TRAINING MANUAL
FOR
HEALTH CARE PROVIDERS

RutgersWPF

ہمارا کل: نوجوانوں کی ترقی کا منفرد پروگرام

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Introduction

Aahung is a Karachi based NGO that has been working on improving the Sexual and Reproductive Health and Rights (SRHR) of men, women, and adolescents in Pakistan since 1995. Aahung's emphasis is on integrating the concepts of sexual health, sexuality and rights within the broader reproductive health framework and has established itself as a leader and technical expert in the field.

Pakistan has a large population that can be categorized as falling within the UN's definition of youth. An estimated 103 million Pakistanis, or 63% of the population, fall under the age of 25 years (UNFPA, 2007). Hence, there is a dire need to address the sexual and reproductive health concerns of youth in order to bring about sustainable change.

A significant impediment to improved youth sexual and reproductive health in Pakistan is the lack of access to quality sexual health services and information. Medical practitioners often lack the necessary knowledge and skills required to treat sexual health issues effectively. Furthermore, the notion of client centered care and counseling is often neglected which prevents the creation of an enabling environment for youth clients seeking health care. In addition, due to repressive societal norms, youth often lack the necessary confidence and comfort in discussing issues openly which inevitably affects health care treatment. Without proper training, health care providers may also shy away from discussions concerning sexuality because they feel uncomfortable to handle complex issues.

This manual has been mainly adapted from Aahung's 'Sexual Health Training Modules' for medical service providers. The manual aims to improve knowledge, comfort and attitudes when dealing with youth clients on sexuality related issues. The topics in the manual allows medical service providers to reflect upon their own beliefs about adolescent sexuality while ensuring that those values and attitudes do not compromise the basic sexual and reproductive health rights to which youth are entitled. The manual also aims to develop communication and counseling skills when dealing with youth sexuality issues along with improved management of RTIs and STIs. This manual had been developed according to the participatory methodology of learning and comprises of case studies, role plays, documentaries, group activities and brainstorming exercises. The content is divided into seven broad modules/themes: sexuality, sexual and reproductive health, sexual rights and the IPPF Declaration, youth friendly service provision, communication and counseling skills and management of RTIs and STIs.

MODULE 1: SEXUALITY

Activity: 1.1

Sexuality Cards Activity

Aim:
To broaden participant's understanding of human sexuality by introducing its components and subtopics.

Objectives:
By the end of this session participants will be able to:
1. Give a definition of "human sexuality"
2. Name the five main components of sexuality
3. Name two or three subtopics of each component.

Materials Required:
- A stack of large cards of paper, suitable for making signs
- Tape
- A copy of the handout 2.1 'An Explanation of the Components of Sexuality' for each participant at the end of the activity.

Advance Preparation:
1. On five of the cards write the main components of sexuality, one per card: **Human Development, Relationships and Emotions, Sexual Behavior, Sexual Health, and Sexual Violence**. Tape the five cards on the walls around the room, leaving plenty of space between each card.
2. Write the following phrases on the remaining cards, one per card:
   - Reproductive Physiology and Anatomy
   - Puberty
   - Reproduction
   - Climacteric and Menopause
   - Body Image
   - Sexual Orientation
   - Gender Identity and Roles
   - Families
   - Friendships
   - Loving, Liking, Caring

- Attraction and Desire
- Flirting
- Dating and Courtship
- Intimacy
- Marriage and Lifetime Commitments
- Raising Children
- Contraception
- Abortion
- Reproductive Tract Infections, STIs and HIV/AIDS
- Genital Care and Hygiene
- Breast Self-Examination
- Testicular Self-Examination
- Prevention of STIs/HIV and Unwanted Pregnancy
- Prenatal Care
- Infertility
- Sexual Dysfunction
- Sexual Abuse
- Incest
- Rape
- Manipulation through Sex
- Sexual Harassment
- Gender Discrimination
- Partner or Domestic Violence
- Harmful Practices
- Masturbation
- Kissing
- Touching and Caressing
- Sexual intercourse
- Abstinence
- Pleasure and Human Sexual Response
- Fantasy

Mix these cards up and divide them into five sets of approximately the same number.

Instructions:

Activity 1: The Difference Between Sex and Sexuality

Step 1:

Introduce the topic by saying that before learning about sexuality, one needs truly to understand what "sexuality" means, and that you all will spend the next hour talking about and exploring what sexuality is and how it is a part of every human life.

Step 2:
Write on the board “What is sex?” and “What is sexuality?” Ask participants how they would answer these questions. Then ask what the difference is between them, if any. Participants may have different opinions. For example, some of them may think these two things both refer to sexual intercourse, while others may think sexuality is a much broader concept.

Key Messages:

Using the participants’ opinions, bring out the idea that sexuality is a much broader concept than sexual intercourse as will be discussed in the next activity.

Activity 2: Components of Human Sexuality

Step 1:
Tell participants that you are now going to explore what sexuality consists of in more depth. Point to the five signs that you have posted on the walls and tell them that sexuality can be broken down into five main components or areas: Human Development, Relationships and Emotions, Sexual Behavior, Sexual Health and Sexual Violence.

Step 2:
Divide participants into five roughly even groups, and give each group a set of cards. The group should read each card, discuss it, and decide which of the five components it best fits under. Tell the participants to tape each card under the component they think it belongs to.

Step 3:
After the groups have finished, bring them back together. Starting with one of the components, go through each card taped under it one at a time and generate a short discussion. For each card:

- Ask the group as a whole: “Do you think this card belongs under this component?”
- If there is any disagreement, ask the group that placed it there; “Why did you decide to put this card here?”
- Ask others what they think. If they don’t agree, ask: “Why not? Where do you think it belongs?”
- Ask questions and use the participants’ comments and ideas to guide them to the correct placement.
- If a card has been misplaced, have a participant put it under the right component. Treat each card the same way regardless of whether it is correctly or incorrectly placed to generate discussion. Use information in the handout “An Explanation of the Components of Sexuality” to supplement the discussion and clarify points. However, do not get into a long discussion about any of the cards at this point. If necessary, tell

participants that you will look more closely at these components later in the course.

- If there is a lot of disagreement, you can note that many of the topics overlap and people may have different ideas about where they go, but you are trying to find the place where it fits best.

Step 4:
Ask participants the following questions;

- "What surprised you about this activity?"
- 'What thoughts and feelings did you have while doing this activity?"
- "Looking at these components, what part does sexual intercourse play in sexuality?"

(Answer: A small part, it is only one subtopic of one of the five components.)

- "What do you notice about sexuality?"(Answer: It is a very broad topic, has a lot of subtopics, is complex, etc.)
- "Which component do you already know the most about? Why do you think that is the case?"
- "Which one raises the most questions for you? Why do you think that is the case?"

Step 5:
Explain to participants that each of these components has overlapping parts. Puberty is under the component Human Development since it is a process that human beings go through as they grow up. Ask participants if they can name one or more parts of the other components that a teenager going through puberty might experience. (For example, under Relationships, participants might identify love, Dating, and Intimate Friendships; under Sexual Behavior, Kissing, Touching, Holding Hands, and Masturbation; under Sexual Health, Sexual Hygiene, Breast and Testicular Self-Exam, Contraception Use, and Abortion; under Sexual Violence, Sexual Abuse, Rape , and Gender Discrimination.)

Step 6:
Share the definition of sexuality with participants:
'Sexuality is much more than sex. Sexuality is a part of who we are, what we think and feel about ourselves, our bodies and how we relate to others. A person's sexuality is unique and individual. It is shaped by many things, culture and tradition, the society we live in, life experiences and personal beliefs. The relationships in which people express their sexuality are many and varied. Sexuality develops and changes throughout a person's life. It is a part of us from birth to death, for all our life. It can be a joyous and enriching part of who we are'.

Conclusion

1. Conclude the session by asking participants the following questions:
    - "Based on what you learned, what are some similarities in the ways in which men and women experience their sexuality?"
    - "What differences are there in the ways men and women experience their sexuality/"
    - "What cultural differences (differences based on race, religion, or natural origin) have you observed in the way people express their sexuality?" (Examples might include differences in dressing, flirting, gender-restricted behavior, toilet training of children, dealing with menstruation or first ejaculations, courtship and marriage, etc.)
2. If you have copies of the two handouts for participants, give them out now.

Key Messages:

1. There are many different ways to define the term "sexuality" it can be defined as 'Sexuality is much more than sex. Sexuality is a part of who we are, what we think and feel about ourselves, our bodies and how we relate to others. A person's sexuality is unique and individual. It is shaped by many things, culture and tradition, the society we live in, life experiences and personal beliefs. The relationships in which people express their sexuality are many and varied. Sexuality develops and changes throughout a person's life. It is a part of us from birth to death, for all our life. It can be a joyous and enriching part of who we are'.
2. Sexuality is an integral part of being human. It begins before birth and lasts until the end of life.
3. Sexuality is essential to the continued existence of humanity.
4. Sexuality is not just about the process of reproduction. Sexual behavior is only one part of sexuality.
5. To simplify the term "human sexuality," it can be split into the following five components:
    - Human Development
    - Sexual Health
    - Relationships and Emotions
    - Sexual Behavior
    - Sexual Violence
6. The components of sexuality and their subtopics are interconnected.[1]

[1] Andrea Irvin, *Positively Informed: Lesson Plans and Guidance for Sexuality Educators and Advocates,* International Women's Health Coalition, New York, 2004.

HANDOUT 1.1: AN EXPLANATION OF THE COMPONENTS OF SEXUALITY

Sexuality

Sexuality is a part of who we are, what we think and feel about ourselves, our bodies and how we relate to others. A person's sexuality is unique and individual. It is shaped by many things, culture and tradition, the society we live in, life experiences and personal beliefs. The relationships in which people express their sexuality are many and varied. Sexuality develops and changes throughout a person's life. It is a part of us from birth to death, for all our life. It can be a joyous and enriching part of who we are

Human Development

Human development involves the interrelationship between physical, emotional, social, and intellectual growth. This component includes:

Reproductive Physiology and Anatomy: The parts of the body that form the reproductive and sexual systems and their functions. Although the whole body is involved in human sexuality, these systems are central to sexuality and to understanding puberty, menstruation, erections, and dreams, reproduction, and sexual pleasure.

Growth and Development: Includes the following key processes related to sexuality:

- Puberty: the physical and emotional changes that occur when the body matures during adolescence, including the development of secondary sex characteristics (such as broad hips and facial hair) and the nurturing of the reproductive system. Puberty results in the ability to reproduce.
- Reproduction: The process of conception, pregnancy, and birth- the beginning of human development.
- Climacteric and menopause: The physiological and psychological changes in our sexual and reproduct9ive functioning that occur in midlife in both women and men, including the period leading up to menopause for women. Menopause occurs when menstruation stops.

Body Image: Attitudes and feelings about one's own body, appearance and attractiveness that affects one's mental well-being, comfort with, and expression of one's sexuality.

Sexual Orientation: The direction of one's romantic and sexual attraction-to the opposite, the same, or both sexes. Includes heterosexual, homosexual, and bisexual orientations.

Gender Identity and Roles: Gender identity is one's biological sex. Gender roles are set of socially prescribed behaviors and characteristics expected to females and males.

Relationships and Emotions:

All people need to have relationships with others in which they experience emotional closeness. This component includes:

Families: The primary social unit to which most people belong and which includes people who are related by blood, marriage, or affection.

Friendships: Relationships between people based on liking, caring, and sharing; these relationships can differ in emotional depth, but usually do not include a sexual relationship.
Loving, Liking, and Caring: Feelings that are the basis of emotional bonds and positive connections and relationships between people.
Attraction and Desire: Emotional and physical feelings that draw someone to another person; these feelings may include emotional and sexual longing and passion.
Flirting: Playful, romantic or sexual interactions that communicate attraction. Flirting can cross the line sand become harassment if the recipient perceives it to be unwelcome or offensive.
Dating and Courtship: Meeting, spending time together, and going out as a part of the process of getting to know and love someone, sometimes with the purpose of deciding whether or not to marry.
Intimacy: emotional closeness to others characterized by feelings of connectedness, openness, sharing and reciprocity.
Marriage and Lifetime Commitments: the union, usually legal, of two people who make a commitment to ideally love and care for each other and share their lives and family responsibilities over the long term.
Raising Children: Bringing up, providing for, and nurturing children, usually as a part of a family.

Sexual Behavior
Sexuality is a natural and healthy part of life from birth to death, which individuals express through a variety of behaviors. This component includes:

Masturbation: Giving oneself sexual pleasure, usually by touching or rubbing one's own genitals.
Shared Sexual Behavior: Includes, but is not limited to:

- Kissing: Touching and caressing someone with one's lips to express affection and love.
- Caressing and Touching: Stroking gently to express affection and love; being in physical contact with someone.
- Sexual intercourse: Vaginal, oral, or anal intercourse.

Abstinence: Not having sexual intercourse. Abstinence may include other types of sexual touching.
Pleasure and Human Sexual Response: The enjoyable response of the body to sexual touching, which may or may not include orgasm, a highly pleasurable release of built-up sexual tension.
Fantasy: sexual or erotic thoughts, dreams and imaginings that are sexually arousing but are not necessarily acted on or even desired in reality.
Sexual Health
Sexual health includes having the knowledge and attitudes and taking the actions necessary to actively maintain the health of one's reproductive system and to avoid unwanted consequences of sexual behavior. This component includes:

Contraception: The use of various methods to intentionally prevent pregnancy; these methods include devices, agents, drugs, sexual practices, and surgical procedures.
Abortion: Induced termination of pregnancy.
Reproductive Tract Infections, Sexually Transmitted Infections (STIs), and HIV/AIDS: a range of infections that occur in the reproductive tract (such as yeast infections or vaginitis), or that can be acquired through sexual intercourse or intimate sexual contact (such as gonorrhea, chlamydia, herpes, and HIV/AIDS). Many can be transmitted in other ways as well, such as during childbirth.
Reproductive Health: Includes:

- Genital Care and Hygiene: Caring for and keeping one's genitals clean, healthy and free from injury.
- Breast Self-Examination: A simple self-help technique in which women feel their breast tissue in a prescribed manner every month to check for changes or lumps that may indicate a problem.
- Testicular Self-Examination: A simple self-help technique in which men feel their testicles in a prescribed manner every month to check for changes or lumps that may indicate a problem.
- Prevention of HIV/STIs And Unwanted Pregnancy: Decisions and actions taken to reduce the risk of infection with an STI or HIV and the risk of an unwanted pregnancy; includes abstinence, seeking advice and preventive care, open and honest communication between sexual partners, and the use of condoms and contraception.
- Prenatal Care: Regular check-ups with a trained health care provider during pregnancy to monitor the health of the woman and the fetus and to help to identify any problems early.
- Infertility: The continuing inability to bear a child.

Sexual Dysfunction: A psychological or physical problem that interferes with a person's ability to express or enjoy his or her sexuality to the fullest degree. Includes lack of desire, inadequate lubrication, and difficulties maintaining erections or achieving orgasm.

Sexual Violence

Sexual violence is any violence (that is abusive or unjust use of power) that has a sexual aspect or element. It includes the use of sexuality to influence, control, or manipulate others. This element includes:

- **Sexual Abuse:** Any sexual contact or interaction between an older or more powerful person and a child or minor; this may or may not involve touch. The abuser is usually someone known to the child.
- **Incest:** A sexual relationship between two people who are too closely related to get married by law or custom.
- **Rape:** Forced or nonconsensual sexual intercourse or other intimate sexual contact. The force may be physical or psychological (that is, through threats or coercion). Sexual intercourse constitutes rape if one of the parties is not capable of giving consent for whatever reason.
- **Sexual Manipulation:** Using sex to indirectly influence, control, coerce, or exploit someone to one's own advantage.

- **Sexual Harassment**: Persistent unwelcome verbal or physical sexual advances or conduct of a sexual nature, or demand for sexual activity in exchange for benefits, for example in a school or work setting.
- **Partner or Domestic Violence:** Physical or sexual violence against a partner with whom one is in a romantic and/ or marital relationship.
- **Gender Discrimination:** Showing preference or prejudice or denying equal treatment to someone based solely on his or her gender.
- **Harmful Practices:** A range of practices, whether traditional or modern, that decreases a person's sexual well-being or ability to experience his or her sexuality safely and pleasurably.

Activity 1.2

Values Clarification about Adolescent Sexuality

Objectives

1. To assess the participant's attitudes about adolescent sexuality.
2. To help the participants understand the impact that their personal attitudes may have on service delivery.

Time

60 minutes.

Materials

- 8 x 10 cards(or paper)
- Flipchart paper.
- Markers
- Four signs: "Strongly Agree," "Disagree," "Strongly Disagree"

Advance Preparation

1. In large letters, write each of the following terms on 8x10" cards (or sheets of paper), one term per card: "Strongly agree," "Agree," "Disagree, "and "Strongly Disagree,"
2. Display the signs around the room, leaving enough space between them to allow participants to stand near each one.
3. Write the following statements on flipchart:
    - Condoms should be available to youth of any age.
    - Young unmarried boys/girls who are sexually active should not be treated
    - Masturbation leads to impotency
    - An unmarried pregnant girl should be denied services for an abortion
    - Sex education can lead to early sex or promiscuity.
    - It is worse for an unmarried girl to have sex than for an unmarried boy.
    - Condoms are the best method of birth control for a young person because they protect against sexually transmitted infections (STIs).
    - Providing sexual and reproductive health services to youth may lead to early sex or promiscuity.

Steps

1. Tell the participants that this activity is designed to give them a general understanding of their own and each other's values and attitudes about working with adolescents and adolescent reproductive health issues.
2. Explain that you will read aloud a statement. The participants will decide what they think about the statement and stand near the sign that most closely represents their opinion. After the participants have made their decisions, you will ask

several of them to share their opinions with the group. Remind the participants that everyone has a right to his or her own opinion, and no response is right or wrong.

3. Also remind the participants that they must listen to each other. This activity is not about debate, but about dialogue. Instruct them to state their personal opinion to support their agreement or disagreement with each statement and not to rebut other participants' opinions.
4. Read aloud the first statement you selected, and ask the participants to stand near the sign that most closely represents their opinion. After the participants have made their decisions, ask for one or two volunteers from each group to explain why they feel that way. Continue for each of the statements you selected.
5. Once all the statements have been read, ask the participants to return to their seats.
6. After reviewing all the statements, facilitate a discussion by asking the following questions:
    - Which statements, if any, did you find challenging to form an opinion about? Why?
    - How did you feel expressing an opinion that was different from that of some of the other participants?
    - How do you think people's attitudes about some of the statements might affect their interactions with young clients or their ability to provide reproductive health services to adolescents?

Note to the Facilitator

For the sake of discussion, if the participants express a unanimous opinion about any of statements, ask a volunteer to play the role of "devil's advocate" by expressing an opinion that is different from theirs.

Summary

State that it is normal to have strong feelings and values about these topics. Tell the participants that learning to be aware of their own values will help them be more open to listening to different points of view. When adolescents notice that service providers are more accepting of differences, they will more openly and honestly assess and express their own values. This, in turn, can help young people assess the attitudes and beliefs that lead to high-risk behavior. [2]

2 Adapted from EngenderHealth, (2002), Youth Friendly Services: A Manual For Service Providers, New York

Activity 1.3

Adolescent Psychological and Social Development

Objective: To help participants understand the psychological and social changes that youth experience through the three stages of adolescence

Time: 45 minutes

Materials:

- Flipchart paper
- Markers
- Handout

Step 1: Share the objectives of the session with the participants

Step 2: Divide participants into three groups representing different phases of adolescence; Early Adolescence (10-13 yrs), Middle Adolescence (14-16 yrs) and Late Adolescence (17-19 yrs)

Step 3: Explain that each group has to brainstorm about the different characteristics of development for the specific adolescent age group. Share the different characteristics of development which include 'Biological/Physiological', 'Relationships', 'Mental/Emotional' and 'Sexuality'.

Step 4: Provide participants with flipcharts and explain that they can divide the flipchart into four columns representing the different developmental categories. Each group can brainstorm and list down in bullet points the different changes experienced for each developmental stage.

Step 5: Ask participants to put up their flipcharts whilst presenting the different development stages. Review the categories in each chart and clarify points under each heading. However, state that these are general characteristics and may not apply to all adolescents in a given time period. Emphasize that the categories of development are closely interlinked and overlap with each other.

Step 6: Ask participants to reflect personally and professional whether they consider the various developmental factors when dealing with adolescents. [3]

HANDOUT 1.3: Adolescent Psychological and Social Development

Developmental changes in adolescents

3 Adapted from EngenderHealth, (2002), Youth Friendly Services: A Manual For Service Providers, New York

Developmental stage	Early Adolescence (10-13 yrs) Characterized by puberty	Middle Adolescence (14-17 yrs) Strong peer group influence	Late Adolescence/Early adulthood (18-21 yrs) Assumption of adult roles
Biological/ Physiological	• Puberty: grow body hair, increase perspiration and oil production in hair and skin, • Girls – breast and hip development, onset of menstruation • Boys – growth in testicles and penis, wet dreams, deepening of voice • Tremendous physical growth: gain height and weight	• Puberty is completed • Physical growth slows for girls, continues for boys	• Young women, typically, are fully developed • Young men continue to gain height, weight, muscle mass, and body hair
Mental/ Emotional	• Preoccupied and confused about body changes • Has wide mood swings • Seeks to make independent decisions • Desires more privacy • Rejects symbols of childhood • Mostly interested in present with limited thought to the future	• Continued adjustment to changing body • Develops analytical and logical thinking skills • Development of self identity • Greater capacity for setting goals • Interest in moral reasoning • Thinking about the meaning of life	• Demonstrates improved problem solving • Is better able to resolve conflicts • Stability in emotions • Self identity deepens • Increased concern for the future

Relationships	• Has close friendships with members of the same sex • Possibly has contact with members of opposite sex • Challenges authority, parents and other family members • Increased influence of peer group	• Forms strong peer group connections/dependency • Begins to explore ability to attract partners • Moves away from parents and towards peers • Continued drive for independence	• Less influenced by peers regarding decisions and values • Relates to individuals more than peer group • Reintegrates into family as young adult • Increased independence and self reliance
Sexuality	• Begins to feel attracted to others • May begin to masturbate • Is preoccupied with physical changes • Is critical of body image	• Is less concerned about body image than before • Interested in physical appearance • Shows an increase in sexual interest • May struggle with sexual identity	• Generally comfortable with body image • Begins to develop serious relationships

Activity 1.4

Life Cycle Approach to Sexuality

Objective: To review and understand the milestones of human sexual development from birth to death

Time: 45 minutes

Materials:

- Flipchart paper
- Cards with milestone statements
- Markers
- Tape
- Handout

Step 1: Draw a time line on three large sheets of flipchart and write the numbers from 0-100 with increments of ten, on it which represents a person's life span from birth to death). Write the milestone statements on cards. Refer to the handout for statements concerning sexual development through the life span.

Step 2: Share with participants that the activity focuses on human sexual development through the life span. Explain that they will be given cards with milestones of sexual development and they have to identify the age at which the specific event/milestone occurs, participants should paste/stick the statement accordingly on the life span chart.

Step 3: Once, all the cards are placed on the time line, ask the participants to discuss whether they agree or disagree with the placement of each card. After discussion provide the correct answers and provide the correct answers by referring to the handout. Move the cards to the correct place on the timeline as needed.

Step 4: Explain to participants that these are general time lines, however experiences of individuals may vary.[4]

4 Adapted from EngenderHealth, (2002), Youth Friendly Services: A Manual For Service Providers, New York

HANDOUT 1.4: MILESTONES OF MALE AND FEMALE SEXUAL AND SOCIAL DEVELOPMENT

Certain aspects of sexual and social development begin at different times in a person's life. These milestones, which occur within a range of years, are:

- **Begins to have a sexual response**

Occurs before birth. A male fetus achieves genital erections in utero; some males are even born with erections. Sexual response in females also occur before/or at the time of birth.

- **Explores and stimulates one's genitals for the first time**

Occurs between ages of six months and one year. As soon as babies can touch their genitals, they begin to explore their bodies.

- **Shows an understanding of gender identity**

Occurs by age 2, children are aware of their biological sex.

- **Shows an understanding of gender roles**

Occurs between age 3 and 5, children begin to conform to society's messages about how males and females should act.

- **Ask questions about where babies come from**

Occurs between ages 3 and 5.

- **Begins to show romantic interest**

Occurs between ages 5 and 12, although this may vary by culture. At this stage, children show the first signs of sexual orientation (sexual preference toward males or females)

- **Shows the first physical signs of puberty (the transition from childhood to maturation)**

Occurs between ages 8 and 13, this usually occurs slightly earlier for girls than boys.

- **Begins to produce sperm (boys)**

Occurs between ages 11 and 18, this milestone depends in part on the child's nutrition and may be delayed when nutrition is compromised.

- **Begins to engage in romantic activity**

Occurs between ages 10 and 18, this milestone depends heavily on cultural factors.

- **Has sex for the first time**

Differs greatly by individual and cultural factors, but late adolescence onwards is fairly common.

- **Gets married**

Varies greatly amongst cultures and different individuals, in the Pakistani context a general rage would be between the ages of 20 and 30 years, however early age marriages are also very common.

- **Begins to have children**

Varies greatly amongst cultures and different individuals, in the Pakistani context a general rage would be between the ages of 20 and 30 years.

- **Experiences menopause**

Occurs in women at around age 50 (however can begin in late 30s and during 40s as well for some individuals). A woman goes through a process of physiological changes characterized by the end of ovulation, menstruation and the ability to reproduce.

- **Experiences male climacteric response (decreased male hormone levels)**

Occurs between ages 45 and 65. A man goes through a process of physiological changes characterized by a decrease in testosterone production.

- **Experiences sexuality in later life**

Older adults (those aged 60 and beyond) can remain sexually active to the end of their lives. Although some age related changes in sexuality take place, the total loss of sexual functioning is not part of the normal aging process.

Adapted from EngenderHealth, (2002), Youth Friendly Services: A Manual For Service Providers, New York

MODULE 2: SEXUAL & REPRODUCTIVE HEALTH

Activity 2.1

Envelope Exercise

Objective:
To identify the mental, social and physical aspects of sexual health especially in the context of youth.

Materials:
- Flipchart
- Markers
- Envelopes
- Cards
- Handout 3.1 (to be distributed at the end of the activity)

Time:
1 hour 15 minutes

Steps:
1. Divide the participants into 3 groups.
2. Take the three envelopes. On one envelope write the words "physical/ physiological", on another write the words "mental/emotional", and on the third "social/cultural". Insert three note-cards in each of the envelopes. Distribute one envelope to each group.
3. Tell groups that they have 5 minutes to brainstorm 5 words on any aspects of sexual health associated with the theme related to youth. For example, the group with the words mental/emotional envelope must brainstorm and write their responses on one of the note cards in their envelopes. After the brainstorming time is complete they must place the card in the envelope and pass their envelope to the group on their right.
4. Give groups another 5 minutes to brainstorm on aspects of sexual health associated with their new envelope. Inform groups that they must think of new words and cannot repeat words listed by the previous group.
5. Continue this process until all groups have had a chance to brainstorm on the themes on all three envelopes.
6. Have the participants hand in the envelopes back to you. Read the participants' responses and write them on a flip chart in a tabular form.

PHYSICAL/PHYSIOLOGICA L	**MENTAL/EMOTIONA L**	**SOCIAL/CULTURA L**

Note to Facilitator: Participants' responses may include the following:

- Physical (i.e. physical structure): organs; body parts; desire; excitement; orgasm; plateau; resolution; masturbation; nocturnal emission; vaginal discharge; urethral discharge; menstruation; nocturnal emission.

- Psychological: impotence; erectile dysfunction; vaginismus; loss of libido; anxiety/depression

- Emotional: feelings such as love and pain.

- Social/Cultural: marriage; knowledge; divorce; separation.

7. Take an opportunity to add your own responses to the list.
8. Circle the words that obviously fall into more than one or all the categories. E.g. divorce, abortion, STI's, HIV
9. Discuss these words with the participants/group.
10. Conclude the session by saying that virtually any sexual health issue will have physical, mental and social consequences.
11. Initiate discussion using the following probing questions:

What does this activity tell you about sexuality in the context of youth?
When dealing with youth clients do we consider all the three components of sexual health?
Ask participants what is the difference between sexual health and reproductive health?

12. Once the different aspects of sexual health have been clarified, we will now see as to what is actually meant by sexual health and reproductive health through the following handout 3.1.

HANDOUT 2.1

Sexual Health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity (WHO, 2002)

In order for youth to be sexually healthy, an individual must have:

- The knowledge, Skills and the Environment capacity to enjoy and carry out decisions about one's sexual and reproductive behavior in accordance with one's personal values.
- Safe, responsible and satisfying sexual experience and relationships those are free from coercion, discrimination and violence.
- Freedom from fear, shame, guilt, false belief and other psychological factors that inhibit sexual response and sexual relationships.
- Freedom from organic disorders, disease and deficiencies that interfere with sexual and reproductive function.

Reproductive Health is a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this are the rights of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health-care services that enable women to safely go through pregnancy and childbirth. (World Health Organization)

Activity 2.2
Sexually Healthy Youth

Objectives:
- To identify characteristics associated with being sexually healthy through case studies of youth and adolescents

Time: 1 hour 30 mins

Materials:
- Flipchart
- Markers
- Four Case Studies
- Handout 2.2: Behaviours of Sexually Healthy Individuals

Steps
1. Divide participants into 4 groups. Distribute the case studies in Handout 1: Ensure that each group is given a different case study.
2. Instruct each group to read and discuss the case study they have been assigned. Ask the groups to identify the sexually healthy and unhealthy characteristics/qualities of the individuals in their cases. Give groups 15 min to discuss their cases
3. After 15 min reconvene the group. Ask a volunteer from each group, to read aloud his/her group's case and present the groups answers. Write the sexually healthy and unhealthy qualities identified by each group on a flip chart.
4. In a plenary session have participants brainstorm on the qualities and characteristics of a sexually healthy person. Write the qualities and characteristics on a flip chart

Note to Facilitator:
Make sure the list includes the following items:
- Appreciate their own body
- Practice health-promoting behaviours, such as regular checkups, doing breast and/or testicular self-exams, and seeking early identification of potential problems
- Avoid exploitative or manipulative relationships
- Identify and live according to their own values
- Take responsibility for their own behaviour
- Communicate effectively with family, peers and partners
- Negotiate sexual limits
- Accept refusals for sex
- If having sexual intercourse, practice safer sex to prevent STIs and unintended pregnancy

5. Distribute the Handout “Behaviours of Sexually Healthy Individuals.” Review handout with participants and ask them to share any thoughts or feelings.

Case Study 1:

Fehmida, 18, and Asim, 22, have been married for the past 1 year. Fehmida was very happy when Asim’s family came to her house to bring the *rishta.* Fehmida had known Asim for many years, and thought he was very nice and attractive. Fehmida’s parents asked her if she would like to marry Asim, and she agreed.

Fehmida and Asim enjoy one another’s company and spend a lot of time together. When Fehmida and Asim first had intercourse, Fehmida found it very painful. Now, Fehmida no longer finds intercourse painful but she does not experience pleasure. Fehmida often refuses to have sex with Asim. Asim expresses his frustration when Fehmida refuses to have sex with him, but she does not allow him to change her mind. Fehmida has started to worry that sex is not supposed to be pleasurable for women, but she feels too embarrassed to ask anyone about her problem.

Do Fehmida and Asim engage in behaviours or have characteristics that are sexually healthy? If so, what are they?

Do Fehmida and Asim engage in behaviours or have characteristics that are sexually unhealthy? If so, what are they?

Are Fehmida and Asim sexually healthy people? Why or why not?

Checklist Case Study 1:

Do Fehmida and Asim engage in behaviours or have characteristics that are sexually healthy? If so, what are they?

Fehmida:

- She chose to marry Asim because she wanted to marry him (her parents did not force her)
- She spends a lot of time with Asim and enjoys his company (love and emotional intimacy)
- She is able to make her own decisions about her sexual behaviour

Asim:

- He spends a lot of time with Fehmida and enjoys her company
- Although he expresses his frustration he does not force Fehmida to have sex with him

Do Fehmida and Asim engage in behaviours or have characteristics that are sexually unhealthy? If so, what are they?

Fehmida:

- She is unable to enjoy sexual intercourse (there may be physical or psychological reasons for this)
- She is too embarrassed to talk to anyone about her problem

Asim:

- He is unable to have sexual intercourse with his wife and is unable to share this level of intimacy with her

Are Fehmida and Asim sexually healthy people? Why or why not?

Both. They are sexually healthy in certain ways and sexually unhealthy in others.

Case Study 2:

Sara is 13-years old. She is unmarried and is in class 9. She started her periods a year ago, and they are regular without any problems. Sara doesn't feel happy about the way she looks. She thinks her skin is too dark and feels she is overweight. Sara often wishes she looked more like her friend Amina. Amina is very fair-skinned and has a slim figure. Sometimes, Sara stops eating properly for days to try and lose weight.

Recently, Sara has noticed that she has started feeling differently about boys. There are a few boys that she has started feeling attracted to. Sara talks openly to her girlfriends about how she feels about these boys. Sara does not feel comfortable talking to the boys that she likes and usually avoids them. She feels they would not want to speak to her because she is not attractive enough.

Does Sara engage in behaviours that are sexually healthy? If so, what are they?

Does Sara engage in behaviours that are sexually unhealthy? If so, what are they?

Is Sara a sexually healthy person? Why or why not?

Checklist Case Study 2:

Does Sara engage in behaviours or have characteristics that are sexually healthy? If so, what are they?

- Her menstrual cycle is regular without any problems?
- She has started feeling attracted to boys
- She is able to talk openly to her girlfriends about her changing feelings towards boys

Does Sara engage in behaviours or have characteristics that are sexually unhealthy? If so, what are they?

- She is unhappy about the way she looks (her complexion and figure)
- She does not eat properly for days to lose weight
- She avoids the boys that she likes because she lacks confidence in herself

Is Sara sexually healthy? Why or why not?

Both. She is sexually healthy in certain ways and sexually unhealthy in others.

Case Study 3:

Shagufta, 16, and Omar, 22, have been married for the past 6 months. Omar and Shagufta's parents decided that the two should marry. Shagufta did not want to get married but her parents told her that she had to marry Omar as he came from a respectable family and had a good job. Omar felt Shagufta was too young but his parents insisted it was a good match. Since they have been married Shagufta and Omar rarely spend time alone or sit together and talk about their lives. Shagufta spends most of her day doing household chores and prefers spending her free time with her friends. She does not feel like she and Omar have much in common. Omar works late hours and is often stressed due to work. He does not talk to Shagufta about work, as he feels she is too young to understand his problems.

Omar and Shagufta have decided that they do not want to have children as yet. Shagufta went to a family planning clinic to learn more about the methods of contraception. She informed Omar of what she learned, and the two of them decided that Omar would use condoms.

Do Omar and Shagufta engage in behaviours or have characteristics that are sexually healthy? If so, what are they?

Do they engage in behaviours or have characteristics that are sexually unhealthy? If so, what are they?

Are Omar and Shagufta sexually healthy persons? Why or why not?

Handout 2.2: Behaviors of sexually healthy individuals

Human Development

- Appreciate their body
- Seek additional information about reproduction as needed
- Believe that human development includes sexual development, which may or may not include reproduction or sexual experience
- Interact with members of both sexes in respectful, appropriate ways
- Affirm there worn sexual orientation and respect the sexual orientation of others

Relationships

- View family as a valuable source of support
- Express love and intimacy in appropriate ways
- Develop and maintain meaningful relationships
- Avoid exploitative or manipulative relationships
- Make informed choices about family options and relationships
- Exhibit skills that enhance personal relationships
- Understand how cultural heritage affects ideas about family, interpersonal relationships, and ethics

Personal Skills

- Identify and live according to their own values
- Take responsibility for their own behaviour
- Enjoy and express their sexuality throughout life
- Express their sexuality in ways that correspond to their own values
- Enjoy sexual feelings without necessarily acting on them
- Discriminate between life-enhancing sexual behaviours and those that are harmful to themselves or others
- Practice effective decision making
- Communicate effectively with family, peers and partners
- Gender/sexualization

Sexual Behaviour

- Enjoy and express their sexuality while respecting the rights of others
- Seek new information and resources to enhance their sexuality as needed
- Engage in sexual relationships that are consensual, non-exploitative, honest, and pleasurable
- Negotiate sexual limits
- Accept refusals for sex
- If having sexual intercourse, practice safer sex to prevent sexually transmitted infections (STIs) and unintended pregnancy

Sexual Health

- Use contraception to prevent unintended pregnancy
- Act consistently with their own values when dealing with unintended pregnancy
- Seek early antenatal care
- Avoid contracting or transmitting STIs, including HIV
- Practice health-promoting behaviours, such as having regular checkups, doing breast and/or testicular self-exams, and seeking early identification of potential problems
- Take action or get support to prevent sexual abuse

Society and Culture

- Demonstrate respect for people with different sexual values
- Exercise democratic responsibility to influence legislation dealing with sexual issues
- Assess the impact of family, cultural, religious, media, and societal messages on their thoughts, feelings, values and behaviours related to sexuality
- Promote the rights of all people to obtain accurate sexuality information
- Avoid behaviours that exhibit prejudice and bigotry
- Reject stereotypes about the sexuality of diverse populations
- Educate others about sexuality

MODULE 3: SEXUAL RIGHTS & THE IPPF DECLARATION

Activity 3.1

Sexual Rights Quiz

Objective:
1. To understand the different sexual rights and understand the violation of rights in the context of case scenarios related to youth.

Time:
60 minutes

Materials Required:
Facilitator Guide 6.3: Case scenarios and Handout 6.4: Sexual Rights in the IPPF Declaration

Advance Preparation:
Make copies of Handout 6.4 for all participants

Instructions:

Step 1:
Divide participants into two groups and distribute a copy of the handout to each participant. Ask participants to read through the handout which includes the ten sexual rights present in the IPPF Declaration.

Step 2:
Tell participants that a quiz will be conducted in which participants have to identify the sexual right which is being violated in each scenario along with providing an explanation. Participants will use handout 6.4 as a reference to identify the sexual right being violated. Each group can be given a scenario turn by turn and given 2-3 minutes to identify the sexual right being violated.

Step 3:
Read out each scenario present in facilitator guide 6.3 and ask each group turn by turn which sexual right is being violated and allocate points for each group accordingly. Refer to handout 6.3 for answers. In many of the case scenarios more than one sexual right may be applicable.

Suggested Questions?

1. Were the case scenarios similar to real life examples faced by youth from our society or have you encountered such cases in your personal or professional life?
2. Do you think that sexual rights are interconnected to each other e.g. do you feel that more than one sexual right was applicable to some of the case scenarios?

Facilitator Guide

CASE SCENARIOS:

1. Fourteen year old bride admitted to hospital with uncontrolled bleeding due to vaginal tears

This case scenario relates to Article 3

2. Husband refuses to permit twenty year old wife to use contraception after the birth of their third child

This case scenario relates to Article 7 & 9

3. Husband suffering from penile discharge refuses to use condom with wife despite her protests

This case scenario relates to Article 7

4. Scared twelve year old boy was scolded by father for being 'dirty minded' when he asked about his first wet dream

This case scenario relates to Article 8

5. Twenty two year old girl was raped by her fiancé when she refuses to have intercourse with him

This case scenario relates to Article 3

6. Eighteen year old boy threatened by father to marry to an older cousin or risk loosing his inheritance

This case scenario relates to Article 9

7. Eleven year old daughter of a labourer married to a 36 year old man living and working in Dubai

This case scenario relates to Article 3

8. Gynaecologist calls up office of young woman banker who tested positive for HIV and reports her results to manager

This case scenario relates to Article 4

9. Enraged mob burns the house of a transsexual teenager (hijra) talking on a radio show about his sexual identity and the discrimination he has had to bear all her life

This case scenario relates to Article 3

10. Fourteen year old girl believes her monthly period is bad and thinks she has blood cancer

This case scenario relates to Article 8

11. Doctor tells a young woman that she must have a consent form signed by her husband before she has her pregnancy terminated.

This case scenario relates to Article 5

Handout 3.1

TEN SEXUAL RIGHTS FROM THE IPPF DECLARATION

ARTICLES	BRIEF EXPLANATIONS
Article 1: right to equality, equal protection of the law and freedom from all forms of discrimination based on sex, sexuality or gender.	All human beings are born free and equal in dignity and rights must enjoy the equal protection of the law against discrimination based on their sexuality, sex or gender.
Article 2: The right to participation for all persons, regardless of sex, sexuality or gender.	All persons are entitled to an environment that enables active, free and meaningful participation in and contribution to the civil, economic, social, cultural and political aspects of human life at local, national, regional and international levels, through the development of which hu8man rights and fundamental freedoms can be realized.
Article 3: The rights to life, liberty, security of the person and bodily integrity.	All persons have the right to life, liberty and to be free of torture and cruel, inhuman and degrading treatment in all cases, and particularly on account of sex, age, gender, gender identity, sexual orientation, marital status, sexual history or behaviour, real or imputed, and HIV/AIDS status and shall have the right to exercise their sexuality free of violence or coercion.
Article 4: Right to privacy.	All persons have the right not to be subjected to arbitrary interference with their privacy, family, home, papers or correspondence and the right to privacy which is essential to the exercise of sexual autonomy.
Article 5: Right to personal autonomy and recognition before the law.	All persons have the right to be recognized before the law and to sexual freedom, which encompasses the opportunity for individuals to have control and decide freely on matters related to sexuality, to

	choose their sexual partners, to seek to experience their full sexual potential and pleasure, within a framework of non discrimination and with due regard to the rights of others and to the evolving capacity of children.
Article 6: Right to freedom of thought, opinion and expression; right to association.	All persons have the right to exercise freedom of thought, opinion and expression regarding ideas on sexuality, sexual orientation, gender identity and sexual rights, without arbitrary intrusions or limitations based on dominant cultural beliefs or political ideology, or discriminatory notions of public order, public morality, public health or public security.
Article 7: Right to health and to the benefits of scientific progress.	All persons have a right to the enjoyment of the highest attainable standard of physical and mental health, which includes the underlying determinants of health and access to sexual health care for prevention, diagnosis and treatment of all sexual concerns, problems and disorders.
Article 8: Right to education and information	All persons, without discrimination, have the right to information and education and information generally and to comprehensive sexuality education and information necessary and useful to exercise full citizenship and equality in the private, public and the political domains.
Article 9: right to choose whether or not to marry and to found and plan a family, and to decide whether or not, how and when, to have children.	All persons have the right to choose whether or not to marry, whether or not to found and plan a family, when to have children and to decide the number and spacing of their children freely and responsibly, within an environment in which laws and policies recognize the diversity of family forms as including those not defined by descent or marriage.
Article 10: right to accountability and redress.	All persons have the right to effective, adequate, accessible and appropriate

	educative, legislative, judicial and other measures to ensure and demand that those who are duty-bound to uphold sexual rights are fully accountable to them. This includes the ability to monitor the implementation of sexual rights and to access remedies for violations of sexual rights, including access to full redress through restitution, compensation, rehabilitation, satisfaction, guarantee of non-repetition and any other means.

HANDOUT 3.2

BASIC INFORMATION ON REPRODUCTIVE AND SEXUAL HEALTH AND RIGHTS

Reproductive Health is defined by the WHO as a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this are the rights of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health-care services that enable women to safely go through pregnancy and childbirth.
(http://www.who.org/html/definition_.htm)

Reproductive Rights are the rights of men and women to be informed and to have access to have safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and child-birth and provide couples with the best chance of having a healthy infant. (ICPD Programme of Action, para 7.3)

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors. (WHO working definition 2002)

Sexual Health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships as well as the possibility of having pleasurable and safe sexual experiences free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (WHO working definition 2002)

The WHO 2002 definition says that sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- The highest attainable standard of sexual health including access to sexual and reproductive health care services:
- Seek, receive and impart information related to sexuality:
- Sexuality education
- Respect for bodily integrity
- Choose their partner
- Decide to be sexually active or not:
- Consensual sexual relations:
- Consensual marriage
- Decide whether or not, and when, to have children
- Pursue a satisfying, safe and pleasurable sexual life

The responsible exercise of human rights requires that all persons respect the rights of others.

How are reproductive health and rights different from sexual health and rights?

Reproductive health refers to health in the context of reproduction, not only of heterosexual people of reproductive age group (between 15 to 45 years), but also people who are younger, older, lesbian, gay, with disabilities and non-procreative. Health-related issues of infertile people and those who seek assisted reproductive technologies are also part of reproductive health.

Sexual health refers to health around sexual matters independent of reproduction, and deals with issues like the prevention and cure of sexually transmitted infections 9STIs), including HIV/AIDS, and sexual problems. Sexual health is a sexual right in itself, but it is also a necessary condition for the fulfillment of sexual rights.

Reproductive rights are about the rights of people to reproduce or not, free of discrimination, coercion and violence. They are meant to create the conditions under which women and men can control their reproduction.

Sexual rights refer to the rights of all people to decide about matters related to their sexuality freely and responsibly. Because they deal with sexuality independent of reproduction, they are wider in their scope. In addition to safety from violence, they offer the promise of a right to pleasure and life enriching experiences. Because of their de-linking from reproduction the right to diverse forms of sexual expression, identity and practice. Therefore sexual rights also apply to people practicing non-heterosexual and non-reproductive sexualities and actively bring men into the picture.

Why is the 1994 International Conference on Population and Development (ICPD) that was held in Cairo significant in the context of reproductive rights?

The 1994 International Conference on Population and Development (ICPD) held in Cairo was significant in the context of reproductive rights. The conference was a turning point

as it marked international recognition that a woman's right to reproductive health was a fundamental human right. It was also the first conference to put into place an explicit call for women's empowerment and gender equity, laying down guidelines for this in its Programme of Action. (PoA). The PoA included recognition of women's participation in development, and the connection between this and population growth. In the area of reproductive health and rights, ICPD's PoA also included the right of couple to plan and space their children, non-coercive family planning integration of family planning efforts into basic reproductive health care, and a general confirmation that successful efforts towards sustainable population growth would include attention to individual family planning needs rather than a general focus of demographic targets, It also emphasized gender equity and sexuality as being essential the women's health rights and stated that comprehensive reproductive health care should include information on family planning, prevention of STIs, prenatal and postnatal care, choice of contraception, prevention of infertility, and prevention of unsafe abortion.

179 governments and over, 500 NGOs from 113 countries attended the ICPD. Women's groups were instrumental in raising awareness of the gender inequities in development and other arenas, and worked to put forth an agenda for women's empowerment and access to reproductive health services as a human right. Funding estimates were given to each country and the ultimate objective was to have family planning and reproductive health services available to people no later than 2015.

What is the background of the Fourth World Conference on Women in Beijing in 1995?

The Fourth World Conference on Women (also known as Beijing Conference built upon the momentum created by ICPD and emphasized the importance of a gender perspective in policies and programmes. The Platform of Action for Beijing addressed issues related to the social and political empowerment of the women, including their right to accessible health services that included reproductive health services, 189 governments and nearly 5,000 representatives from NGOs around the world attended the Conference. A central focus for the conference was that rights are universal and need to be implemented by all nations. It also highlighted the political, social and economic inequities faced by women around the world and the need for change in attitudes and practices that cause these inequities.

MODULE 4: YOUTH FRIENDLY SERVICE PROVISION

Activity 4.1
Identifying with the client

Objective: To explain client provider interaction from the perspective of youth

Materials:
Slide "What is a Client-centred Approach?"

Time: 25 min

1. Share the objectives of the sessions
2. Share and explain the definition of a client centred approach through the following slide:

> **What is a Client-Centered Approach?**
>
> A client-centered approach is where service providers are aware of their clients' needs and respect their clients' rights. In a client-cntered approach service providers place the specific needs, risks, concerns and circumstances of each client at the centre of clinical services, and client-provider interaction becomes a two-way communication that allows clients to:
>
> - Become aware of their own sexual health risks and issues
> - Explore their options for addressing their sexual health concerns
> - Make **informed choices** and decisions on the basis of their own needs and social circumstances
> - Develop the skills required to successfully carry out their **decisions**

3. Explain that in order to place the needs of the client at the centre of clinical service delivery, providers need to see client-provider interactions through the eyes of the client. Tell participants that in order to help them see through the eyes of the client that you will play an audio recording of a short story. Explain that while they hear the story of a client's visit to a clinic, you would like the participants to pretend that they are the client being described. At different points in the story you will stop the recording and ask the participants to write down how they are feeling at that moment.

4. The story is as follows:

Guided fantasy
Imagine you are a 20 year old woman from a low-income community in Karachi, visiting a nearby hospital for the first time. You have five children; three are at home and two are with you. You are uncomfortable reading Urdu or English. It takes you over an hour to

reach the hospital by bus. When you arrive you see that the waiting room is very crowded. You ask a woman standing next to you, who you should speak to about your problem. She points you to a man sitting behind a desk who looks like he might be the receptionist. (NOW STOP. Write down how you feel).

You go up to the receptionist and try and tell him your problem. At first he does not pay much attention and starts talking to a nurse standing next to him. When he looks at you he appears very irritable. You begin to explain your problem. Before you can finish, he interrupts you and asks for your name. He gives you a slip of paper, and asks you to pay the consultation fee. You give him some money and then he points you to the waiting room (NOW STOP. Write down how you feel).

You take the slip the receptionist has given you and find a place to sit in the waiting room. You wait for an hour. Your children are getting very restless and want to go home. You don't know how much longer you will have to wait. You see a nurse standing somewhere nearby. You approach her and try and ask her how long you have to wait. She takes your slip and looks at it briefly and passes it back to you. She tells you in an annoyed tone that you have to wait just like everyone else and that when your name is called it will be your turn. (NOW STOP. Write down how you feel).

After about 20 minutes the nurse leads you and your children into the examination room. There are three other doctors also in the room. The nurse points you to your doctor. She looks much older than you, as though she is in her 50s. The doctor gives you a disinterested look and asks you what your problem is. You notice an older woman, who is a client of one of the other doctors in the room, waiting in front of her doctor's desk for her doctor to return from somewhere. She is watching you as you speak. You tell the doctor that you have been taking the birth control pill and experiencing intense nausea. The doctor looks down scribbling in her notebook. She listens to you briefly and then interrupts you. She tears the sheet of paper from her notebook and hands it to you. She gives the names of the anti-nausea medication and tells you, you must take this medication. She speaks quickly and the names of the medicines are difficult for you to understand. She tells you that you better not be foolish and forget to take your medicine, otherwise, your nausea will continue. You ask the doctor if maybe you should try another form of contraception and start to explain that you don't like the way you feel when you take the pill. The doctor snaps that there is no need to take anything else if you take your anti-nausea medication. You still have some questions and concerns but decide not to ask them. (NOW STOP. Write down how you feel)

5. After completing the story, facilitate discussion by using the following probing questions:
    - How did it feel to pretend to be this client?
    - How would you want to be treated if you actually were this client?
    - What can be done to reduce the negative feelings and emotions described?
    - What are some of the things you may have wanted the doctor to explore with you, but she didn't?
    - Why is it important to see through the clients' eyes?

Activity 4.2
Qualities of Youth Friendly Service Providers

Objective:
To identify the knowledge, skills and attitudes that service providers should have when working on sexual health issues with youth

Materials
- Life sized human silhouette (if prepared before activity)
- Flip Chart
- Tape
- Markers
- Coloured Slips of Paper (3 colours)

Time: 30 min

Steps
1. Share objectives of the session
2. Tape 2 flipcharts together
3. Ask for a volunteer from the audience to lie down on them and trace his/her outline (top half) on the flipchart. Paste this outline on the wall Make sure that the Head, Heart and Hands are clearly marked **Note***: **If participants are uncomfortable with this, prepare the outline before the activity***
4. Tell the participants to imagine that the outline/silhouette represents an ideal youth friendly service provider
5. Distribute one set of coloured slips of paper. The slips should all be the same colour, i.e. green. Give the participants 5 min to write down 3 examples (one on each slip of paper) of the knowledge that a service provider should have when working on sexual health issues of youth. When participants have completed the task, invite them to paste their responses on the "head" of the outline.
6. Distribute another set of the coloured slips (for e.g. pink). Ask the participants to write down 3 examples (one on each slip of paper) of the attitudes a service provider should have when working with youth on sexual health. When participants have completed the task, invite them to paste their responses on the "heart" of the outline.
7. Distribute the third set of coloured slips (for e.g. blue). Give the participants 5 min to write down 3 examples (one on each slip of paper) of the skills a service provider should have when working on youth friendly service provision. When participants have completed the task, invite them to paste their responses on the "hands" of the outline.
8. Invite one of the participants to come up and read all the posted slips of paper. Take this opportunity to add your own responses
9. Share the following slide to emphasize the qualities (knowledge, skills and attitudes) identified by the participants and to discuss qualities that haven't been addressed by the participants. Share that the environment created also needs to be youth friendly, e.g. ensuring privacy and confidentiality and providing a

comfortable surrounding with sufficient privacy and adequate space. Other characteristics of youth friendly services also include convenient practice timings and location (e.g. linkages with schools, clubs or other youth gatherings) so that youth can access services easily.

Important Qualities for YOUTH FRIENDLY Service Providers:

- Respect is shown to young people
- Empathy – Caring about the needs of the client and putting oneself in the client's situation
- Good communication skills
- Being non-judgmental - Tolerance for different values/behaviors especially when dealing with unmarried clients
- Comfort discussing human sexuality and feelings
- Good knowledge about adolescent sexual and reproductive health concerns
- Treatment and management of sexual health issues
- Privacy and confidentiality are maintained
- Adequate time is given for client-provider interaction
- Convenient timings and location of practice

Activity 4.3
Application of Client's Rights

Objective:

Identification of clients rights through practical case scenarios of youth

Time: 40 min

Materials:

- Handout on Client's Rights
- Case Studies

Steps:

1. Distribute the Handout on the Client's Rights
2. Divide the participants into 3 small groups. Assign each group a case study. Give the groups 15-20 min to read and discuss the case studies and answer the corresponding questions.
3. Ask participants to return to the larger group and invite each small group to share their case studies and discussions. After each presentation, ask for reaction and questions from other participants.

Suggested Questions:

- Do you agree with the conclusions of the group? Would you suggest an alternative?
- How would the application of the Clients' Rights help the youth in the case scenarios?

Case Study 1:

Najmah, 16-years old, has been experiencing vaginal discharge and intense vaginal itchiness for the past 10 days. Najmah is not sexually active, and thinks that she may have a yeast infection. She decides to visit a gynaecologist at a nearby clinic. When Najmah arrives at the clinic she sees that there are many women waiting their turn in the waiting room. She approaches a woman behind a desk who looks like the nurse. The woman asks Najmah her name and age. Then she asks her if she is married. Najmah informs the nurse that she is unmarried. "If you are unmarried, why have you come here?" the nurse responds in a very loud voice. Najmah tells the nurse that she has a small problem that she wants to see the doctor about. "I know you have a problem, but what kind of problem do you have?" the receptionist snaps. Najmah embarrassedly tells the nurse that she will talk to the doctor when she meets her herself. The nurse passes Najmah a slip of paper and asks her to sit down and wait.

1. Why didn't Najmah want to tell the nurse her problem?

2. How do you think Najmah felt during this experience?

3. Do you think the nurse should be asking Najmah such questions?

4. Which of the clients' rights should the nurse think of in this situation?

Case Study 2:

Nigat, 22 years old, is married with 2 children. She has decided that she no longer wants to have any more children. She visits a nearby family planning clinic and informs the service provider that she wants to use the birth control pill. The provider tells Nigat not use the birth control pill. She tells Nigat that it will be difficult for her to remember to take the pill every day. Instead, she tells Nigat that DPMA injections will be more a more convenient method for her since she will only have to take the injection once every 3 months. Nigat agrees to use DPMA because she doesn't want to argue with the service provider, and she assumes that the provider knows better than she does. When Nigat starts using DMPA she begins to experience spotting or "break-through bleeding". Nigat finds this very inconvenient as she believes that she cannot pray and is *na-paak* when bleeding. Nigat stops taking the injections. Six months later she returns to the clinic pregnant.

1. Do you agree with how the service provider handled this case? Why or why not?

2. How do provider values and biases affect a client's ability to make and their own decisions?

3. Which of the clients' rights should the doctor think of in this situation?

Case Study 3:

Kamran, is a 19 years old, single man with a good job. He does not want to settle down and describes himself as a "good time guy". Since the past one month he has noticed a scanty, thin discharge from his penis and experiences pain on passing urine. He gets really worried and decides to go to the local doctor. When he tells the doctor his problem, the doctor gets really uncomfortable and tries to divert the topic by asking him other questions. Kamran insists on talking about his problem to which the doctor without examining or asking further details about the symptoms, prescribes some medication and hands it to Kamran.

On taking the medication Kamran experiences no change and goes back to the doctor, who in turn accuses him for not taking his medication on time.

1) Do you agree with how the doctor handled the case

2) How do you think Kamran would have felt during both his experiences?

3) What do you think that Kamran would have done after his second experience with the doctor?

4) Do you agree with how the doctor handled the case on both occasions? If no then suggest ways on how it could have been handled?

HANDOUT 4.3: CLIENT'S RIGHTS

The Clients' Rights Include:

1. The right to information: The right to learn about the benefits and availability of sexual/reproductive health services.

2. The right to access: The right to obtain sexual/reproductive health services regardless of sex, age, religious or political belief, color, marital status or location

3. **The right to choice:** The right to decide freely whether to practice family planning and which method to use.

4. The right to safety: The right to be protected from unwanted pregnancy, disease, and sexual violence. When seeking sexual/reproductive healthcare the right to safety also means that clients have the right to protection from other health risks such as protection from infection through contaminated instruments.

5. The right to privacy: The right to have a private environment during counseling or services.

6. The right to confidentiality: The right to be assured that personal information will remain confidential.

7. The right to dignity: The right to be treated with courtesy, consideration, and attentiveness.

8. The right to comfort: The right to feel comfortable when receiving services.

9. The right to continuity: The right to receive contraceptive services and supplies for as long as needed.

MODULE 5: Communication and Counseling skills

Activity 5.1
Effective counseling and communication

Objectives

1. To help the participants identify effective communication skills, including nonverbal communication, verbal encouragement, simple language, and clarification.
2. To help the participants identify effective counseling skills.

Time

60 minutes

Materials

- Flipchart paper
- Markers
- Handout: "Characteristics of Effective and Ineffective Counselors"

Steps

1. Tell the participants that during this activity they will be discussing and reviewing some key concepts of interpersonal communication that are the foundation for effective counseling.
2. Ask participants what they understand by 'communication', ask what they understand by 'effective communication'. Share the following definitions with them:

Communication is a process of transferring information from one entity to another

Effective communication is a process where a message is received and understood by the receiver in the manner that the sender intended it to be

3. Ask participants if they know the definition of interpersonal communication. Share the following explanation with them:

- Interpersonal communication is information exchanged between people via words, gestures/signs and body language.

- This can be between one sender to the receiver(s) or an exchange between multiple senders and receiver(s)

4. Inform the group that a major part of communication does not involve any words at all. This is called "nonverbal communication by demonstrating actual nonverbal cues. Examples may include the following:

Positive Nonverbal Cues

- Leaning toward a client
- Smiling
- Avoiding nervous mannerisms
- Presenting interested facial expressions
- Maintaining eye contact
- Making encouraging gestures, such as nodding your head

5. Ask participants to brainstorm on negative non verbal cues, include the following:

Negative Nonverbal Cues

- Reading from a chart
- Glancing at your watch
- Yawning
- Looking out the window
- Fidgeting
- Frowning
- Not maintaining eye contact

6. Ask the group to explain the impact that positive and negative nonverbal language has on establishing and maintaining a good relationship with a client.

7. Share that another important aspect of effective communication is called" verbal encouragement." This lets the client know that the service provider is interested and paying attention. Ask the participants to give examples of verbal encouragement that service provider can use to encourage clients to feel comfortable divulging personal information. Examples may include the following:
    - "yes"
    - "I see"
    - "Right"
    - "Okay"
    - "Really? Tell me more about that".
    - "That's interesting"

A part of verbal encouragement involves asking "open-ended questions." These require the person answering the questions to replay with full answers, rather than a simple "yes" or "no". Questions that require only a "yes" or "no" response are called "closed-ended questions".

7. Ask the participants to change the following closed-ended questions to open-ended questions:

Closed-Ended Questions	Open-Ended Questions
Do you want counseling?	Please tell me why you are here today. What can I help you with?
Do you have any questions about puberty?	What sort of questions do you have about puberty?
Are you scared to talk with me?	Why are you scared to talk with me?
Do you have problems at home?	Tell me about your home life.
Were you upset when your friends made fun of you?	How did you feel when your friends made fun of you?
Are you sexually active?	If you are comfortable enough, please tell me about your sexual activity.

8. Tell the participants that when they speak with adolescents, it is important to use simple language that youth can understand. Ask the participants to provide examples of all reproductive health terms that an adolescent may not understand. Also ask them to suggest words that could be used instead.

9. State that appropriate responses from a service provider can also enhance the client-provider relationship. “Paraphrasing” is a way to make sure that the service provider has accurately understood what the client is communicating. It also lets the client know that the service provider is interested in what he or she is saying.

10. Divide participants into groups and ask them to prepare a list on important characteristics of effective counselors. Refer to handout for characteristics of effective counselors

11. Ask any two volunteers to enact a role play to demonstrate effective counseling skills. The volunteers can choose any issue related to youth sexuality. Once, the role play is complete, ask participants to give feedback based on the list developed for effective counselors. Distribute the handout to participants on effective and ineffective counseling.

Summary

Remind the participants that it is important to be conscious of their interactions with adolescents. It is also important to help youth feel comfortable during their first visit. Encouraging them for other visits if they need to is helpful. Tell the participants that adolescents are extremely aware of and sensitive to nonverbal messages. Explain that improving communication and counseling skills will contribute to quality services for youth.[5]

5 Adapted from EngenderHealth, (2002), Youth Friendly Services: A Manual For Service Providers, New York

Handout 5.1: Characteristics of Effective and Ineffective Counselors

Effective Counselors

- Exhibit genuineness: they are reliable, factual sources of information
- Create an atmosphere of privacy, respect, and trust
- Communicate effectively: for example, they engage in a dialogue or open discussion
- Are nonjudgmental: they offer choices and do not criticize the client's decisions
- Are empathetic
- Are comfortable with sexuality
- Make the client comfortable and ensure his or her privacy
- Talk at a moderate pace and appropriate volume
- Present messages in clear, simple language that the client can understand
- Ask questions of the client to make sure that he or she understands the message
- Demonstrate patience when the client has difficulty expressing him or herself or understanding the message
- Identify and remove obstacles

Ineffective Counselors

- Interrupt conversations: they talk to other people and/or speak on the telephone during a counseling session
- Are judgmental: for example, they make decisions for the client
- Do not make the client comfortable and ensure his or her privacy: for example, they provide counseling in the presence of other people without the client's consent and break confidentiality
- Are poor nonverbal communicators: for example, they look away and frown
- Lack knowledge on reproductive health issues
- Are uncomfortable with sexuality
- Are difficult to understand: they talk at a fast pace and an inappropriate volume or use langrage that their clients cannot understand
- Do not ask questions of the client to make sure that he or she understands the message
- Do not demonstrate patience when the client has difficulty expressing him or herself or understanding the message
- Are not empathetic: for example, they are rude and not understanding of the client's problems or needs

Module 6: RTIs, STIs & Family Planning

Activity 6.1
Introduction to RTIs/STIs & Family Planning

Objective: To recall basic information on RTIs, STIs and Family Planning including:

- Epidemiology, Transmission, Prevention
- Signs and Symptoms
- Types
- Complications
- RTIs and Family Planning
- Family Planning Methods

Time: 1 hour

Materials:

- Buzzer or bell for quiz
- Handout for participants

Steps:

1. Share objectives of session

2. Distribute handout on RTIs/STIs and Family Planning. Explain to participants that they will be learning about RTIs/STIs and Family Planning through playing a quiz like game, during which they will be tested on the information in the handouts. Tell the participants that they have 15 minutes to review the handout, and will be able to use the handout during the game. Give the participants 15 minutes to review their handouts.

3. Select a score keeper and divide class into two teams. Give each team a bell or buzzer.

4. Refer to question sheet and ask questions related to the different topics

5. Give each team 15 seconds to discuss and answer the question.

6. If a participant is correct, award his/her team the points. If the participant is incorrect, that number of points will be subtracted from his team's total and the question can be answered by the other team.

Questions and Answers for RTI/STI and Family Planning Quiz

1. Globally, which curable STI is the most prevalent

Trichomonisas 174 million.

2. Asides from vaginal sexual intercourse, name at least 3 modes of STI transmission.

Blood Transfusion (only HIV and Hep B) 2) Contaminated Needles, Syringes, Instruments (HIV and Hep B). 3) Mother to Child (HIV and Hep B) 4) Anal/oral sex in the presence of blisters, cuts, wounds, etc.

3. Name 4 behaviours that an individual can practice to reduce his/her personal risk of contracting an STI

1) Reduce number of partners 2) Abstinence 3) Mutually monogamous relationship 4) Use of barrier protection when performing penetrative sex 5) Practice non-penetrative sex 6) Treating self and partner 7) Prompt health seeking behavior

4. Trichomoniasis is an STI which is asymptomatic for both men and women, true or False?

FALSE: Asymptomatic in men but symptomatic in women. Men often refuse treatment

5. What are the two permanent methods of family planning and name two advantages and disadvantages of each?

Vasectomy: Advantages Does not interrupt intercourse, Permanently prevents pregnancy

Disadavantages: Surgery required, Does not reduce risk of STI and HIV transmission.

Tubal ligation: Advantages: Does not interrupt sexual intercourse, Permanently prevents pregnancy

Disadvantages: Complications such as infection can occur from surgery, No protection against STIs

6. Which of the following pathogens are associated with vaginal discharge:
    - Candida Albicans
    - Treponema Pallidum
    - Herpes simplex virus
    - Gardenerella
    - C. trachomatis

    Answer: Candida Albicans , Gardenerella , C. trachomatis

7. Name the 5 curable/bacterial STIs.
   Gonorrhoea
   Chlamydia
   Trichomoniasis
   Syphilis
   Chancroid

8. Name the 4 incurable/viral STIs.
   HIV/AIDS
   Hepatitis B
   Human Papilloma Virus
   Genital Herpes.

9. Name the 3 RTI types and give a brief definition of each

Exogenous – **Exogenous** or Sexually transmitted infections (STIs) are caused by viruses, bacteria, or parasitic organisms that are transmitted through sexual activity with an infected partner.

Endogenous –**Endogenous infections** result from an overgrowth of organisms that are normally present in the vagina

Itrogenic - In **iatrogenic infections** the cause of infection is introduced into the upper reproductive tract through a medical procedure such as menstrual regulation, induced abortion, the insertion of an IUD, or during childbirth.

10. How can post IUCD infections be prevented?
    1) Careful screening (history and examination to exclude RTIs), required before insertion.
    2) Proper infection prevention techniques such as use of sterilized instruments, proper loading of IUCD, non-touch technique, proper waste disposal

11. Which Family Planning method effectively protect against STIs
    Male and female condoms

12. What is dual protection?
    Dual protection involves both choosing a family planning methods and making decisions about one's sexual behaviour at the same time. Anyone at risk of STIs should use condoms to protect against STIs and another a method to protect against pregnancy.

Handout 6.1 - Answer sheet of the Quiz Game

Epidemiology and Prevalence

1) Global disease burden:

- In 1999, 340 million people were infected with a curable STI
  Gonorrhea ---62 million
  Chlamydia ---92 million
  Syphilis--- 12 million
  Trichomoniasis---174 million.
- Non-sexually-transmitted RTIs are even more common
- HIV/AIDS
  - In 2003, about 5 million people were newly infected with HIV, and
  - An estimated 38 million people now live with HIV and AIDS

2) Prevalence of RTIs in Pakistan

- According to by **Aahnug in 1996:**
  - 379 out of 600 women complained of vaginal discharge
  - 405 out of 600 women sought treatment for normal vaginal discharge

- According to a study by **SACP in 1999** with community women it was found that:
  - Candidial Infection was 11.5%
  - Infections related to unsafe instrumentations were 8.0%
  - Prevalence of STI in symptomatic women was 22.8%

Types of RTIs (Endogenous, Exogenous, and Iatrogenic)

I. Endogenous Infections:

- Result from an overgrowth of organisms normally present in the vagina.
- Include ***candidiasis*** and *bacterial* ***vaginosis***
- Effect the lateral vaginal wall, and duration is intermittent.
- Although endogenous infections are usually *not* sexually transmitted, they may be sexually associated possibly because sexual intercourse affects the vaginal flora (e.g. by increasing vaginal pH).
- In some cases, men experience the itchiness and discomfort of candidiasis.

TYPES OF ENDOGENOUS INFECTIONS:

Bacterial Vaginosis		
Description	***Signs and Symptoms***	***Complications***
• Arises from an imbalance in the normal vaginal flora, which results in a loss of lactobacilli and can change vaginal pH. • It can increase the risk of sexual transmission of HIV • **May be** sexually transmitted	• Thin gray, white or yellow/green discharge • Itching and soreness of the vulva and vaginal area. • Fishy smelling discharge	• Premature rupture of the membranes in pregnancy • Premature birth and low birth weight. • Pelvic inflammatory disease which can lead to ectopic pregnancy, infertility, and chronic pelvic pain.
Candidiasis		
Description	***Signs/Symptoms***	***Complications***
• Caused by the fungus candida. • Recent use of antibiotics, oral contraceptives that contain progesterone, or the presence of stress, allergies, diabetes, pregnancy, or immune suppression can increase a woman's chances of developing candidiasis.	• Thick curd-like discharge. • Itching, soreness of the vulva and vaginal area (vaginitis), can cervical tissue • Painful intercourse, • Burning during urination	If present during pregnancy can cause Stomatitis in infants

II) Iatrogenic Infections

- Result of bacteria being introduced into the upper reproductive tract through a medical procedure, such as the insertion of an IUD, an induced abortion, or during delivery.
- Causal bacteria originate either from improperly sterilized examination or medical instruments or from endogenous or sexually transmitted infections already present in the lower reproductive tract.

III) Sexually Transmitted Infection's/ Exogenous Infections

Exogenous or Sexually transmitted infections (STIs) are caused by viruses, bacteria, or parasitic organisms that are transmitted through sexual activity with an infected partner.

This is a group of Infectious Diseases which rates high among young adults between 15-29 yrs

IV) Types of Sexually Transmitted Infections:

a) STIs in Females:

Trichomoniasis:

- o Women suffering from Trichomoniasis may present with yellowish green, diffuse and offensive smelling vaginal discharge.
- o Trich infections are located in the posterior fornix and these infections aggravate during or after menstruation and pregnancy.
- o Associated symptoms can be of dyspurenia, dysuria and increased frequency of micturation

Gonorrhea:

- o The discharge does not have any specific appearance.
- o Site of infection is the cervix and the onset is usually gradual.
- o The infection can spread above the cervix to the lower abdomen and the back causing lower abdominal pain and backache.
- o Associated symptoms are of dysuria, or frequency of micturation.
- o Other possible complications include ectopic pregnancy, tubo ovarian mass or infertility.

Chlamydia:

- o The discharge is Mucopurlent coming from the cervix.
- o Its onset is intermittent which spreads over the cervix to the lower abdomen and the back.

b) STIs in Males:

- RTIs in men generally begin in the lower reproductive tract (**the urethra**). If untreated they will ascend through the vas deference to the upper reproductive tract which includes the **epididymis** and the testis

1) Urethritis:

Pathogens	Signs and symptoms	Complications
Gonococcal: Gonorrhoea	• Muco purulent or cloudy white or yellowish green discharge from the tip of the penis • Pain or burning during urination • May have pain during sex • In men over 50 there may be dribbling of urine	• Partial or complete blockage of the sperm duct • Low sperm count in semen or abnormal sperms • Male infertility
Non Gonococcal: C trachomatis, Chlymadia Ureaplasma urealticum and mycoplasma genitalium T vaginalis and HSV		

2) **Epididymitis:**

Types	Signs and Symptoms
Sexually transmitted is usually asymptomatic	• Unilateral testicular pain • Tenderness • Hydrocele and palpable swelling of the epididymis • Urinary tract infections

c) Classification of STIs:

Curable/Incurable and Symptomatic/Aysmptomatic STIs

<table>
<tr><td colspan="4">Bacterial are curable:(ulcerative, non ulcerative)</td><td>Viral (incurable)</td></tr>
<tr><td>Ulcerative</td><td>Non Ulcerative</td><td>Men</td><td>Women</td><td></td></tr>
<tr><td rowspan="3">• Syphilis
• Chancroid</td><td>• Gonorrhoea</td><td>symptomatic</td><td>Asymptomatic</td><td rowspan="3">HIV
HPV
Hep B
Genital Herpes</td></tr>
<tr><td>• Chlamydia</td><td>symptomatic</td><td>Asymptomatic</td></tr>
<tr><td>• Trich</td><td>Asymptomatic</td><td>Symptomatic</td></tr>
</table>

d) STI Syndromes:

SYNDROME	CAUSES
Urethral discharge	N.Gonorrhoea, C. Trachomatis
Genital Ulcer	Treponema pallidum, Haemophilis ducreyi, Calymmatobacterium granulomatis, Herpes simplex virus
Vaginal discharge	*CERVICITIS*: N. gonorrhoeae, C. trachomatis, *VAGINITIS*: Trichomonas vaginalis, Candida albicans, Gardnerella vaginalis
Pelvic Inflammatory Disease	N. gonorrhoeae, C. trachomatis, anaerobic bacteria, other pyogenic organisms, T.B
Ophthalmia neonatorum	N. gonorrhoeae, C. trachomatis, Other pyogenic organisms
Scrotal Swelling	N. gonorrhoeae, C. trachomatis, other pyogenic organisms, viruses and surgical conditions

e) Relationship of HIV and the other STIs:

Type of STI	Risk of HIV	Way in which STI transmission is facilitated
Ulcerative STIs: Chancroid Syphilis	3-9 times	The presence of open sores and blisters/ ulcers allows for greater contact of bodily fluids and access to the bloodstream for the virus
Herpes Simplex Virus	2 times	
Inflammation-causing STIs: Chylamadia Gonorrhoea Trichomonas	3-5 times	These infections increase genital shedding of HIV infected cells. In addition, urethral and endocervical infections that cause inflammation allow for more efficient exchange of infectious particles

Consequences and Complications of RTIs:

- Maternal mortality and morbidity
- Infant mortality and morbidity
- Social and economic burden (Relationship problems, economic burden, depression, anxiety, stigmatization, abuse, abandonment)

Women	Men	Infants
PID leading to: Infertility, ectopic pregnancy, chronic lower abdominal pain and tubo ovarian mass/abscess	Infertility	Eye infections or conjunctivitis (gonococcal/chlymadia) leading to blindness

Cervical cancer	Narrowing of urethra/urethral stricture	HIV
Increase chance of HIV transmission	Prostatitis	Death
		Infection of the lungs
		Congenital syphilis
		Encephalitis

Reproductive Tract Infections, Pregnancy and Children

If present during pregnancy RTIs may result in the following complications:

RTI	Possible outcomes			
	Spontaneous abortions	**Premature rupture of membranes**	**LBW and prematurity**	**Still births**
Bacterial Vaginosis	✓	✓	✓	
Syphilis			✓	✓
Gonorrhoea		✓	✓	
Trich		✓	✓	
Herpes simplex			✓	
HIV/AIDS			✓	✓

Prevention of STIs:

Many STIs go undiagnosed or have no treatments available, preventing their transmission is crucial. Risk can be reduced through the adoption of safer behaviors by individuals. Encouragement of these behaviors should then be incorporated into programs and policies

Individual behaviors	Programs and Policy
Reducing the number of partners	Promoting safer sex messages
Abstaining from sexual activity	Public education campaigns which include promoting awareness of early treatment of curable STIs, use of media to promote messages to reduce risk, include STI education in schools and medical curriculums
Being in a mutually monogamous relationship	**Health Facilities**: • Non stigmatizing and non discriminatory environment • Comprehensive management of syndromes • Accessibility and affordability of effective drugs and condoms

	• Training of health care providers to manage and treat STIs
Use of barrier contraception such as male or female condoms during **penetrative sex:**	Tracing, treating and educating target groups and their contacts
Practice non-penetrative sex: Mutual masturbation, rubbing body parts	Promoting Delayed age of marriage/first sexual intercourse
Delaying age of marriage/first sexual intercourse	Reaching vulnerable population such as women and youth
Treating STI in self and partner	Making barrier contraceptives accessible and affordable
Prompt and appropiate care seeking behavior	

RTIs and Family Planning

Reproductive tract infections are related to family planning issues in numerous ways.

- Symptoms of infection may be attributed to contraceptive methods and might thus change attitudes toward contraception.
- Certain family planning methods may create risks for infection or worsen pre-existing RTIs.
- Family planning methods that best protect against unintended pregnancy are not the same that best prevent sexually transmitted infections.

Method	**Relationship to RTIs**	**What can be done?**
Oral contraceptive	- Can disrupt the balance of the vaginal environment (especially high dose pills), predisposing development of candida (yeast infection) - Does not protect from STIs - May decrease risk of PID	Encourage use of low-dose contraceptive pills Suggest the use of barrier methods for additional protection against STIs
Hormonal implant	- Does not protect from STIs. Possibly increase the risk of chlymadial infection. - May decrease the risk, prevalence and severity of PID	Suggest the use of barrier methods for additional protection against STIs
Injectables	-Does not protect from STIs -May decrease risk of PID	Suggest the use of barrier methods for additional protection against STIs

Diaphragm and/or spermicide	-Some **partial** protection against STIs; - - -Unknown protection from viral STIs, including HIV - Regular use of spermicides reduces cervical gonorrhea by 25% and Chlamydia by 22%	Suggest the use of more effective barrier methods for additional protection against STIs
Male latex condoms and polyurethane sheath (female condoms)	Effectively protect against STIs, including HIV/AIDS when used correctly and consistently	Promote the correct and consistent use of male latex and female polyurethane condoms
IUD	Insertion with improperly sterilized medical implements or in a woman with an untreated RTI can introduce bacteria into the uterus, causing iatrogenic infection No protection from STIs	Treat first or provide a different method; consider prophylactic antibiotic administration Suggest the use of barrier methods for additional protection against STIs **Post IUCD infections can be prevented by:** 1) Careful screening (history and examination to exclude RTIs), required before insertion. 2) Proper infection prevention techniques such as use of sterilized instruments, proper loading of IUCD, non-touch technique, proper waste disposal
Female and male sterilization	Risk of iatrogenic (surgical) infection. Does not protect from STIs, although may decrease risks of PID in women.	Sterilize all implements used in surgery and ensure adequate training of surgical providers. Suggest the use of barrier methods for additional protection against STIs

2) Sexually Transmitted Infections and Contraception

Unfortunately, the methods that best prevent pregnancy are not the same methods that best prevent the transmission of sexually transmitted infections. One strategy to protect against both unwanted pregnancy and STIs is called ***dual protection***.

a) Dual Protection: is defined as "the protection from pregnancy and STIs/HIV through condoms alone, condoms plus another contraceptive method, mutual monogamy among uninfected partners using contraception, abstinence, delayed onset of sex and avoiding all forms of risky sexual activity.

c) Methods most effective in preventing transmission of STIs:

- Barrier methods, such as the male and female condoms. The diaphragm with spermicide may help prevent the transmission of cervical STIs

Family Planning Methods

Contraception refers to the prevention of conception by the use of birth control methods

Type	Mode of action	Advantages	Disadvantages

Male condom	Ejaculation is collected in the condom and does not enter the vagina	Reduces the risk of STI and HIV transmission (only through latex condoms) Widely available without doctors prescription Low costs 85-98% effective if used correctly No side effects Fertility not affected	Chances of rupture if not used properly May experience allergic reaction to latex Requires discipline, can disrupt spontaneity during sex If stored incorrectly (warm/moist conditions) can disintegrate
Combined oral contraceptive pills (contain estrogen and progestin)	Inhibits ovulation. Thicken cervical mucus. (makes it hard for sperm to penetrate cervix) Change endometrium Reduce sperm transport in the upper genital tract that in the fallopian tubes	High success rates. Low cost Offers protection against ovarian, endometrial, rectal and colon cancers. Almost 100% effective if used correctly Reduces occurance of menstrual cramps, premenstrual syndrome, irregular bleeding, heavy periods, anemia and breast cysts Improved acne and hirsutism	Requires a lot of discipline and compliance from woman Effectiveness decreases if a tablet is skipped or forgotten Cannot breast feed Can cause: Nausea Bloating Fluid retention Increase in blood pressure Breast tenderness Migraine

			Headaches Irregular bleeding in first few months Mood disorders Weight gain May cause chloasma (dark patches on face) Increased risk of heart attack amongst women over the age of 35 who smoke Sedatives, antibiotics and antifungal reduce effectiveness
Combined contraceptive injections	Prevent monthly ovulation Thicken cervical mucus Change endometrium	Highly effective Decrease menstrual flow Decrease menstrual cramps May improve anemia Protect against ovarian and endometrial cancer Decrease benign breast disease and ovarian cysts Protect against some cause of Pelvic Inflammatory Disease (PID)	Irregular and/or prolonged bleeding Spotting Amonorrhea Client has to return for injection every 30 days Headache Nausea Breast tenderness Weight gain Mood change Acne Effectiveness may be lowered with certain drugs

			Can cause an increase in blood pressure Cannot breastfeed Cannot be used 6-8 weeks postpartum Migraine Breast cancers
Intra Uterine Devices	It thickens the cervical mucus, which provides a barrier that prevents sperm from entering the uterus. It also prevents some women's ovaries from releasing eggs (ovulation) IUDs also alter the lining of the uterus.	Over 99% effective in preventing pregnancy Most cost effective method of birth control over time No interruption of intercourse Safe to use while breast feeding Removable whenever the woman has problems or wants to stop using it Fertility returns with the first ovulation cycle following IUD removal Can be used for emergency contraception within 5 days of unprotected sexual intercourse Can be inserted after a normal vaginal delivery, cesarean section or abortion	Only a health care professional can insert and remove IUD Longer, heavier and more painful menstrual periods Increased blood flow can cause anemia Spotting can occur as a sign of infection Perforation of the uterus can occur while inserting the IUD If Pelvic Inflammatory Infection occurs then chances of infertility increases Can be expelled during periods

NATURAL METHODS

Natural methods include abstinence, withdrawal method, fertility awareness and breast feeding. Natural methods (unless it is abstinence) are not as effective as artificial methods.

Type	Mode of action	Advantages	Disadvantages
Abstinence	Defined as either choosing to abstain from sexual activity, or refraining from any penetrative sexual acts	Nothing to purchase. Can be discontinued at any time Reduces the risk of STI and HIV transmission	Requires the cooperation of both partners which may not be possible at times. Potential to transmit some STIs such as syphilis if there as skin to skin contact during sexual activity
Calendar method (A Fertility Awareness Method)	When a woman keeps track of her menstrual cycle using a calendar for a few months, she begins to see a pattern developing. From this pattern she can calculate the shortest cycle minus 18 days (i.e. 26 – 19 =7) The longest cycle minus 11 days (i.e 32 – 11=22) This calculation gives a window period from day 7 to day 22 during which she must abstain from vaginal intercourse or use a contraceptive	No cost No side effects Acceptable for individuals who cannot use other forms of contraception or have religious concerns Fertility is not affected	Most women do not ovulate at the same time each month, and no woman's cycles are identical every time. For this reason, the calendar-rhythm method is not considered very effective unless menstrual cycles are always the same number of days. High failure rate No protection against STIs May be complicated and time consuming Requires periods of abstinence or back up contraception

<table>
<tr><td></td><td></td><td></td><td>for approx 1/3 of the month</td></tr>
<tr><td colspan="4">Other Fertility Awareness Methods include:

Basal Body Temperature: According to this method the woman has to keep track of her body temperature first thing in the morning before eating or drinking, with a special thermometer. This is because the body temperature rises on the day of ovulation and stays 0.2 degrees higher for approximately two days after ovulation.

Ovulation Method: In order for a woman to determine her time of ovulation, she will have to check the quality of the vaginal mucus which becomes slippery, elastic and clear one day before and after ovulation.</td></tr>
<tr><td>Withdrawal method</td><td>A man withdraws the penis from the vagina before ejaculation (when sperm is released during orgasm)</td><td>No cost

No side effects

Acceptable for individuals who cannot use other forms of contraception

Fertility is not affected</td><td>High failure rate

Advance planning required

No protection against STIs

Commitment from both partners required

Requires practice

Since it requires abrupt interruption it can be frustrating</td></tr>
<tr><td>Breast Feeding/Lactational Amenorrhea</td><td>During breastfeeding the process of ovulation and hence menstruation is suppressed</td><td>No side effects

Nothing to purchase

Exclusive breastfeeding

Does not interfere with sexual intercourse</td><td>No supplements to be used for the baby

Women who have HIV/AIDS may be advised to not breastfeed

Protection lasts for six months after birth</td></tr>
</table>

PERMANENT METHODS

Vasectomy (in males)	A surgical procedure that's seals the vas deferens, preventing sperm from getting into the semen. After a vasectomy, a man still produces semen but there is no sperm in it	Does not interrupt intercourse. Permanently prevents pregnancy Complications are rare	Surgery required Does not reduce risk of STI and HIV transmission. Can be emotionally difficult No protection against STIs Reversal surgeries are not highly successful
Tubal Ligation (in females)	The fallopian tubes are cut through a minor surgical procedure so that the eggs cannot get fertilized	Failure rate is low Does not interrupt sexual intercourse Permanently prevents pregnancy	Complications such as infection can occur from the surgery Can be emotionally difficult No protection against STIs Permanent

OTHER METHODS

Emergency Contraception (EC)	Is a form of birth control and can be sued to prevent pregnancy after having unprotected sexual intercourse. There are 2 types of emergency contraception. With the first, special doses of birth control pills are	Can be used after intercourse Can Use regular birth control pills Can get pills ahead of time so you have them when you need to use them Easy to use	Does not reduce risk of STI and HIV transmission ECPs can only be used up to 5 days after unprotected sex or contraceptive failure. Side effects are nausea, or vomiting.

	taken, with the other, an intrauterine device (also called an IUD) is placed in the uterus or womb.	Does not affect future fertility	Breast tenderness, late or early onset of the next period with heavier or lighter flow

[6]

[6]Adapted from Aahung's Pre Marital Pamphlets 'Fertility and Contraception'

Partners

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Aahung

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