**BSc in Nursing and Midwifery**

**MODULE 19**

**REP 308 – REPRODUCTIVE HEALTH**

**NO. OF HOURS: 100**

**CREDITS : 10**

**Authors 2009**

Mrs E.S. Lengu

Mrs M. G. K. Malemba

**Revised 2013**

Mrs A. M. Namathanga

Mr R Gundo

© Kamuzu College of Nursing, [2009]

All rights reserved. No part of this publication may be reproduced or distributed in any form or by any means or stored in a database or retrieval system, without the prior written consent of Kamuzu College of Nursing.

**MODULE CONTENTS Page number**

Table of contents ---------------------------------------------------------------------------------------------- 2

List of figures and pictures ---------------------------------------------------------------------------------- 5

Overview of the module ------------------------------------------------------------------------------------- 6

Module description ------------------------------------------------------------------------------------------ 6

Overall learning outcomes --------------------------------------------------------------------------------- 6

Learning contract -------------------------------------------------------------------------------------------- 6

Method of assessment ------------------------------------------------------------------------------------- 7

**UNIT 1: INTRODUCTION TO SEXUAL AND REPRODUCTIVE HEALTH RIGHTS (SRHR)**

1.1 Learning outcomes------------------------------------------------------------------------------------- 9

1.2 Assessment criteria ----------------------------------------------------------------------------------- 9

1.3 Definition of concepts used in SRH---------------------------------------------------------------- 10

1.4 Determinants of SRH --------------------------------------------------------------------------------- 12

1.5 Human sexuality -------------------------------------------------------------------------------------- 13

**UNIT 2: STRATEGIES AND APPROACHES TO SRH SERVICES IN MALAWI**

2.1 Learning outcomes --------------------------------------------------------------------------------- 14

2.2 Assessment criteria -------------------------------------------------------------------------------- 14

**UNIT 3 FAMILY PLANNING**

Learning outcomes------------------------------------------------------------------------------------- 16

Assessment criteria ----------------------------------------------------------------------------------- 16

Introduction -------------------------------------------------------------------------------------------- 16

Definition of concepts ------------------------------------------------------------------------------- 16

WHO Medical Eligibility Criteria (MEC) for contraceptive use ---------------------------- 22

WHO MEC classification categories ------------------------------------------------------------- 23

Family Planning Methods available in Malawi ----------------------------------------------- 25

Emergency contraceptives -------------------------------------------------------------------------------- 25

Implants -------------------------------------------------------------------------------------------------------- 26

Intrauterine devices ---------------------------------------------------------------------------------------- 28

Permanent ---------------------------------------------------------------------------------------------------- 30

References ---------------------------------------------------------------------------------------------------- 33

**UNIT 4: THE ALDOLESCENT CLIENT AND YOUTH FRIENDLY SERVICES**

Learning outcomes ----------------------------------------------------------------------------------------- 35

Assessment -------------------------------------------------------------------------------------------------- 35

Introduction ------------------------------------------------------------------------------------------------- 35

Adolescent fertility ---------------------------------------------------------------------------------------- 37

Gender role development ------------------------------------------------------------------------------- 39

Youth friendly health services -------------------------------------------------------------------------- 41

Determinants of health problems in young people ----------------------------------------------- 42

Strategies to improve accessibility of SRH services for the youth ---------------------------- 42

Standards for youth friendly services ---------------------------------------------------------------- 42

References ------------------------------------------------------------------------------------------------- 46

**UNIT 5 GENDER BASED VIOLENCE (GBV)**

 Learning outcome -------------------------------------------------------------------------------------- 47

Assessment criteria ------------------------------------------------------------------------------------- 47

Definition of terms -------------------------------------------------------------------------------------- 48

Factors that protect or put women at risk of GBV ---------------------------------------------- 49

Effects of GBV ------------------------------------------------------------------------------------------- 50

Prevention of GBV ------------------------------------------------------------------------------------- 51

References----------------------------------------------------------------------------------------------- 52

**UNIT 6: NURSING MANAGEMENT OF PROBLEMS OF FEMEALE REPRODUCTIVE SYSTEM**

6.1 Learning outcome --------------------------------------------------------------------------------------------- 53

6.2 Assessment criteria ------------------------------------------------------------------------------------------- 53

6.3 Introduction ----------------------------------------------------------------------------------------------- 53

6.4 Structural disorders ------------------------------------------------------------------------------------- 54

6.5 Abortion --------------------------------------------------------------------------------------------------- 55

6.6 Ectopic pregnancy -------------------------------------------------------------------------------------- 59

6.7 Menopause ----------------------------------------------------------------------------------------------- 63

6.8 Infertility -------------------------------------------------------------------------------------------------- 66

6.9 Obstetric fistula ----------------------------------------------------------------------------------------- 69

7.0 Breast cancer -------------------------------------------------------------------------------------------- 71

7.1 Cervical cancer ------------------------------------------------------------------------------------------- 76

**UNIT 7: NURSING MANAGEMENT OF PROBLEMS OF THE MALE REPRODUCTIVE SYSTEM**

7.1 Learning outcome -------------------------------------------------------------------------------------- 85

7.2 Assessment criteria ------------------------------------------------------------------------------------ 85

**UNIT 8: SEXUALLY TRANSMITTED DISEASES (STIs)**

Learning outcome ------------------------------------------------------------------------------------------ 86

Assessment criteria ---------------------------------------------------------------------------------------- 86

Introduction ------------------------------------------------------------------------------------------------- 87

Relationship between STIs, HIV and AIDS ----------------------------------------------------------- 88

The Syndromic management -------------------------------------------------------------------------- 89

References ------------------------------------------------------------------------------------------------- 95

**Figures Page number**

Figure 1: The female reproductive system -------------------------------------------------------- 53

Figure 2: Pelvic laparoscopy --------------------------------------------------------------------------- 62

Figure 3: obstetric fistula -------------------------------------------------------------------------------- 70

Figure 4: BSE standing -------------------------------------------------------------------------------------- 73

Figure 5: BSE lying down ------------------------------------------------------------------------------------ 74

Figure 6: The male reproductive system ---------------------------------------------------------------- 85

Figure 7: ophthalmia neonatorum ---------------------------------------------------------------------- 87

**OVERVIEW OF THE MODULE**

The module provides the learner with the opportunity to develop and synthesize knowledge, skills and appropriate attitudes necessary for implementation of good nursing in reproductive health.

**MODULE DESCRIPTION**

This module is designed to equip the learner with knowledge and skills to recognize, manage and refer clients with reproductive health conditions. It emphasizes on life threatening conditions. The learner will apply communication and counseling skills to deliver services.

**HOW TO USE THIS MODULE**

While using this module, you are expected to do the following:

i) Read widely the content area under each unit utilizing books, journals, internet

ii) Consult widely on each topic including collaboration with colleagues

iii) Participate actively in class and seminar presentations.

**HOW THE MODULE FITS INTO THE PROGRAMME**

The knowledge contained in this module shall be integrated/applied in nursing and midwifery practice, education, management and research. Sexual reproductive health rights and policies shall form the framework for clinical reasoning and clinical decision making. Philosophical and professional values will enrich the required professional conduct on the nurse/midwife

**OVERALL LEARNING OUTCOMES**

At the end of the learning experience the learners shall be able to:

* Discuss the concepts used in sexual and reproductive health.
* Discuss the national SRH policies and initiatives in Malawi.
* Discuss problems of the male and female reproductive systems.

**LEARNING CONTRACT**

**Students Role**

* You are responsible for your own meaningful learning
* You need to continuously monitor your progress and reflect on whether you are achieving the learning outcomes
* You are to carry out all activities stipulated in this module in a logical sequence.
* Submit all arrangements on time
* You are expected to attend all classes and actively participate in class seminars /discussions
* Actively participate in group projects

**Lectures Role**

* Provide students with modules containing expected learning outcomes, content areas, students activities, assessment criteria and methods
* Provide guidance and support to achieve learning outcomes
* Monitor and evaluate performance of students learning activities
* Facilitate students discussion and seminars

I will complete this module within the specified period in order to gain the appropriate knowledge, skills and attitudes. I am aware that I have to achieve the stipulated outcomes in readiness for clinical placement and assessments.

Students Name:…………………………………………………………………………………….

**Students Signature:……………………………………………………………………………**

**Date: ………………………………………………………………………………………………..**

**Time Allocation**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Lectures**  | **Seminar**  | **Lab/simu** | **Total hours** | **Credit**  |
| 60 | 20 | 20 | 100 | 10 |

**METHOD OF ASSESSMENT**

Continuous assessment 40%

Examination 60%

 **MODULE CONTENT**

**UNIT I**

 **INTRODUCTION TO SEXUAL AND REPRODUCTIVE HEALTH RIGHTS (SRHR) AND POLICIES**

This unit discusses the basic concepts in sexual and reproductive health; it also provides information on various policies influencing provision of reproductive health services.

**1.1 Learning Outcomes:**

*Upon completion of this unit learners should be able to:*

* Understand concepts used in sexual and reproductive health.
* Analyze policies, protocols, guidelines and standards influencing men’s and women’s sexual and reproductive health.

**1.2 Assessment Criteria:**

* Define concepts commonly used in SRH
* Explain the components of Malawi’s SRH program.
* Describe the SRH policy in Malawi
* Identify the Millennium Development Goals relevant to SRH and the potential barriers to achieving these goals by 2015
* Identify human rights that are relevant to SRH
* Explain the socio-cultural, economic and political factors that influence SRH in Malawi.
* Discuss human sexuality
	1. **DEFINITIONS OF CONCEPTS USED IN SRH**

**1.3.1 Reproductive Health**

Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity. It deals with the reproductive processes, functions and systems at all stages of life. The concept of sexual and reproductive health emerged following the 1994 International Conference on Population and Development (ICPD) conference in Cairo. The concept developed in response to the fragmentation of the existing services related to health in reproduction and their orientation.

The status of the reproductive health of Malawians ranks among the lowest in Sub-Saharan Africa and the total fertility rate is high at 5.7. Childhood mortality rates are also unacceptably high, under-five mortality is 112:1000 and infant mortality is 66:1000. Maternal mortality is 675:100000 live births, STIs rates are estimated at 6.3% and HIV prevalence rate is at 11%. This makes reproductive health a major issue.

**1.3.2 Human Rights**

Human rights are primarily about the relationship between the individual and the state. International human rights law consists of the obligations that governments have agreed on in order to be effective in promoting and protecting the rights of individuals. When governments fail in their obligations to, or when they deliberately restrict rights without valid justification, they can be seen under international law as being responsible for violating rights. The key human rights document is the *Universal Declaration of Human* *Rights* (UDHR). It is not a legally binding document; it represents the shared aspirations of governments about what rights are, and why they should exist for all people everywhere. The two covenants, the *International Covenant on Economic, Social* *and the Cultural Rights and the International Covenant on Civil and Political Rights,* further clarify the rights set out in the UDHR. Unlike the UDHR, theyare legally binding documents on those countries which ratify them.These three documents together are often called the *International* *Bill of Human Rights.*

For every right, governments have three levels of obligation: they have to **respect** the right, **protect** the right, and **fulfill** the right. To respect a right means not to directly violate it. To protect the right means enacting laws setting up mechanisms to prevent violation of the right by non-state actors. To fulfill the right, means to take active steps to put in place institutions and procedures, including resource allocation that will enable people to enjoy the right.

**1.3.3 Reproductive Rights**

Reproductive rights relate to an individual woman’s or man's ability to control and make decisions about her or his life which will impact on her or his reproductive and sexual health.

**1.3.4 Sexual Rights**

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the human rights of women and men to have control over and decide freely and responsibly on matters related to their sexuality, including protecting and promoting their sexual and reproductive health, free from coercion, discrimination and violence.

Many people consider sexual rights to be a subset of reproductive rights. These two sets of rights are, however, conceptually different in significant ways, and hence require different remedies. Reproductive rights are limited to certain groups. Sometimes one hears practitioners saying “We just put it all under reproductive rights“. The problem with this is that it can mean that the needs of people who fall outside the arena of reproduction are ignored e.g. older women; women and men who do not have children. Sexual rights create the conditions which enable individuals to determine whether to connect sexual activity with desired reproductive ends. They reinforce people’s right to engage in a range of non reproductive sexual practices (some of which are illegal in many countries, for example anal sex). People have sexual relations from adolescence into old age. As long as they are having sexual relations, they have sexual health needs – related to information, education, services, and protection from sexually transmitted infections, and to problems of sexual function. The term “sexual rights “includes the right to sexual health irrespective of one’s reproductive status.

|  |
| --- |
| ***Self Activity 1.1****1.Explain the following reproductive health concepts:*1. *Sexual health*
2. *Sexuality*
3. *Sexual identity/Gender Orientation*
4. *Reproductive Decision making*
5. *Equality and equity for men and women*

*2. Explain components of the National sexual and reproductive Health (SRH) Policy**3. Analyse national and international SRH documents**4. Read through the Universal Declaration of Human Rights document and select those*  *rights that impact on sexual and reproductive health* |

**1.4 Determinants of Sexual and Reproductive Health**

Sexual and Reproductive health affects, and is affected by, the broader context of peoples life, economic, education, employment, living conditions and family environment, social and gender relationships and the traditional and legal structures within which they live. Sexual and reproductive behaviors are governed by complex biological, cultural and psycho-social factors.

It can be said the four factors (that can be referred to as four **P**’s) contribute to the determination of health in general and reproductive health in particular: providence, people, politicians and providers of health services.

**Providence -** constitutes our genetic constitution, including diseases to which we are more susceptible.

**People’s** - life style behavior can promote or undermine their own health. Their behaviors can even affect other people’s health. The social-economic condition of the society in which we are born and in which we live is another determinant of our health.

 **Politician’s** - and legislators play an important role in the shaping of societies by controlling the resources that can be allocated to health, they are, consciously or unconsciously , making decisions on who shall live or who shall die. Laws and policies can advance women’s rights and health and can obstruct their autonomy and choice in decisions regarding their sexual and reproductive health.

 **Providers** - of health care services are also strong determinants of SRH.

**1.5 Human Sexuality**

Human sexuality is how people experience the erotic and express themselves as sexual beings. Frequently driven by the desire for sexual pleasure, human sexuality has biological, physical, and emotional aspects. Biologically, it refers to the reproductive mechanism as well as the basic biological drive that exists in all species and can encompass sexual intercourse and sexual contact in all its forms. Emotional aspects deal with the intense emotions relating to sexual acts and associated social bonds. Physical issues around sexuality range from purely medical considerations to concerns about the physiological or even psychological and sociological aspects of sexual behavior.

The term can also cover cultural, political, legal and [philosophical](http://en.wikipedia.org/wiki/Philosophy) aspects. It may also refer to issues of [morality](http://en.wikipedia.org/wiki/Morality), ethics, theology, spirituality or religion and how they relate to all things sexually.

**UNIT 2**

**STRATEGIES AND APPROACHES TO SRH SERVICES IN MALAWI**

**2.1 Learning Outcomes:**

Discuss the national SRH initiatives in Malawi

**2.2 Assessment Criteria**

Upon completion of this unit learners should be able to discuss the following national initiatives;

* Life skills
* Adolescent health
* Family planning (current trends)
* Youth friendly reproductive health program
* Cancer screening- cervix, prostrate and breast
* Safe motherhood
* Girl-child trafficking
* Infertility
* Prevention and treatment of fistulas

|  |
| --- |
| ***Self Activity 2.1****Assemble all documents/ policies on the following SRH national initiatives:*1. *Life skills*
2. *Adolescent health*
3. *Family planning (current trends)*
4. *Youth friendly reproductive health program*
5. *Cancer screening- cervix, prostrate and breast*
6. *Safe motherhood*
7. *Girl-child trafficking*
8. *Infertility*
9. *Prevention and treatment of fistulas*
 |

**UNIT 3**

 **FAMILY PLANNING**

**LEARNING OUTCOMES**

* Discuss family planning services in Malawi
* Describe the characteristics of a caring F/P provider
* Describe the family planning client assessment
* Describe family planning methods available in Malawi

**ASSESSMENT CRITERIA**

* State health benefits of family planning to women, families, communities and societies.
* Describe the usage of family planning in Malawi.
* State the unmet need for contraception in Malawi.
* Describe the concept of healthy timing and spacing of pregnancy (HTSP).
* Discuss the experiences you have had of F/P providers
* Describe the purpose of client assessment for FP
* Describe the counseling process for informed choice in family planning
* Describe the key types of contraceptive methods available in Malawi.
* Describe the concept of long-term and permanent methods (LAPM).
* Identify information that can be gathered during client assessment for FP methods
* Identify the assessment tasks required for specific FP methods
* Explain how to be reasonably sure a client is not pregnant using the pregnancy checklist

**INTRODUCTION**

Family planning helps individuals prevent unwanted pregnancies. As a result many women’s lives can be saved from high risk pregnancies or unsafe abortions, thereby reducing the number of maternal deaths.

**DEFINITION**

Family planning is a voluntary decision made by individual men, women, adolescents or couples to determine how many children to have, when to have them and at what intervals

****

***ACTIVITY 3.1***

* *Explain the problems that people may encounter for not practicing family planning.*
* *Read the Malawi Demographic Health Survey 2004 (MDHS) and identify family planning unmet needs in Malawi*
* *What are the causes of unmet needs for family planning in Sub Saharan Africa and Malawi.*
* *In your groups discuss the characteristics of a caring F/P provider*

**HEALTHY TIMING AND SPACING OF PREGNANCIES** (HTSP)

**Definition**

Healthy Timing and Spacing of Pregnancies (HTSP) is a FP intervention that is associated with the best health outcomes for newborns, infants, and mothers through the practice of recommended pregnancy spacing.

**Why HTSP**

The appropriate spacing and timing of pregnancies in combination with the correct use of modern and/or natural family planning (FP) methods is an essential part of reproductive health, safe motherhood, and reducing morbidity and mortality in infants and children to help women and families delay or space their pregnancies to achieve the healthiest outcomes for women, newborns, infants, and children, within the context of free and informed choice.

****

***ACTIVITY 3.2***

*Discuss the following*

* *HSTP messages,*
* *Windows of opportunities and*
* *HSTP and HIV*

******

***Activity 3.3 Case Study: Story of Nabanda****You are a registered nurse. On a routine visit to a household you meet Nabanda, a mother of two children. She was married at the age of 19, and her elder son is two years old. On entering the house you find the younger child, 7 months old, crying. The child looks weak and ill. Nabanda looks tired and irritated. She looks pale and weak. On inquiry, she says that she is not feeling well, and after doing only a few household chores, she needs rest but is unable to find time for herself because she has two small babies. She says that the little one demands breastfeeding frequently, and, because she does not have enough milk, he is always hungry. She also tells you that her husband is unhappy with her since she cannot maintain the house and kitchen well. She says that she does not know what to do and asks you to help her get out of the situation.*

***Discussion Questions***

*1. Identify Nabanda’s problems as related to this case study.*

*2. What could be the possible reasons for the condition of Nabanda and her children?*

*3. What other questions would you like to ask Nabanda in order to better advise her on her situation?*

*4. How will you help her?*

*5. Explore her current relationship with her spouse, specifically the dynamics of the relationship.*

 **FAMILY PLANNING COUNSELLING**

**DEFINITION**

Counseling is an interactive process where the provider listens to the client’s needs, tries to elicit the client’s concerns and offers relevant information to enable the client make informed decisions. Counseling could be done to individuals or groups.

**PRINCIPLES OF COUNSELLING**



***Activity 3.4***

1. *Review the principles of counseling*
2. *Explain the meaning of ‘’informed choice’’ in family planning.*
3. *Mention the benefits of counseling*
4. *In your groups , discuss the steps you would follow when counseling a client for RH services*

**The 6 topics to include in counseling for family planning methods**

* Effectiveness
* Advantages and disadvantages
* Side effect and complications
* How to use the method
* STI/HIV and AIDS prevention
* When to return

**COUNSELING CONTINUING CLIENTS**

Counseling continuing clients usually focuses on talking their experiences and needs. This includes need for more supplies of contraceptives, answers to questions, help with problems, a new method, removal of implants or an IUCD or help with another reproductive health problem such as STIs or unexplained vaginal bleeding.

**COUNSELING SUBSEQUENT CLIENTS**



***Activity 3.5***

*Describe how you would counsel a subsequent visit client*

**FP CLIENT ASSESSMENT**

**DEFINITION**

Client assessment is the collection of information or data in order to come up with a proper Method.

The primary objectivesof assessing clients prior to providing family planning services are to determine:

* that the client is not pregnant,
* whether any conditions requiring precaution exist for a particular method, and
* Whether there are any special problems that require further assessment, treatment or regular follow-up.

This can usually be accomplished by a rapid or routine evaluation through:

* Observation
* History taking
* Complete physical examination

Laboratory investigations



***Activity 3.6***

 *Visit the f/p clinic and observe how breast and pelvic assessments are done*

* Initial assessment of each and every f/p client is very important as baseline data to identify conditions contraindication a method.
* While pelvic examination is not a hindrance to initiating most FP methods it should be encouraged for screening for other conditions such as Cervical Cancer and STI.
* Where resources are limited, a medical evaluation and/or laboratory testing (e.g., blood glucose; hemoglobin) before providing modern contraceptive methods is not justifiable.
* To enable clients to obtain the contraceptive method of their choice, only those procedures that are essential and mandatory for all clients in all settings should be required.
* In very busy clinics the provider should use a hormonal methods checklist and schedule a day for thorough examination rather than turn away clients. The findings from the checklist determine whether a physical examination is necessary (i.e., if the client answers “YES,” a brief physical examination or additional questions may be necessary)

The table that follows summarizes the client assessment requirements for all contraceptive methods. Depending on answers given during counseling to the WHO Medical Eligibility Criteria (MEC) questions for specific methods physical and pelvic examinations may be needed as indicated.

**Summary of Client Assessment Requirements for All Contraceptive Methods**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Assessment | FAM,LAM or Withdrawal | Barrier Methods (Male or Female Condoms)  | Hormonal Methods (COCs, POPs, ECPs, injectables or Implants) | IUCDs | Voluntary Sterilization (Female/Male) |
| **Reproductive Health Background** | No | No | No | No | No |
| **STI History** | No | No | No | Yes, to determine if at high personal risk | No |
| **Physical Examination** |
| **Female** General (including BP) | No | No | No**a** | No**a** | Yes |
| Abdominal | No | No | No**a** | Yes | Yes |
| Pelvic Speculum | No | No | No**a, b** | Yes | Yes |
| Pelvic Bimanual | No | No | No**b** | Yes | Yes |
| **Male** (groin, penis, testes and scrotum) | No | No | N/A | N/A | Yes |

a If screening checklist responses all negative (NO), examination is not necessary. b Only necessary if pregnancy is suspected and pregnancy test is not available. |

#### j0432579

#### *ACTIVITY 3.7*

* *Describe the information to be gathered during client assessment*
* *Explain how you would ensure the client is not pregnant*

**WORLD HEALTH ORGANIZATION (WHO) MEDICAL EIGIBILITY CRITERIA (MEC) FOR CONTRACEPTIVE USE**

**Introduction**

The WHO MEC is a guideline that provides evidence-based recommendations on whether an individual can safely use a contraceptive method based on medical reasons.

This guideline is intended for use by policy-makers, program managers, and the scientific community in the preparation of national family planning/sexual and reproductive health programs for delivery of contraceptives. The first edition of the *Medical eligibility criteria for contraceptive use* was published in 1996; subsequent editions were published in 2000 and 2004 and 2008

The guidelines provide guidance on the safety of 19 contraceptive methods by women and men with specific characteristics or known medical conditions. These characteristics and conditions range from age, smoking, and parity to cardiovascular disease, cancer, and infections.

**WHO MEC CLASSIFICATION CATEGORIES**

According to the WHO, Medical eligibility for each contraceptive method, with the exception of female and male surgical sterilization, was classified using **four categories:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Classification/Category** | **Description** | **Interpretation when clinical judgment is available** | **Interpretation when clinical judgment is limited** |
| **1** | A condition where no restriction for the use of the contraceptive method. | **Use method in any circumstances** | **Yes** **Use the method** |
| **2** | A condition where the advantages of using the method generally outweigh theoretical or proven risks. | **Generally use:****advantages outweigh risks** | **Yes****Use the method** |
| **3** | A condition where the theoretical or proven risks usually outweigh the advantages of using the method | **Generally DO NOT use:****risks outweigh advantages** | **No****DO NOT use the method** |
| **4** | A condition which represents an unacceptable health risk if the contraceptive method is used. | **Method NOT to be used** | **No****DO NOT use the method** |

Where resources for clinical judgment are limited, the four-category classification

Framework can be simplified into two categories. With this simplification, a category 1 or 2 classification indicates that a woman is medically eligible to use the method. A category 3 or 4 classification indicates that a woman is not medically eligible to use the method.

Recommendations for surgical sterilization are defined according to the following four categories:

• A (accept) = There is no medical reason to deny sterilization to a person with this condition;

• C (caution) = The procedure is normally conducted in a routine setting, but with extra preparation and precautions;

• D (delay) = the procedure is delayed until the condition is evaluated and/or corrected. Alternative temporary methods of contraception should be provided;

• S (special) = The procedure should be undertaken in a setting with an experienced surgeon and staff, equipment needed to provide general anaesthesia, and other back-up medical support. For these conditions, the capacity to decide on the most appropriate procedure and anaesthesia regimen is also needed. Alternative temporary methods of contraception should be provided, if referral is required or there is otherwise any delay.

**WHO MEC FOR TEMPORARY METHODS Example**

|  |  |  |
| --- | --- | --- |
| **Example: COCs** | **Classification** | **Definition** |
| History of gestational diabetes | 1 | Use method in any circumstances |
| Diabetes without vascular involvement | 2 | Generally use:advantages outweigh risks  |
| Hypertension140-159/90-99 | 3 | Generally DO NOT use:risks outweigh advantages |
| Hypertension>160-100 | 4 | Method NOT to be used |

***ACTIVITY 3.8***

*Using MEC summary tables answer the following question in two scenarios*

 *A 36 year old woman with three children comes to the health centre requesting oral contraceptives. She tells you she smokes 10 cigarettes per day.*

*A) Are oral contraceptives medically appropriate?*

*B) Does she have any other highly effective temporary contraceptive options*?

 *A 25 year old woman has just given birth and plans to breastfeed. She would like an injection for contraception prior to returning home. Which of the following options is medically appropriate?*

*A) A combined injectable contraceptive provided immediately*

*B) A combined injectable contraceptive provided at 6 weeks postpartum*

*C) A progestin-only injectable contraceptive provided immediately*

*D) A progestin-only injectable contraceptive provided at 6 weeks postpartum*

**FAMILY PLANNING METHODS AVAILABLE IN MALAWI**



***Activity 3.9***

*Group presentations*

*In your groups discuss the following family planning methods (COCs and POPs) used in Malawi. In your discussion include l the following;*

*Composition, mechanism of action, benefits (contraceptive and non-contraceptive), disadvantages, who can use / who should not use the method, client instructions and management of common problems and side effects of each method, client assessment check list and when to initiate each method.*

**EMERGENCY CONTRACEPTION (ECs)**

**DEFINITION**

Emergency contraception is a method of preventing pregnancy after unprotected sexual intercourse.

**TYPES OF EMERGENCY CONTRACEPTIVES**

There are 2 broad types of ECs.

* Pills designed to cause medical menstrual regulation. Emergency contraceptive pills (ECPs) are pills used for this purpose. They can be POPs (containing a progestin alone) or COCs (containing a progestin and an oestrogen together). There are also pills that are specifically formulated and packaged for emergency contraceptive use. ECPs are sometimes called “morning-after pills” or post coital contraceptives.
* IUCDs designed to modify the endometrial activity. IUCDs may also be used as emergency contraception within 5 days after sexual intercourse.

#### Types of ECPs available in Malawi

* Postinor-2 (Pills specifically formulated and packaged for emergency contraceptive use, with the progestin levonorgestrel)
* Progestin-only pills (Ovrette, Microlet) with levonorgestrel or norgestrel
* Combined oral contraceptive pills (Microgynon, Lo-Femenal) with an oestrogen and a progestin



***ACTIVITY 4***

*Explain*

* Mechanism of action
* *indications and contraindications*
* *Benefits and disadvantages*
* *Management of side effects*
* *client instructions for EC*

**INITIATION OF METHOD**

**Low-dose COCs**

* Take 4 tablets of a low-dose COC (Lo-Femenal) (30–35 μg EE) orally within 72 hours of unprotected intercourse.
* Take 4 more tablets 12 hours after first dose.

**High-dose COCs**

* Take 2 tablets of a high-dose COC (Eugynon) (50 μg EE) orally within 72 hours of unprotected intercourse.
* Take 2 more tablets 12 hours after first dose.

**POPs**

* Take 1 tablet (Postinor 2) (750 μg levonorgestrel) or 20 Ovrette tablets (75 μg norgestrel each) orally within 72 hours of unprotected intercourse.
* Take 1 more tablet (Postinor 2) (750 μg LNG) or 20 more (75 μg) tablets 12 hours after the first dose.

**IMPLANTS**

**DESCRIPTION**

Implants are thin, flexible plastic rods or capsules, each about the size of a match stickwhich contains 36 mg of Levonorgestrel**,** a synthetic progestin widely used in combined oral contraceptives and in the Progestin Only Pill**.** The capsules are inserted just under the skin of a client’s upper arm by means of a minor surgical procedure.The progestin diffuses slowly through the wall of the capsules in a continuous low dose.

**TYPES**

|  |  |  |
| --- | --- | --- |
| **Implant**  | **Formulation**  | **Length of Use**  |
| **Norplant**  | 6 rods, each with 36mg levonorgestrel  | 5 years  |
| **Jadelle**  | 2 rods, each with 75mg levonorgestrel  | 5 years  |
| **Implanon**  | 1 rod, with 68mg etonogestrel  | 3 years  |
| **Sinoplant** | 2 rods, each with 75mg levonorgestrel  | 5 years  |



***ACTIVITY 4.1***

*Explain*

* *the mode of action of implants*
* *Effectiveness*
* *Advantages and disadvantages*
* *MEC for implants*
* *The client instructions*
* *Myths and roumours of implants*
* Management of common side effects

**Other side effects are:**

* Abdominal pains
* Dizziness
* Mood changes
* Nausea

**WARNING SIGNS FOR IMPLANTS USERS**

* Delayed menstrual period after several months of regular cycles
* Severe lower abdominal pain, heavy bleeding (twice as long or twice as much as normal) or prolonged bleeding (more than 8 days duration)
* Bleeding or infection at insertion site
* Expulsion of a capsule
* Migraine (vascular) headaches repeated very painful headaches or blurred vision.

**INDICATION FOR REMOVAL OF IMPLANTS**

* When five years have passed since insertion of the implant capsule.
* At the woman’s request:
* For any symptom which troubles her
* For personal reasons e.g. the woman may want to have a child
* If a condition that is considered a precaution for the use of implants develops and the client will use a reliable non – hormonal method (remember: low dose progestin only methods are always safer than pregnancy).

**INTRAUTERINE CONTRACEPTIVE DEVICES (IUCDS)**

**DEFINITION**

A small flexible device inserted in the uterine cavity to prevent pregnancy.

**TYPES**

Available types are made of plastic and are medicated with copper, silver or progestin (e.g., Copper T380A (most readily available in Malawi), Multiload 375, Progestasert® and LevoNova®)

**MECHANISMS OF ACTION**

• Interfere with ability of sperm to pass through uterine cavity (copper-releasing)

• Inhibit fertilization

• Thicken cervical mucus (progestin-releasing)

• Change endometrial lining (progestin-releasing)



***Activity 4.2***

*Explain*

* *Effectiveness of IUCDs*
* *Benefits (contraceptive and non contraceptive) and disadvantages*
* *MEC for IUCDs*
* *Indications and contraindications*
* *The client instructions*
* *Discuss Myths and rumors of IUCDs*

**CLIENT ASSESSMENT CHECKLIST**

If the client answers “**NO**” to all questions, and pregnancy is **not** suspected, the client may go directly for method-specific counseling,pelvic examination and provision of the contraceptive.

If the clienthowever answers “**YES**” to any one of the questions below, she willneed further counseling and possible evaluation before making a final decision.

|  |  |  |
| --- | --- | --- |
| **IUCD CHECKLIST**  | **YES** | **NO** |
| Active STI’s |  |  |
| Pelvic infection (PID) or ectopic pregnancy (within the |  |  |
| last 3 months) |  |  |
| Heavy menstrual bleeding (twice as long or twice as |  |  |
| much as normal) |  |  |
| Prolonged menstrual bleeding (> 8 days) |  |  |
| Severe menstrual cramping (dysmenorrhoea) requiring |  |  |
| analgesics and/or bed rest |  |  |
| Bleeding/spotting between periods or after intercourse |  |  |
| Missed periods |  |  |
| Client (or partner) has other sex partners |  |  |

**WHEN TO INSERT**

• Days 1 – 7 of menstrual cycle.

• Anytime during the menstrual cycle when you can be sure the client is not pregnant. If starting after day 7 the client should use a backup method or abstain from sexual intercourse for 7 days.

• Postpartum (immediately following delivery, during the first 48 hours postpartum or after 4 – 6 weeks, or after 6 months if using LAM)

• Post abortion (immediately or within 7 days) provided there is no evidence of pelvic infection



***ACTIVITY 4.3***

*Explain*

* *the mode of action of implants*
* *Effectiveness*
* *Advantages and disadvantages*
* *MEC for implants*
* *The client instructions*
* *Myths and rumors of implants*
* Management of common problems and side effects

**PERMANENT METHODS**

**VOLUNTARY STERILIZATION**

**FEMALE SURGICAL CONTRACEPTION (TUBAL LIGATION).**

It is a surgical procedure by which the fallopian tubes are blocked. The occlusion is done by mini laparatomy and laparoscopy.

**MECHANISM OF ACTION.**

By blocking the fallopian tubes: that involves tying and cutting, sperms are prevented from reaching ova and causing fertilization.

****

***ACTIVITY 4.4***

*Mrs. Toto**a 32 years old lady with 6 children would like to have a permanent method of contraception.*

*Explain the following about the tubal ligation;*

* *Benefits and disadvantage*
* *Indications and contraindications*
* *WHO MEC for TL*
* *Management of side effects/complications*
* *Client instructions*

**MALE SURGICAL CONTRACEPTION**

**DEFINITION**

* Male surgical contraception is a procedure by which the vas deferens is blocked.

**TYPE.**

* Vasectomy by the standard method (one or two small incisions) or the non- scalpel vasectomy technique (preferred method).



***Activity 4.5***

* *Explain the following about vasectomy:*
* *Mechanism of action*
* *Benefits and disadvantages*
* *Indications and contraindications*
* *WHO MEC*
* *Management of side effects and complications*
* *Client instructions*

**BARRIER METHODS**

* + Male Condoms
	+ Female Condoms
	+ Vaginal Methods- Spermicides, Diaphragm And Cervical Cap

**FERTILITY AWARENESS METHODS (NATURAL FAMILY PLANNING METHODS)**

* Calendar -Based Methods
* Symptoms -Based Methods Cervical Secretions, Basal Body Temperature
* Lactational Amenorrhea Method
* Withdrawal Method

****

***Activity 4.6***

*Discuss the above mentioned barrier, and natural family planning methods in relation to:*

* *Definition*
* *Composition*
* *Mechanism of action*
* *Indications*
* *Contraindications*
* *Advantages*
* *Disadvantages*
* *Client instructions*
* Management of common problems and side effects

**REFERENCES**

 Family Planning, *A global handbook for providers* (2007) WHO and Johns Hopkins Bloomberg.

 Malawi National Reproductive Health Service Delivery Guidelines, Sept 2007.

 Revised Family planning practitioners training curriculum trainer material, February 1995.

Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use. Research Triangle Park, NC: Family Health International, 2006. <http://www.fhi.org/NR/rdonlyres/eb7o4zjhhvwo6dk2e33xhrdagnvru5j24iqds2oyyfbgpxiw6s476tbh2zlj6tnor2bbj6igu5xtrf/MECENG.pdf>

WHO Updates MEC for Contraceptives, INFO Reports: <http://www.infoforhealth.org/inforeports/mec/index.shtml>

HTSP 101: Everything You Want to Know about HTSP, ESD
<http://www.esdproj.org/site/DocServer/HTSP_101_Brief_Final_corrected_4.9.08.pdf?docID=1761>

Comparing Effectiveness of Methods Chart, WHO
<http://www.fhi.org/NR/rdonlyres/ebrjx34v4ltkpve23ajfowame5hqqdm2youb6puzqqbblfj3vmtdgsiazhaylskjepyoehpjqee4ab/EffectivenessChart1.pdf>

LAPM: Addressing Unmet Need for FP in Africa, FHI
<http://www.fhi.org/en/RH/Pubs/servdelivery/LAPM/index.htm>

LAPM and Development
<http://www.acquireproject.org/archive/files/2.0_invest_in_fp_and_lapms/2.2_resources/2.2.2_advocacy_briefs/Advocacy-Brief-3-final.pdf>
(PRINTED PDF OURSELVES)

LAPM ACQUIRE 10 principles
<http://www.acquireproject.org/fileadmin/user_upload/ACQUIRE/ACQUIRE-Ten-Guiding-Principles-for-LAPM-Service-Programs.pdf>
(PRINTED PDF OURSELVES)

Implants: The Next Generation, Population Reports: <http://www.infoforhealth.org/pr/k7/k7.pdf>

 Implants: Tools for Providers, Info Reports: <http://www.infoforhealth.org/inforeports/implants/implants.pdf>

Hormonal Implants: New, Improved, and Popular When Available, ACQUIRE, 2008. <http://www.acquireproject.org/fileadmin/user_upload/ACQUIRE/Publications/Hormonal-Implants-2Pager-final.pdf>

Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD. Research Triangle Park, NC: Family Health International, 2007.  Available at: <http://www.fhi.org/NR/rdonlyres/eirceolzcpfztqwso6gaj5dx2dr4ntxu65cci5ycsqqncjabwssecncfoxay5g65jherl5ocmhno6p/IUDchecklistenrh.pdf>

Family Planning Needs during the Extended Postpartum Period in Tanzania, ACCESS-FP: <http://www.accesstohealth.org/toolres/pdfs/ACCESSFP_Tanzania_DHSanalysis_Feb08.pdf>

LAM: A PP Contraceptive Choice for Women Who Breastfeed, ACCESS-FP: <http://www.usaid.gov/our_work/global_health/pop/news/issue_briefs/lam_brief.pdf>

FP Choices for Women With HIV, Population Reports: <http://www.infoforhealth.org/pr/l15/l15.pdf>

Women with HIV: Questions Answered, INFO Reports: <http://www.infoforhealth.org/inforeports/women_hiv/womenhiv.pdf>

How to Be Reasonably Sure a Client Is Not **Pregnant**. Research Triangle Park, NC: Family Health International, 2007. <http://www.fhi.org/NR/rdonlyres/edytiv3yfiq4t6ubhsllidfnpwlp76fhu4qj24cks4ef4t37ttyiooyuziv3272uvf6jns2f6uliud/PregnancyChecklistenrh1.pdf>

FP: A Global Handbook for Providers, WHO: <http://www.infoforhealth.org/globalhandbook/handbook.pdf>

Do you know your FP Choices Wall Chart, WHO: <http://www.infoforhealth.org/globalhandbook/wallchart/WallChart_5-04-07.pdf>

COC Checklist-General, FHI: <http://www.fhi.org/NR/rdonlyres/ezwflnmmohsijfofd2ljr7dsbgm235fqxj4j7jt5m4dnvxkb42re44mncq32kjwhy6ly5chnxhcgqe/COCchecklistenrh.pdf>

Checklist for Screening Clients Who Want to Initiate **DMPA**.  Research Triangle Park, NC: Family Health International, 2007.  Available at: <http://www.fhi.org/NR/rdonlyres/ezezt5jvxpbiwwo3o3t7nnqah22r5yoqx5zviq6wiqhs45ju46lqrdn42scgjq5xzagqqmdxzj2f5m/DMPAchecklistenrh.pdf>

UNIT 4: THE ADOLESCENT CLIENT & YOUTH FRIENDLY HEALTH SERVICES

**LEARNING OUTCOMES**

* Describe the adolescent client
* Discuss youth friendly health services
* Describe strategies to improve accessibility and utilization of SRH services to the youth.
* Describe standards for youth friendly health services

**ASSESSMENT CRITERIA**

* Describe the following terms: adolescent, adolescence, youth, and young people.
* Explain the normal biological and psychosexual growth and developmental of an adolescent.
* Explain adolescent fertility.
* Explain the reproductive health, psychosocial, economical and cultural consequences faced by the adolescents
* Describe RH services required by the youth
* Describe factors hindering youth from accessing RH services.
* Explain characteristics of youth friendly services.

**INTRODUCTION**

Teenage/adolescent pregnancy is a prominent health problem in Malawi. The 2004 Malawi Demographic health Survey (MDHS), showed that one third of adolescent females either had a child or were pregnant. Pregnancy in adolescents is four times riskier than in adults of 25 – 29 years old. Adolescent sexual activity usually exposes them to health problems such as HIV, STIs and unwanted pregnancy. Young people in Malawi do not have adequate nor equitable access to sexual and reproductive health (SRH) and HIV services. Adolescents require special Reproductive health (RH) care and attention because of the uniqueness of their lifestyle and the challenges they encounter or get exposed to.



***Activity***

* Describe the following terms: adolescent, adolescence, youth, young people, menarche, puberty and ovulation

**NORMAL BIOLOGICAL AND PSYCHOLOGICAL GROWTH AND DEVELOPMENT IN ADOLESCENTS**

#### Psychosocial Development

· To formulate and consolidate an adult identity requires cultural or group identity, social identity, and gender identity.

· Period is characterized by egocentricism e.g. the adolescent believes that he/she is special, unique and immune. This belief leads girls, for example, to believe that they can have sex but will not get pregnant. Risk taking, often characteristic of adolescence, may also account for unprotected sexual activity.

#### Cognitive Development

· This is characterized by the ability of the adolescent to use reasoning in their thinking and actions.

· The adolescent who does not use reasoning in thinking may have difficulty in planning for the future and may not be able to separate fantasy from fact.

· It is a period of experimentation which is necessary for cognitive development. Through experimentation teenagers will learn what they are expected to do, how they should behave to develop inner control.

#### Physical Development

· At puberty ovaries and testes secrete hormones leading to growth of genital structures and development of secondary sex characteristics. Puberty occurs 6-12 months earlier in girls than in boys, and it is influenced by central nervous system involving hypothalamus, pituitary gland, ovaries and testes.

#### Sexual Development

· Sexual development involves the search for identity, gender roles, sexual attitudes, behaviors and feelings, relationships, affection, caring, physical touch, recognition and acceptance as a sexual being.

· Through sexual experimentation, adolescents test their feelings and establish their sexual identity.

· The forms of sexual expressions adolescents experiment will include fantasy, day dreams, masturbation, petting, sex without penetration and sexual intercourse.

· The sexual experimentations may not satisfy the adolescents, but instead may make them feel guilt, shame, fear of sexual inadequacy or anger

### ADOLESCENT FERTILITY

Adolescents begin to be sexually active and are able to reproduce from the age of 12 years. The onset of puberty is due to maturation of the central nervous system. The hypothalamus increases its production of gonadotrophin releasing hormone. This leads to increased production of Follicle Stimulating Hormone by the anterior pituitary gland which stimulates the ovaries to release estrogen. Eventually estrogen levels increase.

# The anterior pituitary gland then secretes Luteinizing hormone in response to high levels of estrogen. Estrogen increases and luteinizing hormone reaches the highest peak ovulation occurs. During this process, the ovary releases a mature egg which can be fertilized. At puberty, a boy is capable of producing spermatozoa and can impregnate a woman/girl.

# The effects of socio-economic and cultural factors on adolescent fertility

· Low socio economic status of parents or guardians may force adolescents to seek economic support outside their homes and often for girls from older members of the opposite sex (sugar daddies).

· Large family size, in which case the parents cannot manage to adequately support all members of the family. Children from such backgrounds are less likely to remain in school for long and more likely to abuse drugs and indulge in early sexual activity.

· Peer pressure may force adolescents to behave badly in order to conform or please their peers.

· Social problems in the family e.g. broken marriages may lead children to seek attention outside the home.

· Children of single parents may lack male/female guidance and tend to underrate their mother’s/father’s advice.

· Some adolescents just want to prove their fertility.

· The declining age of menarche means that the reproductive life for girls starts early and the period they have to be protected against pregnancy of sexual activity is lengthened. This is also why premarital sexual activity and teenage pregnancies are increasing.

· Initiation ceremonies coincide with menarche and spermache. The instructions during initiation ceremonies emphasizes that the boys and girls have now reached adulthood and thus are expected to perform adult functions. As a result the adolescent’s response is to marry or indulge in premarital sex inorder and prove their fertility.

· Urbanization leads to relaxation of some cultural values and disrupt family morals. Adolescents grow up in an environment where out of wedlock pregnancies and drug abuse are common.

· Most adolescents who are sexually active, do not use any form of contraception. It is partly because religious teaching considers this morally unacceptable and while most adolescents may engage in sexual activities, use of contraception is very low.



***Activity***

# Explain the health and psychosocial consequences of adolescent pregnancy

1. Identify the reproductive health risks faced by adolescents
2. Explain the reproductive health, psychosocial, economical and cultural consequences faced by the adolescents
3. Discuss factors that contribute to the vulnerability of girls to HIV and AIDS than boys of the same age

**GENDER ROLE DEVELOPMENT, GENDER ISSUES, HARMFUL PRACTICES AND HOW THEY CAN AFFECT ADOLESCENCE AND ADOLESCENT HEALTH**

**Gynecomastia**

The male breast, although not strictly part of male reproductive system, responds to hormonal changes. Some degree of bilateral or unilateral breast enlargement occurs in boys during puberty. If condition persists or is extensive to cause embarrassment or produce doubts, plastic surgery may be indicated.

**Eating Disorders**

**Anorexia Nervosa**

* Is characterized by a refusal to maintain a minimally normal body weight and severe weight loss in the absence of an obvious physical cause.
* Onset takes place at or near menarche.
* The aetiology remains un clear

Nursing Management

* Management is directed towards correction of the severe state of malnutrition and resolution of the psychological dynamics. Nurses need to adopt and maintain a kind, supportive, yet firm manner in managing the adolescent.
* Encouraging education and activities that strengthen self- esteem facilitates the resocialisation process and promotes social acceptance among peers.

**Bulimia**

Commonly in older adolescent and young women.

* It is a disorder characterized by binge eating. The binge is counteracted by a variety of weight control methods (purging, induced vomiting)

Nursing Management is similar to Anorexia Nervosa

**Obesity**

Is defined as an increase in body weight resulting from an excessive accumulation of body fat relative to lean body mass (Keller and Stevens, 1996). *Overweight* refers to the state of weighing more than average for height and body build.

Contributing factors include;

* **Altered nutrition** related to dysfunctional eating patterns, hereditary factors
* **Activity intolerance** related to sedentary lifestyle, physical bulk
* **Ineffective individual coping mechanism** related to little or no exercise, poor nutrition, and personal vulnerability.
* **Self esteem disturbance** related to perception of physical appearance, internalization of negative feedback.

Nursing management

* Ideal diet; increasing fibre and complex carbohydrates, modifying fat intake.
* Exercise because weight loss will occur only when calorie expenditure is greater than calorie intake, regular physical exercise is an integral part of weight reduction.
* Behavioural therapy, group involvement, medical therapy and prevention also contribute to obesity management.

**Smoking**

Teenagers begin smoking for a variety of reasons, such as imitation of adult behaviour, peer pressure and emulation of traits popularly attributed to smokers.

* Cigarettes smoking and the drinking of alcohol are complex behaviours that cannot be explained by any single causative factor.
* The hazards of smoking at any age are undisputed; Smoking almost immediately brings about reduced lung function. Most harmful of all is the likehood of lifelong addiction because the earlier one starts smoking, the more difficult to quit later. A preventive approach to teenager smoking is especially important.

**Substance abuse**

The use of other substances by adolescents to produce an altered state of consciousness is believed to reflect the changes taking place in their lives and the stresses engendered by these changes.

* There is steady increase in the incidence of adolescents using alcohol and marijuana.
* For many young people, drugs produce a dreamy state of altered consciousness or feeling of power, excitement, heightened acuity or confidence.
* Others seek visual hallucinatory experiences and sexual sensation.

***Types of drugs used*** include; alcohol, cocaine, narcotics, Central Nervous System depressant, and Stimulants, Mind Altering Drugs

**Suicide**

Is the third leading cause of death during teenage years, surpassed only by death from injury and homicide

**YOUTH FRIENDLY HEALTH SERVICES**

Youth friendly health services are high quality services that are, relevant, accessible, attractive, affordable, appropriate and acceptable to the young people

`

***Activity***

* Records from health facilities indicate that youths are not utilizing SRH services adequately
1. As a youth, describe RH services that you would require
2. Describe factors that hinder youths from accessing RH services. .

# Characteristics of youth friendly services

* Friendly non-judgmental and welcoming staff
* Distinct units set apart for youth services which ensure privacy
* Outreach clinics with specially-trained staff to meet the needs of the youth
* Special hours of operation for the convenience of the youth, such as after school and weekends
* Convenient and safe locations
* Promotion of peer-to-peer education among youth
* Offer life planning skills to youth
* Offer a wide range of Reproductive Health services such as Family Planning including emergency contraception, STI, HIV/AIDS, PMTCT, HTC, Maternal and Neonatal Health, PAC; provision of ARV’s
* Counseling on the above services, sexuality, nutrition, provision on psychosocial support and education on harmful sexual practices and beliefs such as rape, ritual sexual cleansing,
* Low or no-cost services
* Community and political acceptance and support

**DETERMINANTS OF HEALTH PROBLEMS IN YOUNG PEOPLE**

1. Provision of inadequate and inappropriate services to young people
2. Poor client provider relationship at health facilities
3. Paucity of information available to young people
4. Inadequate human and financial resources

# STRATEGIES TO IMPROVE ACCESSIBILITY OF SEXUAL AND REPRODUCTIVE HEALTH (SRH) SERVICES FOR THE YOUTH



***Activity***

1. Explain how you would design SRH services to increase access and utilization by the youth
2. Read MDGs and identify what the Malawi Government has put in place to address SRH services for young people
3. Explain strategies that you would put in place to make sure that the youth are prevented from HIV infection.

**STANDARDS FOR YOUTH FRIENDLY HEALTH SERVICES**

**Standard 1**

Health services to be provided to Young people according to existing policies, procedures and guidelines at all Service delivery points

* Availability of policies, procedures and guidelines eg Youth policy, RH policy etc
* Orientation of all staff including support staff
* Provide services according to policies
* Satisfaction of the services by Young people

**Standard 2**

**Young people** to obtain health services appropriate to their needs that include: preventive, promotive, curative and rehabilitative

* Minimum package
* Adequate infrastructure
* Visibility and clear explanation of schedules, time location and scope of YFHS
* Respect and equal care of services to Young People
* Outreach services
* Satisfaction of the services by Young People

**Standard 3**

**Young people** to obtain health information including (SRH & HIV) relevant to their needs, circumstances and stages of development

* Adequate IEC materials that are easy to understand and appropriate to YP
* Linkages
* Mobilization and orientation of communities (Leaders, parents and YP)
* YP given adequate knowledge on health including SRH and their rights
* YP able to take services of their choice appropriate to their individual needs

**Standard 4**

Service providers have the required knowledge, skills and positive attitudes to effectively provide YFHS

* Training all service providers on YFHS including health rights
* Orientation of YFHS to all support staff and relevant stakeholders
* Appropriate referral by service providers
* Satisfaction with YP

**Standard 5**

Health information related to YP is collected, analysed and utilized in decision making at all levels

* YP disaggregated by age, sex, marital status
* Availability of HMIS to support provision of YFHS
* Documentation on best practice

**POINTS FOR HEALTH WORKERS TO CONSIDER**

Most doctors, nurses and community-based providers have little if any training in working with sexually active adolescents, especially unmarried teenagers.

Providers generally lack understanding about the barriers that teenagers experience when they consider using contraceptives. An awareness of what adolescents encounter and feel may help providers as they consider the relative advantages and disadvantages of contraceptive methods and services for this age group.

**Guilt and embarrassment**

Adults generally do not approve of unmarried teenagers being sexually active. Hence, adolescents often feel guilty and embarrassed to admit they are sexually active or to talk about contraception openly. Discussing contraception with adolescents in a private, confidential setting and in a non-judgmental way is very important. Helping teenagers become more comfortable talking about sexuality (removing secrecy and shyness) may also help.

**Lack of knowledge**

Knowledge about sexuality and how contraceptive methods work remains limited among teenagers. Sex education courses, a more open atmosphere about sexuality, the use of peer educators, and explicit information on contraception can help. Providers must be certain that basic facts such as the menstrual cycle are understood, so that methods are more likely to be used properly.

**Peer pressure**

Peer norms about what is currently fashionable or “cool” influence teenagers significantly. Hence, teenagers worry about being embarrassed by using contraceptives such as condoms when the partner is involved. Messages that help teenagers gain self confidence in their own decisions may help.

**Communication difficulties**

Many of the contraceptive methods most accessible and most familiar to teenagers require good communication – condoms, non-penetrative sex and complete abstinence. Providing teens an opportunity to practice discussing sexually issues with their peers can be of great assistance.

**Inexperience**

When an adolescent begins to experiment with sex, certain contraceptive methods, such as non-penetrative sex, will be particularly hard to use correctly. Also these adolescents may not think of themselves as “sexually active” and hence may be more receptive to using a one-time protection (i.e. condoms) than a “family planning” method, such as oral contraceptives or NORPLANT.

**Lack of access**

Adolescents often seek contraceptives without their parents’ knowledge and, hence, must cope with transportation problems in reaching clinics, the cost of contraceptives, harassment or refusal to be served at pharmacies, and other difficulties. Making contraceptives more easily accessible through outreach and other efforts would help solve this problem.

**Official and cultural barriers**

Some laws, policies, cultural attitudes and traditional medical practices limit services to adolescents or add to fears about an unfamiliar situation. Examples of such barriers include mandatory pelvic exams, prescriptions and parental consent requirements before obtaining oral contraceptives.

**Physiological considerations**

Young, nulli-parous females have relatively small uteri, making an intrauterine device (IUCD) an inappropriate method due to the likelihood of excessive pain and bleeding.

REFERENCES

Allendar, J. & Spradley, B. (2005). *Community health nursing*. Promoting and protecting the publics health(6 Ed). New York: Lippincott

Clemen-Stone, S., McGuire, S.L. & Gerber, D. (2002). Comprehensive Community Health Nursing: Family, Aggregate and Community Practice. (6th Ed). Toronto: Mosby.

Stanhope, M & Lancaster, J. (2008). Public Health Nu*rsing Population Centred health Care in the Community*. St Louis: Mosby Publishing

Stanhope, M, & Lancaster, J. (2006). Foundations of Nursing in the Community Oriented practice *y*. St Louis: Mosby Publishing

Youth Friendly Health Services Manual

Youth Friendly Health Services Standards

RH Policy

HIV/AIDS Policy

National Youth Policy

**UNIT: 5 GENDER BASED VIOLENCE (GBV)**

**LEARNING OUTCOMES**

* Describe Gender Based Violence
* Establish factors that protect women or put them at risk of GBV.
* Describe the effects of GBV on health.
* Describe the laws and policies against GBV.
* Explain the roles of the nurse on GBV.
* Discuss prevention of GBV.

**ASSESSMENT CRITERIA**

* Define gender based violence.
* Describe forms of GBV.
* Explain factors that protect women or put them at risk of GBV
* Explain the prevention of GBV
* Discuss women’s/men’s coping mechanisms to GBV.

**DEFINITIONS**

**GENDER**

Refers to the economic, social and cultural attributes and opportunities associated with being male or female in a particular social setting at a particular point in time.

**GENDER BASED VIOLENCE**

According to the National Strategy to Combat Gender Based Violence (GBV) (2002),

GBV has been defined as “any unlawful act perpetrated by a person against another person on the basis of their sex that causes suffering on the part of the victim and results in, among others, physical, psychological and emotional harm and economic deprivation.

Gender based violence can happen in the domestic arena in the confines of homes, public places and institutions, and at the work place.



***Activity***

1 Explain the difference between sex and gender

2 Explain Forms of GBV

**FACTORS THAT PROTECT OR PUT WOMEN AT RISK OF GENDER BASED VIOLONCE**

There are personal, family (partner) and social factors that might protect a woman from violence or might put her at greater risk.

1. **Individual factors**
* Level of education – WHO found that higher education was associated with less violence.
* Financial autonomy – women with no financial autonomy are more at risk of violence than those that a good financial stand.
* Age – young women, especially those aged 15-19 years, are at higher risk of physical or sexual violence or both by a partner. Younger men tend to be more violent than older men, and violence tend to start early in m any relationships.
* Level of empowerment and social supports – in some settings, older women have greater status than younger women and may therefore be less vulnerable to violence.
* Previous victimisation
* History of violence in one’s family as one was growing up.
1. **Partner factors**
* Level of communication with one’s partner.
* Use of alcohol or drugs by partner.
* Whether one witnessed violence between one’s parents as a child.
* Whether one is physically aggressive towards people of same sex.
* When husband or wife dominates in power and makes all the decisions.
1. **Social factors**
* Degree of economic inequalities between men and women.
* Levels of female mobility and autonomy.
* Attitudes towards gender roles.
* Extent to which family neighbours and friends intervene in domestic violence incidences.
* Levels of male-male aggression and crime.
* Some measures of social capital.

**FACTORS THAT PROTECT WOMEN OR PUT THEM AT RISK OF GBV**

There are personal, family (partner) and social factors that might protect a woman from violence or might put her at greater risk.

**Individual factors**

* Level of education – WHO found that higher education was associated with less violence.
* Financial autonomy – women with no financial autonomy are more at risk of violence than those that a good financial stand.
* Age – young women, especially those aged 15-19 years, are at higher risk of physical or sexual violence or both by a partner. Younger men tend to be more violent than older men, and violence tend to start early in m any relationships.
* Level of empowerment and social supports – in some settings, older women have greater status than younger women and may therefore be less vulnerable to violence.
* Previous victimisation
* History of violence in one’s family as one was growing up.

**Partner factors**

* Level of communication with one’s partner.
* Use of alcohol or drugs by partner.
* Whether one witnessed violence between one’s parents as a child.
* Whether one is physically aggressive towards people of same sex.
* When husband or wife dominates in power and makes all the decisions.

**Social factors**

* Degree of economic inequalities between men and women.
* Levels of female mobility and autonomy.
* Attitudes towards gender roles.
* Extent to which family neighbours and friends intervene in domestic violence incidences.
* Levels of male-male aggression and crime.
* Some measures of social capital.

**EFFECTS OF GENDER BASED VIOLENCE**

GBV leads to short and long-term effects not only to the victim (abused) but to other relatives, friends and children. Victims of GBV go through a lot of problems including the following:

**Health**

• Injury (from lacerations to fractures and internal organ injuries)

• Depression, the victim may become socially isolated due to constant fear and tension

• Unwanted pregnancies

• Risk to sexually transmitted infections including HIV

• Miscarriage

• Chronic pelvic pain

• Headaches

• Permanent disabilities

• Irritable bowel syndrome

• Eating problems

• Inability to reproduce due to damages caused in the private areas

• Self-injurious behaviors (e.g. smoking, unprotected sex)

• Death

**Psychological**

• Stigmatization; some people view rape victims with a negative attitude and the stigmatization may lead to suicide

• Mental illness including traumatic stress disorders and generalized anxiety

• Self blame and withdrawal from social life activities

• Impaired memory

• Sexual dysfunction

• Loss of self-esteem

• Depression

• Fear

• Obsessive-compulsive disorder

• Post-traumatic stress disorder

• High propensity towards promiscuous behavior

**Social**

• Difficulty in obtaining, maintaining and adjusting, to employment due to the tense and violent atmosphere

• Low productivity caused by confusion

• Breakdown of family units which leads to relocation of victim and children

• Physical damage leading sometimes to disability

• Children do not develop to their full potential in an abusive environment

• Perpetuation of violence by a child who grew up in a violent environment

• Delinquency and crime including drug and alcohol abuse

• Breakdown of family structures/eroding family cohesion

**Effects of GBV to the community**

* High crime rate
* No developments in the community
* No good relationships
* Lack of community cohesiveness

**PREVENTION OF GENDER BASED VIOLENCE**



***Activity***

1 Explain prevention of GBV in Malawi

2 Explain the role of the nurse in the prevention of GBV

3 Identify policies and laws that address GBV

4 Explain coping mechanisms used by people to cope with GBV

**REFERENCES**

Blackwell’s Nursing Dictionary, (2005), 2nd Ed, Oxford, Blackwell Publishing Ltd.

Initiatives against Gender Based Violence in Malawi with a focus on the Prevention of Domestic Violence, (Act no. 5 of 2006): Gender balance and women’s rights committee under human rights commission, Lilongwe.

MOH. (2007). Malawi National Reproductive Health Service Delivery Guidelines, Lilongwe. Ministry of Health.

Stanhope, M, & Lancaster, J. (2006). Foundations of nursing in the community: Community oriented practice. (2nd Edition). St Louis: Mosby Elsevier.

WHO, multi- country study on women’s health and domestic violence against women, (2005), WHO Press, Geneva.

**UNIT 6**

 **NURSING MANAGEMENT OF PROBLEMS OF THE FEMALE REPRODUCTIVE SYSTEM**

**6.1 Learning Outcomes:**

Upon completion of this unit learners should be able to:

Explain the management of patients with problems of the female reproductive system.

**6.2 Assessment Criteria:**

* Explain the gynaecological assessment of the female client.
* Identify the diagnostic measures used to determine alteration in female reproductive function and describe the nurse’s role before, during, and after these examinations
* Explain the nursing management of a patient having the following gynaecological problems utilizing the nursing process; menstrual disorders, abortions, ectopic pregnancy, fistulas, cancers of reproductive organs, infertility, menopause, rape and surgical interventions such as mastectomy, hysterectomy and laparotomy.

**6.3 INTRODUCTION**

Common problems of the female reproductive system include those that affect the vagina, cervix, uterus, fallopian tubes, and breasts.

|  |
| --- |
| ***Self Activity 6.1*** 1. *Explain the diagnostic measures used to determine alteration in female reproductive function and the nurse’s role before, during, and after these examinations and procedures.*
2. *Discuss the etiology, pathophysiology, clinical manifestations, nursing and medical management and complications of the following menstrual disorders:*
3. *Dysmenorrhoea,*
4. *pre- menstrual tension*
5. *Amenorrhoea*
6. *Menorrhagia*
7. *Metrorrhagia*
 |

**6.4 STRUCTURAL DISORDERS IN WOMEN**

These are structural problems of the reproductive tract experienced by women that result primarily from stretching and weakening of ligaments supporting the uterus or of the muscles of the perineum.

**Types**

* Cystocele
* Rectocele
* Displacement of the uterus

|  |
| --- |
| ***Self Activity 6.2****Read about structural disorders and answer the following questions*1. *Define cystocele, rectocele, and displaced uterus.*
2. *Explain the causes of cystocele, rectocele, and displaced uterus.*
3. *What are the signs and symptoms for cystocele, rectocele, and displaced uterus.*
4. *Discuss the management of cystocele, rectocele and displaced uterus.*
 |

**6.5 ABORTION**

**6.5.1 Definition of Abortion**

Abortion is the death and expulsion of the fetus from the uterus either spontaneously or by induction before 22 weeks gestation.

* Early abortion : occurs before 12 weeks of gestation
* Late abortion : from 12 to 22 weeks

|  |
| --- |
| ***Self Activity 6.3: Group presentations****.**Discuss the causes, clinical manifestations, nursing and medical management and complications of the following types of abortions:*1. *Spontaneous abortion*
2. *Threatened abortion*
3. *Inevitable abortion*
4. *Complete abortion*
5. *Incomplete abortion*
6. *Legal abortion*
7. *Illegal abortion*
8. *Missed abortion*
9. *Habitual or recurrent abortion*
10. *Unsafe abortion*
11. *Septic abortion*
 |

**6.5.2 Incidence of Abortions**

Forty to fifty million abortions are performed every year worldwide and twenty million are unsafe abortions. In Malawi complications from spontaneous and induced abortions are a threat to women's health. They account for 60% of acute gynecological admissions and 30% of maternal mortality. Adolescents comprise a large percentage of women presenting with complications of unsafe abortions.

|  |
| --- |
| ***Self Activity6.4****1. What is the estimated number of abortions that take place worldwide on a daily basis?**2. What percentage of abortions takes place in the developing world?**3. What are the three signs or symptoms of incomplete abortion?**4. What are the three presenting complications frequently seen with incomplete abortion?**5. Which three of the following stages of abortion require removal of retained products of conception: threatened abortion, incomplete abortion, inevitable abortion, missed abortion, complete abortion?**6. What are five individual risk factors for abortion?**7. What are five community risk factors for abortion?**8. What are five health services risk factors in relation to abortion?**9. When taking a history from a possible abortion patient, what specific information must you asks for?* |

**6.5.3 Post- Abortal Care**

Post-abortion care is the care given to a woman who has had an unsafe, spontaneous or legally induced abortion. It consists of the following components:

* Emergency treatment of complications from a spontaneous or unsafe induced abortion
* Family planning counseling and services
* Access to comprehensive reproductive health care, including screening and treatment for STI, RTIs and HIV/AIDS
* Community education to improve reproductive health and reduce the need for abortion.

|  |
| --- |
| ***Self Activity 6.5**** 1. *Discuss the role of a nurse/midwife in post abortal care.*
	2. *Discuss factors that promote or hinder utilization of family planning services*
 |

**6.5.3.1 Manual Vacuum Aspiration (MVA)**

 MVA is a simple, cost-effective procedure involving the use of suction to remove tissue and blood through a cannula and into a syringe. The procedure is highly effective in removing retained products of conception from the uterus and is associated with a low complication rate. It is an effective method of treatment for uterine sizes up to 12 weeks LMP (i.e. 12 weeks from the first day of the last menstrual period). MVA does not require a general anaesthetic and can be performed in an examination or procedure room, rather than in an operating room.

MVA relies on a suction source, or aspirator, which applies suction via a cannula. There are various types of aspirators. These include large syringes with different types of values to control the suction, foot pumps, and electric pumps. Collectively these devices are called aspirators. The word aspirator in this manual therefore refers to any type of the above.

Certain serious complications resulting from unsafe abortion, such as shock, uterine perforation or sepsis must be identified and treated before uterine evacuation is attempted. It is also contraindicated in large fibroids.

**6.5.3.2 Complications and risks of MVA**

MVA has very low risk of complications if performed by a competent provider

Early complications (during procedure and 28 days post procedure) can include perforation of the uterus, injury to the cervix, bleeding, abdominal and pelvic infection

**6.5.3.3 Clients that require referral**

* Documented cardiac conditions and asthma patients
* Patients on anticoagulant therapy or history of bleeding tendencies
* Second trimester terminations
* Suspected abortion complications
* Anemia
* Patients who require general anesthesia
* Evacuation

**6.5.3.4 Post-abortal Counseling**

All clients must be counseled after the MVA procedure or before they are discharged from the hospital to ensure that they are informed about the normal recovery, danger signs and about family planning. The health care provider should ask the woman/young lady whether she wants to become pregnant again soon, if she has used any family planning method before, any problems encountered while using it and if she has a preferred method.

**6.5.3.5 Normal Process of Recovery**

Bleeding slowly disappears after abortion, and blood stained discharge ceases after 5-21 days. It is common for bleeding to stop for 2-3 days, and then start to bleed for 2-3 weeks.

Clients should preferably not use tampons until the bleeding stops to prevent ascending infection and to allow lochia to drain. There may be little abdominal pains, cramping or discomfort in the first 24 hours, particularly after 2nd trimester abortion. Client may experience breast tenderness, fullness or discomfort from about the third day.

**6.6 ECTOPIC PREGNANCY**

Ectopic pregnancy refers to any pregnancy occurring outside the uterine cavity. It is often caused by damage to the fallopian tubes.

The most common site of extra uterine implantation is the fallopian tube (97.7%), but it may occur in the abdominal cavity (1.4%) and in the ovary or cervical canal (less than 1%).

The fetus cannot survive, and often does not develop at all in this type of pregnancy.

**6.6.1 Predisposing factors**

An ectopic pregnancy is often caused by a condition that blocks or slows the movement of a fertilized egg through the fallopian tube to the uterus. This may be caused by a physical blockage in the tube by hormonal factors and by other factors, such as smoking.

**Causes of ectopic pregnancy**

* Past ectopic pregnancy
* Past infection in the fallopian tubes
* Previous surgery of the fallopian tubes
* Previous history of pelvic inflammatory disease
* IUCD
* Birth defects of the fallopian tubes
* In a few cases, the cause is unknown.

#### 6.6.2 Diagnosis

#### Tubal pregnancy can present in many ways and misdiagnosis is very common.

**Low back pain**

* Stabbing or cramp-like ‘uterine colic’.
* Shoulder pains caused by diaphragmatic irritation from hemoperitoneum which stimulates the phrenic nerve.
* Pain may be so severe as to cause fainting.

**Vaginal bleeding**

* Usually occurs after the death of ovum and is an effect of oestrogen withdrawal.
* Dark brown and scanty (vaginal spotting)
* 25% of tubal pregnancies present without any vaginal bleeding.

 **Internal blood loss** will, if gradual, lead to anemia. If a large blood vessel is eroded the usual signs of collapse and shock will appear.

If the area of the abnormal pregnancy ruptures and bleeds, symptoms may get worse. They may include:

* Feeling faint or actually fainting
* Intense pressure in the rectum
* Pain that is felt in the shoulder area
* Severe, sharp, and sudden pain in the lower abdomen

Internal bleeding due to a rupture may lead to low blood pressure and fainting in around 1 out of 10 women.

#### Exams and Tests

The health care provider will do a pelvic exam, which may show tenderness in the pelvic area.

Tests that may be done include:

* Culdocentesis
* [Pregnancy test](http://www.nlm.nih.gov/medlineplus/ency/article/003432.htm)
* [Quantitative HCG blood test](http://www.nlm.nih.gov/medlineplus/ency/article/003510.htm)
* [Serum progesterone level](http://www.nlm.nih.gov/medlineplus/ency/article/003714.htm)
* [Transvaginal ultrasound](http://www.nlm.nih.gov/medlineplus/ency/article/003779.htm) or [pregnancy ultrasound](http://www.nlm.nih.gov/medlineplus/ency/article/003778.htm)
* [White blood count](http://www.nlm.nih.gov/medlineplus/ency/article/003643.htm)

A rise in quantitative HCG levels may help tell a normal (intrauterine) pregnancy from an ectopic pregnancy. Women with high levels should have a vaginal ultrasound to identify a normal pregnancy.

Other tests may be used to confirm the diagnosis, such as:

* Dilatation and Curettage
* Laparoscopy
* Laparotomy

|  |
| --- |
| ***Self Activity 6.6****Discuss the preoperative and post operative care of a woman going for salpingectomy*  |

#### 6.6.3 Management

An ectopic pregnancy cannot continue to term as such the developing cells must be removed to save the life of the woman. She will need emergency medical and surgical help if the area of the ectopic pregnancy ruptures. The rupture can lead to shock, which is an emergency condition and the management would include:

* Blood transfusion
* Intravenous fluids
* Keeping warm
* Oxygen therapy
* surgery - to stop blood loss.

Nearly all ruptured ectopic pregnancies require surgical treatment which can either be radical or conservative.

* Radical
	+ Salpingectomy with or without oophorectomy
	+ Hysterectomy
	+ Laparotomy (especially in abdominal pregnancy)
* Conservative
	+ Salpingostomy
	+ salpingotomy
	+ Segmental resection (partial salpingectomy)
* A minilaparotomy and laparoscopy are the most common surgical treatments for an ectopic pregnancy that has not ruptured.

#### 6.6.4 Prognosis

#### One-third of women who have had one ectopic pregnancy are later able to have a baby however repeated ectopic pregnancy may occur in one-third of the women. Some women do not become pregnant again.

The likelihood of a successful pregnancy depends on:

* The woman's age
* Type of surgical treatment
* Cause of the first ectopic pregnancy

#### 6.6.5 Possible Complications

The most common complication is rupture with internal bleeding that leads to shock. Death from rupture is rare.

#### 6.6.6 When to Contact a Medical Professional

If you have symptoms of ectopic pregnancy especially lower abdominal pain or abnormal vaginal bleeding

#### 6.6.7 Prevention

Most forms of ectopic pregnancy that occur outside the fallopian tube are probably not preventable. However, a tubal pregnancy (the most common type of ectopic pregnancy) may be prevented in some cases by avoiding conditions that might scar the fallopian tubes.

The following may reduce the risk:

* Avoid risk factors for pelvic inflammatory disease (PID) which includes multiple sex partners, un protected sex and getting sexually transmitted infections(STIs)
* Early diagnosis and treatment of STIs
* Early diagnosis and treatment of salpingitis and PID
* Stop smoking

**6.7 MENOPAUSE**

**6.7.1 Description of Concepts**

**Menopause** is a normal and natural phase in every woman’s life. It can be described as a natural series of gradual changes that mark the end of the woman’s reproductive years. Menopause is a significant change in a woman’s life, but it is neither an illness nor a state of mind.

The word menopause is derived from two Greek words mens (month) and pausis (to stop). It the permanent cessation of menstruation caused by failure of ovarian follicular development and estradiol production in the presence of elevated gonadotropin levels.

It is associated with some atrophy of breast tissue and genital organs, loss in bone density, and vascular changes. Menopause starts gradually and is usually signaled by changes in menstruation. The monthly flow may increase, decrease, become irregular, and finally cease. Often, the interval between periods is longer; a lapse of several months between periods is not uncommon.

Changes signaling menopause begin to occur as early as the late 30s, when ovulation occurs less frequently, estrogen levels fluctuate, and FSH levels rise in an attempt to stimulate estrogen production.

The mean age of menopause is 51 but tends to occur earlier in more disadvantaged societies. It can also occur before the age of 51years after total hysterectomy or oopherectomy.

Ignorance about menopause sometimes lead to anxiety and stress, because women are not prepared for, and do not understand this important transition phase in their lives.

**Climacteric**

**C**limacteric is the physiological period in a woman’s life during which there is regression of the ovarian function. It starts approximately at 35 years of age and continues until the ability to reproduce no longer exists.

**Pre-menopause** is the transition between fertility and the last menstrual period

**Post-menopause** the years after the end of menstruation

|  |
| --- |
| ***Self Activity 6.7***1. *Explain the causes of menopause*
2. *Explain the physiology of menopause*
3. *Explain the clinical manifestations of menopause*
4. *Explain the effects of menopause on the systems of the body*
5. *Discuss the management of a menopausal client*
 |

**6.7.2 MANAGEMENT OF MENOPAUSE**

**HORMONAL REPLACECEMENT THERAPY**

In some women menopausal symptoms can be severe, but many of these women still find it difficult to seek health care when they experience these symptoms. In many cases, simple reassurance and information is enough, although some women will need medical intervention to address health concerns. In many cases the symptoms are still treated in isolation without providing the necessary information on menopause.

Hormonal replacement therapy (HRT) can be used successfully for the more troublesome symptoms of menopause. It should, however, only be prescribed after careful screening, to exclude health risks to hormonal replacement treatment.

|  |
| --- |
| ***Self Activity 6.8****Explain the contraindications and risks of HRT* |

**COUNSELLING**

It is important for women to be prepared for this stage in their lives because understanding these changes may make it easier for them to accept the inevitable, and cope with it more effectively.

|  |
| --- |
| ***Self Activity 6.9 :*** ***Case scenarios****Mrs. Umi, 50 years old cashier, complains of hot flashes 2 or 3 times a day over the past month. She feels tired most of the day due to lack of sleep. Her symptoms make her lose concentration at work. She feels tired most of the day due to lack of sleep. She states that she has been having irregular menstrual cycle, and the last menses were two months ago. On examination she looks tired, temperature is 36 degrees Celcius, blood pressure 130/82 mm Hg, pulse rate 80 beats per minute, respirations are 18 breaths per minute.* 1. *Explain the assessment of Mrs. Umi*
2. *Discuss the management of Mrs. Umi*

*Mrs Umi lives with her daughter who reports that her mother is moody and has been criticizing everything the daughter has been doing for the past two months.*1. *Demonstrate a role play where counseling of Mrs Umi and the daughter will be done.*
 |

**6.8 INFERTILTY**

The ability to reproduce is a highly valued part of people’s existence and an important part of ovulation. The ability to have children is at times taken for granted however failure to reproduce children can lead to social disgrace and divorce because in many cultures children are a sign of wealth. Ten to twenty percent of couples in the world suffer from infertility. In Africa this rate may be as high as 20-30% in some areas, and vary from region to region even within the same country. Malawi has a primary infertility rate of 2%, and a much higher secondary infertility rate of 17% of couples between 20 and 44 years old.

**6.8.1 Definitions**

* **Infertility:** is the inability of couples of reproductive age to establish a pregnancy by having sexual intercourse within a period of one to two years. Demographers usually use a longer period of five to seven years in their definition of infertility. Infertility can be primary or secondary.
* **Primary infertility:** the woman has never conceived or given birth to a live child.
* **Secondary infertility:** the woman has given birth at least once, and subsequently becomes infertile.
* **Sterility:** Implies the absolute inability of a couple to conceive.

**6.8.2 Components of fertility**

Understanding the elements essential for normal fertility can help the nurse identify the main factors that may cause infertility. The following components must be present for normal fertility.

**Female Partner**

* The cervical mucus must be favorable to the survival of spermatozoa and allow passage to the upper genital tract
* The fallopian tubes must be patent and have no fimbria with peristaltic movement toward the uterus to facilitate normal movement and interaction of ovum and sperm.
* The ovaries must produce and release normal oval in a regular cyclic fashion
* There must be no obstruction between the ovaries and the uterus
* The endometrium must be in a health state and physiologically allow implantation of the blastocyst for growth and development.

**Male partner**

* The testes must produce spermatozoa of normal quality/quantity and motility,
* The male genital tract must not be obstructed
* The male genital tract secretions must be normal
* Ejaculated spermatozoa must be deposited in the female vagina in such a manner that they reach the cervix

|  |
| --- |
|  ***Self Activity 7*** 1. *Discuss the causes of infertility*
2. *Explain the assessment that would be carried out on infertile couple to evaluate infertility*
3. *Explain the treatment options in infertility*
4. *Explain the prevention of infertility*
5. *Discuss the complications that are associated with infertility treatment*
6. *Explain the possible reasons for high infertility rates in Africa.*
 |

**6.8.3 CAUSES OF INFERTILITY**

The exact cause of infertility varies among different populations and cannot be precisely determined but it includes the following:

* Ovulatory disorders
* Tubal disorders
* Endometriosis
* Male factors
* Unexplained factors (10 - 20% of the infertility cases)

**6.8.4 Psychological Aspects of infertility**

Infertility can cause severe mental trauma and its management requires insight, sympathy, compassion and tact. Infertile clients of both sexes have more neuroticism, dependency, anxiety, hostility and emotional instability as such counseling is integral to the total management of an infertile couple.

|  |
| --- |
| ***Self Activity 7.1*** 1. *Explain the following causes of infertility in females*
2. *Ovulation*
3. *Tubal causes*
4. *Uterine*
5. *Cervical and Vaginal causes*
6. *Sexual dysfunction*
7. *Explain the following causes of infertility in males*
8. *Congenital causes*
9. *General illness and drugs*
10. *Obstruction*
11. *Failure to deposit sperms*
12. *Sexual dysfunction*
13. *Discuss the psychosocial effects of infertility*
14. *Compare the burden of infertility between male and female clients*
 |

**6.9 OBSTETRIC FISTULA**

Obstetric fistula is a hole that develops between the vagina and the bladder or vagina and the rectum of a woman or girl after child birth. A fistula is caused by prolonged and obstructed labour when the head of the baby cannot pass safely through the birth canal of the mother. The constant pressure of the baby’s head inside the mother causes ischemia of the affected area which eventually tears off and creates a hole. As a result the woman passes urine and/ or faeces continuously through the vagina. The prolonged labour can also cause some neurological damage to the legs making it impossible for some girls and women to walk.

Fistulas are a common occurrence in the developing world. It is estimated that more than 2 million young women live with untreated Obstetric Fistula. It is estimated that between 50 000 to 100 000 new women are affected each year. Fistulae cause girls and women to live with a constant smell and wetness of faeces and urine. The constant wetness can also lead to ulceration of the genital area and the woman suffers severe humiliation and isolation. Studies from Africa show that fistula often results in divorce and abandonment leaving the women in a position that makes it extremely hard to attain social, psychological and economic security.

|  |
| --- |
| ***Self Activity* *7.2 :* *Case scenario*** *Tiyamike Tambula fifteen years old, married, delivered a dead baby by caesarean section 6 months ago after experiencing prolonged labour at a Traditional Birth Attendant (TBA).**Since delivery she has been experiencing urinary incontinence, foul smell and is isolated by friends and relatives.**On assessment, she is anxious, and dehydrated. A diagnosis of Vesical vaginal fistula (VVF) is made and has been scheduled for surgery.*1. *Explain the pathophysiology of the presenting clinical manifestations.*
2. *Explain the factors that contributed to the development of VVF.*
3. *Discuss the nursing management of Tiyamike Tambula.*
4. *Discuss complications of VVF repair.*
5. *Discuss appropriate strategies/ initiatives on how the problem of fistula can be or is being dwelt with in Malawi*
 |

**7.0 BREAST CANCER**

**7.1 Description of Breast Cancer**

The cause of breast cancer is poorly understood despite current extensive investigations; nevertheless breast cancer develops when there is uncontrolled growth of malignant tissue in the breast. It starts when a single cell doubles in size every three days (in fast growing tumours) or up to 240 days (in slow growing tumours).

**Breast tumour**

Is a lump found in the breast tissue. A tumour can be an overgrowth of body cells, which form a lump of tissue

**Types of tumours**

1. **Benign**: Not life threatening , can be easily removed and tend not to recur. The size and the position of the tumour may cause some pain and discomfort and should always be investigated.
2. **Malignant**: Life threatening, capable of spreading within the body in various ways i.e.
* Spread to the draining lymph nodes (usually in the armpit) where it may cause swelling or an ulcer that may get infected. It may also cause swelling of the arm due to blockage of the lymph vessels or the veins of the arm. It may also spread to the lymph nodes above the collar bone, the other armpit, or onto the chest.
* With time the cancer may spread in the blood stream to other vital organs such as the brain, lungs, liver and bones, where it will form space occupying lesions that will eventually destroy the host organ.
* It is the effects of metastases in the vital organs that usually lead to mortality.

**7.1.1 Risk factors**

Epidemiologists have documented some risk factors that provide clues in understanding the pathophysiology of the disease development in certain high risk groups of women. Risk factors simply mean that if one or more of these factors are present in a woman, they appear to increase the likelihood of her developing breast cancer.

|  |
| --- |
| ***Self Activity 7.3***1. *Explain the following risk factors of breast cancer*
	1. *Family history of breast cancer.*
	2. *Previous history of breast cancer.*
	3. *Diet high in animal fat.*
	4. *Smoking*
	5. *Radiation*
	6. *Age*
	7. *Prolonged use of Hormonal Replacement Therapy with high dosage.*

*2. Explain the warning signs of breast cancer.* |

**7.1.2 Breast Self-Examination (BSE)**

Ninety percent of breast tumours are discovered by women themselves. Although this does not mean that breast cancer can be prevented, it means that the cancer can be treated early, before the cancer can spread to other parts of the body.

* + 1. **Why BSE**?
* It is a straight forward examination that can be done by any woman.
* Although there is no scientific evidence that breast examination can reduce mortality, women notice 9 out of 10 breast lumps. They are therefore able to screen for abnormalities- even if it is benign tumours.
* Breast cancer is more easily treated and cured when it is detected early.
* Raise awareness of SRH, and good health seeking behaviour.

**7.1.4 When should it be done?**

* The best time for breast self-examination is + or – 3-10 days after the last day of menstruation, when the breasts are not tender and swollen.
* Post –menopausal women or women not menstruating can do it any time of the month. Do it the same time every month to maintain the habit.
	+ 1. **How should it be done?**
1. Stand in front of a mirror with the arms relaxed at the sides and observe the breasts. Repeat with the arms stretched above the head and with the hands on the hips. Observe for:
* Changes in size and shape of the breast.
* Swelling of the upper arm or in the armpit.
* Dimpling of the skin.
* Discharge, bleeding or skin eruption from and around the nipple.
* Retraction of the nipple (can be normal in some cases).
1. Lie down with one arm behind the head, and a pillow under the shoulder of the breast being examined (helps to spread the breast tissue and makes it easier to examine). Think of the breast being divided into four quarters of a circle.
* Use the finger pads of the free hand, and gently feel the breast, moving round in small circles until each quarter of the breast has been covered. Press firmly enough to feel for abnormalities.
* Examine the armpit in a similar manner, starting in the hollow of the armpit and working towards the breast. The breast extends into the armpit region where there is a collection of lymph nodes (small glands about the size of a bean).Lymph acts as a defence against disease, and swelling indicates that it is reacting to an abnormality.
* Repeat the same procedure on the other breast. If something is felt in one breast compare with the other breast to make sure it is not just the way the breast tissue feels.
* Now gently squeeze behind each nipple, using the thumb and index finger, and check for any fluid expressed from the nipple.

If any abnormalities are found, contact a health professional for further investigation. Even if lumps are not malignant they must be investigated to ensure early intervention.

**7.1.6 Diagnostic measures**

Once a lump is felt, a doctor may suggest any one of the following tests to make a diagnosis for treatment:

* **Mammography.** A breast x-ray that can detect breast cancer- often before it can be felt during breast self- examination.
* **Needle aspiration.** A quick and simple procedure done in out patients. The doctor takes a sample of cells from the breast using a fine needle and syringe. The sample is sent to the laboratory for testing.
* **Needle Biopsy.** A procedure done under local anaesthetic that numbs the area. The needle used is larger than the one used for aspiration. A small sample of tissue is taken from the lump (biopsy), and sent to the laboratory for testing.
* **Excision Biopsy.** The whole lump with the surrounding margin of the normal tissue is removed under general anaesthetic. It requires hospital admission.

**7.1.7 Treatment**

**Surgery**

* **Lumpectomy:** Removal of the breast lump together with the surrounding tissue. Usually remove the least amount of breast tissue and usually gives a good cosmetic result.
* **Segmentectomy:** Similar to lumpectomy but more breast is removed. It is more noticeable especially in women with smaller breasts.
* **Mastectomy:** Simple mastectomy (removal of the breast tissue of the whole breast), or radical mastectomy (removal of the whole breast and the muscles of the chest wall).

**Radiotherapy**

* Use of high energy rays which destroy cancer cells.
* Side effects include: Reddening (weeping of the skin) and tiredness.

**Chemotherapy**

* Special anti-cancer drugs, given orally or by intra-venous injection.
* The drugs interrupt the growth and division of the cancer cells and in the process destroy cancer cells.
* Side effects include: nausea, vomiting, diarrhoea, hair loss, mouth ulcers.

**Hormone therapy or treatment with Tamoxifen**

* Tamoxifen is a synthetic anti-oestrogen drug used as an oestrogen repressor (to block the effect of oestrogen).
* Side effects include: irregular periods, hot flushes or sweats, (usually stops after a few days), upset stomach, increased pain at first, weight gain.
* Most women using Tamoxifen experience no side effects.

|  |
| --- |
| ***Self Activity 7.4*** *Utilizing the nursing process explain the nursing management of a client who has undergone mastectomy*  |

**7.1 CERVICAL CANCER**

**7.1.1 Definition**

**Cervical cancer** is malignant neoplasm of the cervix uteri or cervical area or abnormal, uncontrolled growth of abnormal cells of the cervix.

**7.1.2 Incidence**

Currently cervical cancer is most prevalent in areas where no effective screening has been established. This mostly occurs in the developing world where lack of resources and medical infrastructure prevents successful screening activity. Worldwide, an estimated 400,000 women develop cervical cancer each year. The disproportionate impact of cervical cancer morbidity and mortality in developing countries is enormous, with less than 5% of women receiving screenings. Almost 80% of all cervical cancer cases occur in these developing countries. The areas of greatest incidence include sub-Saharan Africa, Latin America, Caribbean, and Southern Asia. In countries with organized screening programs the development of invasive cancer has been reduced greatly, however, these programs have been difficult to replicate in low-resource settings.

Most women who die from cervical cancer, particularly in the developing countries are in their prime of their life. Their death is both a tragedy, sad and unnecessary loss to their family and their community. Unnecessary, because there is compelling evidence that cervical cancer is one of the most preventable and treatable forms of cancer, as long as it is detected early and managed effectively.

**7.1.3 Progression of Cervical Cancer**

1. **The Normal cervix** becomes infected with a high –risk type of HPV resulting in HPV related changes in the cells. The HPV infection can be cleared spontaneously, remain stable, or progress to low grade dysplasia.

There is no treatment to eradicate HPV. Use of condoms offers some protection although it does not cover the whole anogenital area.

**2. Low-Grade Squamous Intraepithelial Lesion (LSIL).** This is usually transient, and about 60% will return to normal (regress) within 2 to 3 years. About 15% will progress to HSIL within 3-4 years. The general consensus is that co-factors must be present for this progression to occur e.g. smoking, recurrent STIs, HIV infection, etc.

These lesions are usually closely monitored rather than treated, since most lesions regress spontaneously. Mostly appears between the ages 25-35 years.

3. **High-Grade Squamous Intraepithelial Lesion (HSIL).** The majority of women with HSIL will develop invasive cancer within 10-15 years, although the progress of the disease may be more rapid when the woman is HIV positive. HSIL should be investigated and treated, because a significant proportion progress to invasive cancer. (Severe dysplasia is most common in women between the ages of 30 and 40 years).

**4. Invasive Cancer.** Treatment for this condition is expensive, and often not effective in the advanced stages. With an effective screening programme abnormal cell changes will be identified long before this stage.

During the pre-invasive stage of the disease when the cancer cells begin to grow and change, the woman will experience no pain, and there will be no symptoms to indicate cell changes. **If the abnormal cells are identified at this stage, it can be treated easily and successfully.**

During the invasive stage of the disease the symptoms of the disease will appear e.g. abnormal bleeding. It will now be more difficult and expensive to treat.

 **7.1.4 Risk factors**

|  |
| --- |
| ***Self Activity* 7.5**1. *Explain the risk factors of cervical cancer.*
2. *Explain the clinical manifestations of cervical cancer*.
 |

**7.1.5 Relationship between Cervical Cancer and HIV**

* There is a higher HPV prevalence rate in HIV positive women, and a greater incidence of pre-cancerous lesions. The lesions are more aggressive, progressive, persistent, more likely to occur in young women, and more likely to recur when treated.
* Cervical cancer is considered an important AIDS related disease in women, and since 1993 considered an AIDS defining illness in women infected with the HIV virus.
* Several studies found that the prevalence of dysplasia among HIV infected women ranges from 31% to 63% and HIV positive women are almost 5 times likely to present with dysplasia than HIV negative women.
* Recent research suggests that Vit A deficiency in HIV positive women may play a role in the development of squamous intraepithelial lesions (SIL).
* Shorter and different screening intervals are suggested for HIV –positive women (pap smears every six months, and referral of atypia or dysplasia for colposcopy).HIV women may however succumb to other HIV- related opportunistic infections before cervical cancer of the cervix develops.
* Recent research has shown a dramatic increase in HIV shedding in HIV –positive women treated for pre-cancerous lesions, highlighting the importance of abstaining from sexual intercourse while the cervixheals, to reduce the risk of transmitting the HIV to the partner.

**7.1.6 Cervical Cancer Screening**

‘Screening’ is defined as the presumptive identification, by a simple test, of unrecognised disorders in individuals who are asymptomatic.

 **Cervical Cancer Screening Methods**

**The Pap smear**

The most common screening method for cervical cancer is cervical cytology (using the Pap smear).

A Pap smear is a painless, simple, quick, and harmless test to check for abnormal cells of the cervix.

**Taking a Pap smear**

A speculum is inserted into the vagina to enable the health provider to observe the cervix for abnormalities. Cells are then scraped from the cervix with an Aylesbury spatula, and smeared onto a glass slide. The glass slide is then sent to the laboratory where the cells will be examined under the microscope to identify abnormalities or cancer.

|  |
| --- |
| ***Self Activity 7.6*** 1. *Visit the family planning clinic and observe how a Pap smear is taken*
2. *Describe the Pap smear collection procedure*
3. *Explain the following categories of abnormal Pap smear results;*
4. *atypical squamous cells*
5. *low grade squamous intraepithelial lesions*
6. *high-grade squamous intraepithelial lesions.*
 |

**Visual Screening Methods**

In a visual test, the provider applies acetic acid (in VIA) or Lugols iodine solution (in VILI) to the cervix, and then looks to see if there is any staining. A VIA test is positive if there is a raised and thickened white plaques or acetowhite epithelium; a VILI test is positive if there are mustard or saffron-yellow coloured areas, usually near the squamo-columnar junction (SCJ). Either test is suspicious for cancer if a cauliflower-like fungating mass or ulcer is noted on the cervix. Visual screening results are negative if the cervical lining is smooth, uniform and featureless; it should be pink with acetic acid and dark brown or black with Lugol’s iodine.

|  |
| --- |
| ***Self Activity 7.7 :***1. *Visit the family planning clinic and observe how VIA is done*
2. *Outline the materials and equipment needed for VIA*
3. *Describe the procedure for performing VIA.*
 |

**7.1.7 Prevention of Cervical Cancer**

Cervical cancer is a preventable disease. Without early detection and treatment, 30-70% of women with high grade pre-cancerous lesions will develop cervical cancer within 10 years.

**Women can prevent cervical cancer if they:**

* Delay the onset of sexual activity as long as possible.
* Have regular Pap smears according to the National policy and guidelines to detect abnormal cervical cells. They must follow up on the results of the Pap smear, and go for treatment as recommended by the doctor or nurse (based on the protocol for Abnormal Pap Smear Results).
* Have one faithful and uninfected sexual partner and be faithful to that partner.
* Use condoms with every sexual act. It protects the woman against unwanted pregnancy as well as STI and HIV infection. It also reduces her exposure to the HPV virus, which is linked to the development of cervical cancer.
* Get early treatment for STIs, and use the treatment as prescribed by the health care provider.
* Don’t smoke.
* Good health seeking practices. Motivate clients to access available health services for information and early treatment.

**7.1.8 Diagnostic measures**

1. **Cone biopsy**

The procedure can be used for diagnosis and treatment.

**Cold knife conization**

It is the removal of a cone –shaped area from the cervix, including portions of the outer (ectocervix) and inner cervix (endocervix). It is usually used to establish a diagnosis of cervical cancer, before performing surgery or initiating radiation therapy. The procedure is rarely used as a sole treatment for the disease, unless a woman wants children and the microscopic amount of cancer present hasn’t spread beyond the cervix. Conization involves the removal of a large area of the cervix with a scapel, and is done under general or regional anaesthesia. The procedure takes an hour and the patient may be discharged the same or next day. Because of possible side effects, cold knife conization should be reserved for cases that cannot be resolved with cryotherapy or LEEP exclusion. The extent of the conization depends on the size of the lesion and the likelihood of finding invasive cancer. The woman’s desire to have more children should also be taken into consideration, as conization may result in cervical stenosis or incompetence in a few women. The tissue removed is sent to the laboratory for histological diagnosis and to ensure that the abnormal tissue has been completely removed.

Cold knife conization is performed by providers with surgical skills, in an equipped surgical facility. It is usually done by surgeons and gynaecologists trained to perform the procedure.

|  |
| --- |
| ***Self Activity 7.8***1. *Outline the indications and exclusion criteria for cold knife conization.*
2. *Discuss cold knife conization procedure*
 |

**2. Colposcopy**

Examination of the cervix with a low powered microscope (colposcope) which magnifies the image. The cervix is painted with a 3-5% acetic acid solution, swabbed, and then observed. Abnormal areas will be stained white by the acetic acid, while the normal areas will stay pink. Where the entire lesion cannot be visualised, the patient will be booked for a cone biopsy in the theatre.

The procedures may cause cramping and a watery discharge that may last for several weeks. Regular follow- up is important to monitor the condition. Some clients may require some additional radiation therapy or chemotherapy afterwards. Women with advanced cancers often require combinations of surgery, radiation and chemotherapy.

**7.1.9 Treatment Options for Cervical Cancer**

Treatment for cervical cancer will depend on:

* How early the cervical cancer is diagnosed.
* Location of the tumour within the cervix
* Tumour type
* Age of the woman
* General health
* Child bearing plans or whether or not the woman is pregnant.
1. **Chemotherapy**

Chemotherapy is the killing of cancer cells using cytotoxic drugs. It is the treatment of choice for cancer that has spread too far from its origin to be treated by surgery or radiation, or cancer that recur after surgery or radiation therapy. Chemotherapy may also be used to relieve pain associated with advanced cervical cancer, or to shrink cancer tumours to an operable size before surgery is performed.

1. **Radiation Therapy**

It Uses high energy x-rays to destroy cancer cells. Cancer that extends beyond the cervix into the pelvis, lower vagina, and urinary tract, typically receive radiation.

1. **Cryotherapy**

It is the freezing of the abnormal cells or tissues of the cervix by using a low-temperature metal probe cooled with liquid nitrogen. It is used to treat cancer that has not yet penetrated the deep layers of the cervical tissue, or spread beyond the cervix. It takes only 3 to 4 minutes and it causes some cramping for a few days. Some women experience a watery discharge for about 2-4 weeks.

|  |
| --- |
| ***Self Activity 7.9***1. *Outline the material and equipment used in cryotherapy.*
2. *In your groups discuss the procedure for cryotherapy.*
3. *Explain the follow- up care for post cryotherapy.*
 |

1. **Surgery**

Surgery is effective and has a survival rate of 85% to 90%.

1. **Loop Electrosurgical Excision Procedure (LEEP)**

LEEP is the removal of abnormal areas from the cervix, using a thin wire heated with electricity under anaesthesia. It is used to treat cancer that has not spread beyond the area where it originated. It is successful in treating cancer in 9 out of 10 women. Post operatively the woman may experience some cramping for several days. Discharge and bleeding may occur for up to six weeks and may require additional treatment. The method is 90-95% effective in treating high-grade dysplasia.

|  |
| --- |
| ***Self Activity 8***1. *Outline the material and equipment for LEEP*
2. *In your groups discuss how LEEP is performed.*
3. *Describe the complications of LEEP and their management*
 |

1. **Hysterectomy**

Hysterectomy is the removal of the uterus. Women with later stage cancers usually receive radiation treatment and hysterectomy is usually considered as the primary treatment. Hysterectomy may: preserve ovaries and vagina, reduce the treatment time, and allow for a more thorough examination of the cancerous lesions.

|  |
| --- |
| ***Self Activity 8.1***1. *Discuss the pre and post- operative care of a client going for hysterectomy.*
2. *Explain the complications of hysterectomy.*
 |

**UNIT 7**

 **NURSING MANAGEMENT OF PROBLEMS OF THE MALE REPRODUCTIVE SYSTEM**

**7.1 Learning Outcomes**

* Review the anatomy and physiology of the male reproductive organs
* Explain the pathophysiology of the clinical manifestations.
* Identify the diagnostic procedures used to determine alteration in male reproductive function.
* Describe the nurse’s role before, during, and after the diagnostic procedures.
* Discuss the nursing management of the following male reproductive system disorders; Benign prostrate hypertrophy, hydrocele, prostate cancer and andropause

**7.2 Assessment Criteria**

* Explain the clinical manifestations of the male RH disorders.
* Explain the diagnostic procures used to determine alteration in male reproductive function
* Describe the nurse’s role before, during, and after the diagnostic procedures.
* Explain the nursing management of the following male reproductive system disorders: benign prostrate hypertrophy (BPH), hydrocele, prostate cancer, and andropause

|  |
| --- |
| ***Self Activity 8.2***1. *Explain the diagnostic procedures used to determine alteration in male reproductive function.*
2. *Explain the nurse’s role before, during, and after the diagnostic procedure .*
3. *Explain the pathophysiology of the clinical manifestations of the following: BPH, andropause, hydrocele and prostate cancer*
4. *Discuss the nursing management of BPH, andropause, hydrocele and prostate cancer*
 |

**UNIT 8: SEXUALLY TRANSMITTED INFECTIONS**

**8.1 Learning Outcomes**

* Explain the pathophysiology of the clinical manifestations of the following sexually transmitted infections: gonorrhea, syphilis, genital warts, bubo, PID, candidiasis, chlamydia, trachomoniasis, balanitis, bartholins abscess, scrotal swelling, urethral discharges and chancroid.
* Discuss the nursing management of clients with the above mentioned STIs utilizing the nursing process and syndromic approach.

**8.2 Assessment Criteria**

* Explain the clinical manifestations of gonorrhoea, sphyllis, genital warts, bulbo, PID, candidiasis, chlamydia, trachomoniasis, balanitis, bartholins abscess, scrotal swelling, urethral discharges and chancroid.
* Discuss the nursing management of a client with chancroid, chlamydia , cytomegalovirus, gonorrhoea, hepatitis B, hepatitis C, herpes simplex, HIV infection, Human papilloma virus and syphilis.
* Explain the medical management of a client with chancroid, chlamydia , cytomegalovirus, gonorrhoea, hepatitis B, hepatitis C, herpes simplex, HIV infection, human papilloma virus and syphilis utilizing syndromic approach

**8.3 Introduction**

STIs cause a large proportion of global burden of ill health. There are more than 25 types of STIs but the most widely known are gonorrhea and syphilis. Many of the STIs are curable with effective treatment; nevertheless they continue to be a major public health concern in both industrialized and developing countries. The World Health Organization estimates that, globally, more than 340 million new cases of syphilis, gonorrhea, chlamydia and trichomoniasis occur every year in men and women aged between15–49 years. In Malawi, most of the studies on STI prevalence have been conducted among selected groups such as sex workers, antenatal mothers, prisoners, STI clinic attendees and others. Nevertheless a high prevalence of STIs is found in most population groups even among those considered to be at low risk. A study done at Kamuzu Central Hospital STI clinic revealed that 45% of the clients are HIV positive.

This unit introduces you to various STIs, their clinical manifestations, management utilizing the nursing process and syndromic case management approach.

|  |
| --- |
| ***Self Activity 8.3***1. *Explain the pathophysiology of the clinical manifestations STIs*
2. *Explain the modes of transmission of STIs.*
3. *Explain the factors that increase the risk of STI transmission?*
4. *Identify the Vulnerable populations to STIs*
5. *Explain the management of STIs utilizing the syndromic case management approach.*
 |

**8.4. THE RELATIONSHIP BETWEEN STIs, HIV AND AIDS**

**8.4.1 STIs and the risk of acquiring HIV**

It is essential to treat STIs because most STIs enhance HIV transmission. The risk of sexual transmission of HIV increases 5 to 10 times more in the presence of STIs. It increases the infectiousness of an HIV-positive person as well as the susceptibility of the HIV-negative partner by altering the integrity of the mucosal barriers. This is especially true of the STIs that cause genital ulceration. Herpes ulceration increases the risk five-fold; where-as other STIs double the risk of acquiring HIV disease. Herpes infection is recurrent in nature and cannot be cured. Research has proven that adequate treatment of symptomatic STIs reduces HIV transmission.

**8.4.2 The effect of HIV on STIs**

HIV infection may complicate diagnosis and treatment of other STIs because HIV may change the pattern of disease or clinical manifestations of certain infections and may affect laboratory tests results.

* Syphilis progresses to the secondary stage more rapidly and more often in HIV infected individuals. The other bacterial and protozoal STIs respond as readily to treatment in HIV-infected clients and non-infected individuals.
* As the immune system deteriorates with HIV disease, the ulcers of herpes simplex take longer to heal. Herpes ulceration that persists for several weeks is an AIDS defining condition.
* Human papilloma virus can cause anogenital warts or condyloma accuminata. These

may become quite large and difficult to treat in HIV-positive individuals. Human

papilloma virus is also associated with increased incidence of cervical carcinoma.

**8.4.3 Approaches to STI diagnosis**

1. **The traditional diagnosis of STIs (definite etiology method)**

The method relies on identifying the organism causing the symptoms through sophisticated laboratory facilities. In Malawi such facilities are not readily available as such it places constraints on time, resources and reduces access to treatment.

1. **Sydromic Managemet Approach (SMA), the clinical method**

SMA is based on the fact that most common causes of STIs present signs and symptoms (syndromes) that can be grouped and used as basis for treatment.

**THE SYNDROMIC MANAGEMENT APPROACH**:

SMA is a clinical approach in the management of STIs which depends on the ability of the health care provider to identify and treat a syndrome. Malawi adopted the SMA in 1992 for the management of STIs as recommended by the World Health Organization**.** The approach:

1. Is problem-oriented (it responds to the patient’s symptoms);
2. Is highly sensitive and does not miss mixed infections; treats the patient at the *first* visit;
3. makes STI care more accessible as it can be implemented at primary health-care level;
4. Uses flowcharts that guide the health worker through logical steps; provides opportunity and time for education and counseling.

**Identifying the syndromes**

A number of different organisms that cause STIs give rise to only a limited number of syndromes. A syndrome is simply a group of the symptoms a patient complains about and the clinical signs you observe during examination. The 7 most important STI related syndromes are:

1. Urethral discharge in men

2. Scrotal swelling

3. Vaginal discharge

4. Lower abdominal pain in women

5. Genital ulcer in men or women

6. Inguinal bubo (swelling) without ulcer in men or w omen

7. Balanitis / balanoposthitis in men

**Syndromic flowcharts**

* The syndromes are relatively easy to identify and it is possible to devise a flowchart for each one. A flowchart is a diagram or type of map representing steps to be taken through a process of decision-making.
* A major benefit of the flowcharts is that, once trained, service providers find them easy to use – so non-STI specialists at any health facilityare able to manage STI cases.
* In turn, this means that: you can offer prompt treatment because patients with STIs are

treated at their first visit; many more patients with STIs have access to treatment; there are opportunities for introducing preventive and promotive measures such as education and condom distribution.

**Using the flowcharts**

A flowchart is a diagrammatic map that guides you through a series of decisions and actions you need to make. Each decision or action is enclosed in a box, with one or two routes leading out of it to another box, with another decision or action. Upon learning a patient’s symptoms, you would turn to the relevant flowchart and work through the decisions and actions it suggests.

Each flowchart is made up of a series of three steps:

* The clinical problem – the patient’s presenting symptom at the top– this is the starting point;
* A decision to make, usually by answering "yes" or "no" to a question;
* An action to take: what you need to do (different boxes suggest treatment, education and condom promotion, etc, and patient referral if necessary).

|  |
| --- |
| ***Self Activity 8.4*** * *Turn to the national flowcharts and spend some minutes looking through them (some are more complicated than the others but they work in exactly the same way)*
* *Use the scenarios below to practice on how flow charts work*.

***Scenarios***1. *A male patient complains that he has a sore penis. Upon examination, you can see no discharge, but there is an ulcer on the penis. The sore is large and there is no history of recurrence.*
2. *Which flowchart will be used?*
3. *What will be the treatment of the patient?*
4. *A young woman complains of pain in her stomach, low down. You take her history and examine her. She tells you that her periods are normal and she has never been pregnant. She has no rebound tenderness but clearly feels pain when you palpate her abdomen.*
5. *Which flowchart will be used?*
6. *What action will be taken?*
7. *A week later, the same woman returns. She tells you that she feels no better, though she is taking all the tablets you gave her as you suggested. Upon examination, you discover that she has a temperature of 38.2°C.*
8. *What action do you take now?*
9. *A middle-aged man tells you that he has felt pain in his groin for a week or so. Upon examination, you confirm that he has a painful fluctuating mass in the right groin. The patient winces when the mass is touched. There are no ulcers on his penis.*
10. *Which flowchart will be used?*
11. *What will be the treatment of the patient?*
12. *A woman has come from the postnatal ward to the under five clinic with her four-day-old baby for polio 0 and BCG before discharge. As you attend to the baby you noticed that the eyelids are swollen and there is a purulent discharge in both eyes.*
13. *Which flowchart will be used?*
14. *What will be the treatment of the baby?*
15. *Who else will be treated and for which STI?*
16. *A young man complains of a swollen scrotum. An examination confirms the swelling*

 *but the testis is not rotated or elevated and there is no history of trauma.*1. *Which flowchart will be used?*
2. *What will be the treatment of the young man?*
3. *A young man tells you shyly that he has a discharge from his penis. You ask him to milk the urethra and you confirm that there is some discharge. There are no other lesions or ulcers.*
4. *Which flowchart will be used?*
5. *What will be the treatment of the patient?*
6. *A young woman complains of a sore. Upon examination you notice an*

 *Ulcer on the outer labia which indicates the syndrome of genital ulcer.* *There are two main bacterial causes of genital ulcer: chancroid and* *Syphilis.* *What will the management of the young woman?* |

* + 1. **The control of STIs**

The control of STIs is based on 3 principles:

1. Education of people at risk on modes of transmission of STIs and how to reduce transmission.

2. Effective diagnosis and treatment of patients with symptoms.

3. Detection of STIs in asymptomatic carriers and in people with symptoms who would

 Otherwise not present for consultation.

* STIs are diseases of ignorance as such prevention is based on providing the necessary information to change patterns of sexual behaviour, which put people at risk.
* Every health care provider treating patients with STIs should be able to educate and counsel the patients on the risks of STIs and behavioral choices.
* Patients should be counseled on the methods to use to lower their risk of acquiring STIs e.g. abstinence, careful selection of partners, reducing the number of partners, the use of condoms and regular physical examination.
* Condoms should be available at outlets that are readily available to the public. Instruction and information regarding their proper use should be provided.

The management of STIs should always include the following:

• Medical and sexual history taking

• Performance of a physical examination

• Establishment of a diagnosis and provision of treatment

• Education and counseling of the patient on:

* Compliance with treatment
* Prevention of complications of STIs
* reduction in acquiring STIs
* increased risk of HIV
* Prophylactic testing for HIV (also of partner)
* Promotion and provision of condoms and demonstration of their use
* Tracing and treating of sexual contacts.

Based on guidelines of the Standard Treatment and Guidelines and Essential Drug

|  |
| --- |
| ***Self activity 8.6****Explain the advantages and disadvantage s of the Syndromic Management Approach* |

**References**

Brunner, S.L. & Suddarth, D.S. (2008). *Medical-Surgical Nursing*. Philadelphia : J.B. Lippincott.

Guilebaud, J.(2004) Contraception 4th edition. London, Churchill Livingstone

Hart D.M. and Norman J. (2000) 5th edition. Gynaecology Illustrated. Edinburgh, Churchhill Livingstone.

Karz V.L., Lentz G.M., Lobo R.A. and Gershenson D.M. (2007) Comprehensive Gynecology. Philadephia :Mosby

Lewis, S.M., Heitkemper, M.M. & Dirksen, S.R. Camera I.M. (2011). *Medical-Surgical Nursing.* Mexico: Mosby.

Malawi Ministry of Health (July 2007): Implementation Framework for Reproductive Health Strategy (2007-2010)

World Health Organization. (2007). Gender and rights in reproductive and maternal health: a manual for learning workshop. Retrieved January 7th, from World Wide Web:<http://www.who.int/bookorders/anglais/detart1.jsp?sesslan>.

Fogel, C. I. and Woods, N. F (1981) Health care of women. A nursing perspectives, St Louis, CV Mosby

Sutherland , C. (2001). Women Health: A handbook for nurses Edinburg, Churchill Livingstone

Kahn, A and Holt, L. H. (1987). Menopause: The best years of your life London, Bloosbery Publishing Limited

UNFPA, (2008). The Status of Reproductive Health within the Sector Wide Approach Context: Towards universal Access to Reproductive Health. Malawi.

Malawi MOH, (2009). National Sexual and Reproductive Health and Rights (SRHR) Policy

Malawi MOH, (2007) Road Map for accelerating the reduction of Maternal and Neonatal Mortality and Morbidity in Malawi. Revised version

Malawi MOH, (2009). Launch of the Campaign on accelerated reduction of maternal mortality in Africa (CARMMA)

Malawi MOH, (2008), The status of reproductive health within the sector wide approach context Malawi. Towards universal access to reproductive health. Malawi cares: ‘*’No woman should die during child birth’’*