ----- / ----- / -----

To ----- / ----- / -----

Please evaluate the following aspects of the training program by circling the appropriate number below					
	Excellent	Very good	Good	Fair	Unacceptable
	5	4	3	2	1
1. Pre – Post Tests	5	4	3	2	1
2. Topics of the workshop	5	4	3	2	1
3. Session dynamics (Methodology of the training)	5	4	3	2	1
4. Relevance of training to your job requirements	5	4	3	2	1
5. Achievement of the workshop objectives	5	4	3	2	1
6. Usefulness of program materials (handouts and presentations)	5	4	3	2	1
7. Training environment	5	4	3	2	1
8. Competency of the trainers	5	4	3	2	1
9. Working groups, exercises and role plays	5	4	3	2	1
10. Logistical arrangement (training room, training equipment, transportation, accommodation ...etc)	5	4	3	2	1
11. Evaluation tools	5	4	3	2	1

12. What did you like least about the workshop?

13. What did you like most about the workshop?

14. What are your suggestions/recommendations to improve the workshop for the next times?

15. Do you have other comments?

References

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5. Sexuality and Sexual Health Training Curriculum, Engenderhealth
6. Fact Sheet No.241 June 2000, Female Genital Mutilation, WHO
7. Family Planning: A Global Handbook for Providers, WHO
8. WHO Medical Eligibility Criteria for Starting Contraceptive Methods
9. Comprehensive Reproductive Health and Family Planning Training Curriculum, Module 16 - Reproductive Health Services for Adolescents, Pathfinder International
10. Family Life Education, Teaching Adults to Communicate with Youth from a Muslim Perspective, FHI
11. Standards of Practice: Ministry of Health and Population of Egypt