Manual

Sexual and Reproductive Health and Rights (SRHR)

KENYA YWCA

KISUMU BRANCH

FK Norway Exchange Program 2018

Coordinating Partner:

Y-Global Norway

Other Partners:

Africa Alliance of YMCA

Amathea Norway

YWCA Kenya (Kisumu Branch)

ABOUT THE SRHR EXCHANGE PROGRAM:

The SRHR Exchange Program is an exchange program between two organizations in Norway and two organizations in Kenya. In Norway the two partners are Y-Global (YMCA/YWCA Norway) and Amathea Norway and in Kenya the partners are YWCA Kenya and Africa Alliance of YMCAs. The program is funded by FK Norway, an organization that supports the exchange of employees and members between businesses and organizations in Norway, Africa and Asia. FK Norway is exclusively financed by the Norwegian National Budget, and forms a part of the Norwegian Government's developmental policy and is directly subordinated the Norwegian Ministry of Foreign Affairs.

The overall goal of the SRHR exchange program is to: "Address the right of girls and young women in Kenya and Norway to receive correct SRHR information and to access SRHR services".

We are aiming to achieve this through:

- Outreach to young people who need SRHR information/training/advice.
- Conduct trainings/discussions with groups of young people and with leaders.
- Refer young people to appropriate SRHR service providers.
- Running campaigns to promote SRHR services.
- Network with partners and donors to strengthen SRHR information and services.

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1. Introduction to SRHR

Our sexual and reproductive health is often influenced by social and personal factors such as: lack of acknowledgement of human rights; gender inequality; perceptions of sexuality; interpersonal relationships; and communication and decision-making skills. Social and cultural norms also play its part. We should therefore show great sensitivity when addressing sexual and reproductive health.

A key step is to improve people's sexual and reproductive health is to ensure that people have access to information and services. Another step is to create more just social conditions; including gender equality and respect for people's rights.

We know it can be difficult to talk to people about topics related to sexuality and reproduction. These topics are not commonly spoken about, but we need to break the silence to improve ourselves and other people's health and wellbeing. The more comfortable you are talking about these topics, the more comfortable will other people also be. When people feel safe and comfortable, they speak more freely, give honest answers, ask questions and learn more. You create an open, safe and comfortable space if you show and ensure: *respect*, *privacy* and *confidentiality*. You show respect by accepting people's views, beliefs, values and experiences even if they are different from your own. You ensure privacy by making sure your discussions is conducted in a place where you cannot be overheard by others and that you are in a place that is free of interruptions. You ensure confidentiality not sharing the conversations with others. However, in some cases it can be necessary to share (i.e. to prevent further abuse). If that is the case you should explain why it is important to share, whom you are going to share with, when and how you plan to do so.

There are many different definitions on sexual and reproductive health and rights (SRHR). The World Health Organization (WHO) states that SRHR involves five key components:

(1) ensuring *contraceptive* choice and safety, and infertility services;
(2) improving *maternal and newborn health*;
(3) reducing *sexually transmitted infections* (STI), including HIV, and other reproductive morbidities;
(4) eliminating *unsafe abortion* and providing post-abortion care; and
(5) promote *healthy sexuality*, including adolescent health, and reducing harmful practices.

1.1. Sexual and Reproductive Rights

The *International Human Rights* protects the various elements of reproductive health. Human Rights are universal, meaning that they apply to everyone regardless of sex, age, marital status, sexual identity or behavior, gender identity, race, ethnicity, national or social origin, political beliefs, citizenship, religious beliefs, social or economic status, where we live, our physical or mental ability, or our health status. The Human Rights[1] have been agreed upon by

[1] The most important official human rights documents include: "*The Universal Declaration of Human Rights*" (1948); "*The UN Convention on the Right of the Child*" (1989); "*The Convention on the Elimination of All Forms of Discrimination Against Women*" (1979); "*The International Conference on Population and Development (ICPD) Program of Action*".

the global community of states (through the United Nations), formalized in international agreements and formally ratified by most governments.

Some of the most important sexual and reproductive rights include:

- It is only you who can decide about your own body.
- It is only you who decide if you want to have sex or not.
- It is only you who decide who you want to have sex with.
- It is only you who decide who you want as a partner or to marry.
- You decide if you want to become pregnant/father a child, how many children you want, when you want to have them and with whom you want to have children with.
- You are entitled to good contraceptive guidance and to choose a contraceptive you feel safe and comfortable with.
- You are entitled to pregnancy checkups.
- You are entitled to help and treatment of sexual problems.
- You are entitled to free diagnosis and treatment of sexually transmitted infections.

1.2. Access to Sexual and Reproductive Health Services

Access to health care services that are accessible to everyone, affordable and of good quality is essential to being able to fulfill our rights to maintain good sexual and reproductive health. We also have the right to be treated respectfully and for our privacy to be ensured. Unfortunately, many barriers keep us from seeking and obtaining the health services we need and deserve.

Barriers can include discrimination, stigma and even formal policies. Governments may not provide free or affordable health care services in all areas. Governments, providers or pharmacies may withhold access to certain health services or medications. These are actions which may be influenced by political or religious beliefs. Pharmaceutical companies may change unaffordable process for drugs and supplies. Some health programs may require that young people (particularly girls) obtain parental consent before receiving sexual or reproductive health care.

Another barrier may be poor quality of care which may discourage people from accessing available health services. Poor quality can include long waits and not receiving supplies or services needed. Some clients (especially unmarried, poor, sex workers, racial/ethnic minorities, transgendered, people living in same-sex relationships, or people living with HIV or AIDS) may experience judgmental treatment. Young people fear that their confidentiality may not be ensured, in addition to being stigmatized by health care providers. Lastly, gender norms may limit men from seeking sexual health services, especially when such services focus mainly on women, and women and young people often lack the decision-making power or money needed to access the services.

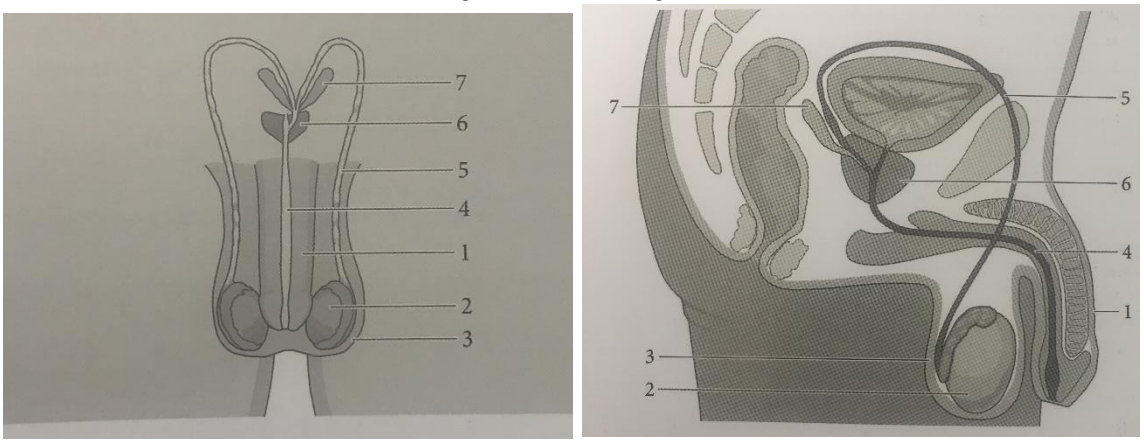
2. Body, Puberty and Reproduction

It is important that we all grow up with a sense of familiarity and confidence about our own body. This will enable us to take better care of our own sexual and reproductive health. If we have the knowledge about our body and the information about sexual and reproductive health issues we know how to protect ourselves from unintended pregnancies and infections, and we know when we should seek the advice and services from health care providers.

2.1. Sexual and Reproductive Organs, Functions and System

The sexual and reproductive systems share some but not all organs. The sexual system consists of those organs involved in sexual activity and pleasure. The reproductive system consists of organs playing a role in reproduction (conception, pregnancy and birth). The male reproductive system includes those organs that produce, store, or transport sperm for reproduction. The female reproductive system consists of those organs involved in pregnancy and birth.

2.1.1. Male Sexual and Reproductive System



(1) The ***penis*** has several functions. It is involved in sexual feeling; in this function it corresponds to the clitoris in the female. The penis may fill with blood and become hard and erect in response to sexual stimulation. The reproductive function of the penis is to deliver semen into the vagina. The third function is the excretion of urine (see urethra below). The end of the penis is covered by a layer of skin called the foreskin. In many populations, the foreskin is removed through a procedure called male circumcision.

(2) The ***testicles*** (or ***testes***) are two ball-shaped glands inside the scrotum which produce sperm and the male hormone testosterone. The scrotum and testes are sensitive to touch and can be a source of pleasure.

(3) The ***scrotum***, a loose bag of skin, holds and protects the testicles. When cold, it is pulled up tight toward the body to keep the testicles at the right temperature to produce sperm.

(4) The ***urethra*** is a tube that runs from the bladder through the penis. The urethra is the passageway through which semen (a mixture of seminal fluid, prostatic fluid and sperm) travels out of the body during ejaculation; urine also passes out of the body

through the urethra. A valve at the bottom of the bladder closes when the penis is erect to prevent urination during ejaculation.

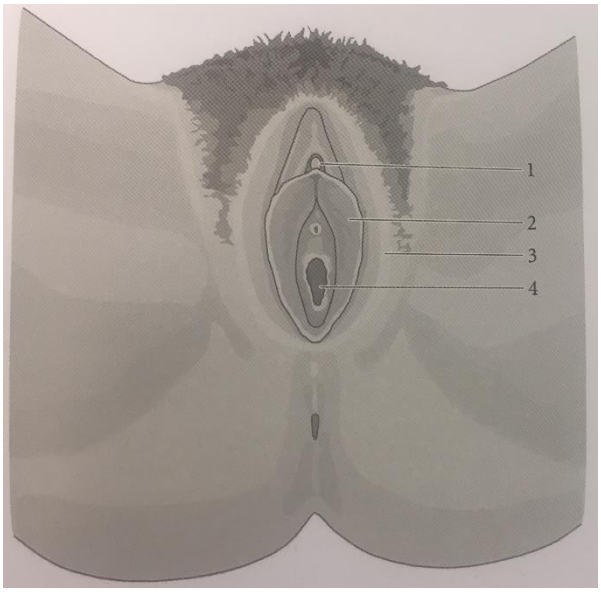
(5) The ***vas deferens*** are two long thin tubes that carry the sperm toward the urethra. They contract during ejaculation.

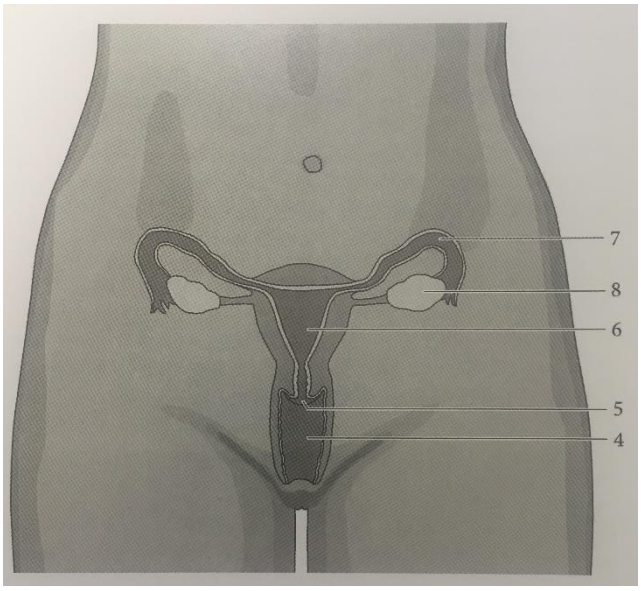
(6) The ***prostate gland*** produces a fluid that makes up part of the semen and helps sperm to move. Many men find stimulation of the prostate to be sexually pleasurable.

(7) The ***seminal vesicles*** produce much of the fluid that ultimately becomes semen. This fluid nourishes the sperm.

The ***epididymis*** (not numbered on these pictures) is a highly coiled tube that sits on top of each testicles and stores sperm as they mature until they are ejaculated. The ***Cowper's glands*** (not numbered) produce a thick alkaline fluid, called pre-ejaculate, that neutralizes the acid in the urethra before ejaculation.

2.1.2. Female Sexual and Reproductive System





The ***vulva*** (left picture) consists of all the visible external genital organs of the woman.

(1) The **clitoris** is a small organ, shaped like a slower bud with a bit of tissue forming a small "hood". The only function of the clitoris is to give girls and women sexual pleasure; it contains a rich network of nerve endings for sensation. During sexual arousal and during orgasm, the clitoris (and the genitalia in general) engorge and fill with blood, causing the clitoris to become erect. Women may feel vaginal contractions during orgasm.

(2) The ***labia minora*** (or ***inner lips***) also swell during sexual arousal.

(3) The ***labia majora*** (or ***outer lips***) cover and protect the vaginal opening.

(4) The ***vagina*** is an elastic canal, leading from the vulva to the cervix and uterus. When a woman is sexually aroused, the vagina produces lubrication. It has a few nerve endings and is therefore not highly sensitive. In vaginal intercourse, the penis penetrates he vagina. If the man ejaculates, semen enters the vagina and travels through the cervix into the uterus and fallopian tubes, where fertilization can occur if an egg is present. Menstrual blood leaves the body through the vagina, as does the baby when it is born. The vagina cleans itself and does not need to be washed out.

Women should not insert substances to dry or tighten the vagina; such substances can be harmful.

(5) The ***cervix*** is the lower part of the uterus that extends into the top of the vagina. An opening in the cervix, called the *os*, connects the vagina to the uterus. Menstrual blood passes out of the uterus through the os; and semen passes through it to the uterus. The cervix produces a secretion (cervical mucus) that aids sperm in entering the uterus. The cervical mucus changes during the menstrual cycle; women can learn to identify the fertile period according to the characteristics of the mucus. During childbirth, the cervix stretches, allowing the baby to pass through.

(6) The ***uterus*** is hollow, muscular organ that rests above the bladder. It is sharpened like an upside-down pear. Its lining (called endometrium) thickens with blood and tissue during the first part of the ovulation-menstrual cycle. If no embryo implants itself, the lining breaks down, becoming the menstrual flow. If an embryo implants itself, a fetus develops in the uterus.

(7) The ***fallopian tubes*** are two narrow, 4 to 5 inches long tubes through which the egg travels from the ovary to the uterus and in which the egg may be fertilized.

(8) The ***ovaries***, two organs, each the size of an almond or a grape, store the immature eggs in follicles, produce and secrete female hormones (estrogen and progesterone), and produce and release mature eggs (all women are born with a certain number of eggs, while men reproduce his sperm throughout his life).

The ***hymen*** (not numbered) is a thin membrane that may stretch across part of the vaginal opening. The hymen can be easily torn during sports or other physical activity and can be stretched open if a girl uses tampons. Therefore, a torn or stretched hymen does not indicate that a girls or woman has engaged in sexual intercourse.

2.2. Sexuality

Sex and sexuality are often thought of as sexual intercourse and activities. However, sex is whether a person is male or female and is determined by reproductive organs and how people express their gender. Sex is a part of sexuality. Sexuality is much more than sexual feelings and sexual intercourse. Sexuality includes thinking of oneself as a sexual being, feeling attractive, and behaving, dressing or communicating in a sexy way. It also includes feeling being in love and being in relationships with sexual intimacy and sexual activities.

Our culture, traditional beliefs and gender roles play an important part in defining what we consider normal sexual feelings and behavior for men and women. For example, some people choose to abstain from sex before marriage because of their family values or religious beliefs. Some cultural traditions recognize that women have sexual desires and urges whereas other cultures do not. In some cultures it is very important for girls to be virgins when they get married, while men are expected to be sexually active before they are married.

There are many aspects that make up sexuality. Each of these is connected and makes a person who he or she is. These aspects include:

- *Body image*: how we look and deal about ourselves, and how we appear to others.
- *Gender roles*: the way we express being male or female, and the expectations people have for us based on our sex.
- *Social roles*: how we contribute to and fit into society.

- *Relationships*: the ways we interact with others and express our feelings for them.
- *Intimacy*: close sharing of thoughts or feelings in a relationship, may or may not involve physical closeness.
- *Love*: feelings of affection and how we express those feelings for others.
- *Sexual arousal*: the different things that excite us sexually.
- *Sexual desire*: a longing for sexual expression or a feeling of sexual attraction.
- *Genitals*: the parts of our bodies that define our sex and that are part of reproduction and sexual pleasure.
- *Anatomy and sexual pleasure*: remembering that the brain is deeply involved in sexual experience and pleasure in addition to parts of the body.
- *Sexual behavior*: masturbation, caressing, kissing, stimulating partners genitals using hands, mouth and penetrating intercourse.
- *Sexual diversity*/orientation/identity: sexual desire for the other sex, the same sex or both (heterosexual, homosexual, bisexual, transgender etc.).
- *sexual consent and coercion*: mutually respectful and responsible sexual relationships.
- *Concerns about sexual function*: not being able to have or maintain an erection, ejaculating too soon or feeling that ejaculation is not under control, not being able to have an orgasm or taking longer to climax than desired, not being able to help their partner to reach orgasm, not responding to sexual stimulation, or experiencing persisting pain during intercourse.

An important part of healthy sexuality is being able to tell the difference between sexual behaviors that are healthy and those that are harmful. Before acting on your sexual feelings, you should think about the consequences of your actions:

- Will I or anyone else be put at risk for unwanted pregnancy, STIs or HIV?
- Will acting on my sexual feelings cause any other problems in our relationship (such as misunderstandings or miscommunication)?
- Will it make me or my partner feel uncomfortable? Will anyone's feelings get hurt?

2.3. Puberty

During puberty, a girl becomes physically able to become pregnant and a boy becomes physically able to father a child. Hormones start to produce and create changes in the body which turns young people into adults. Our bodies grow bigger and taller, genitals mature, hair starts growing in new places and the skin becomes oilier which can cause acne. As the body grows taller, we might experience growing pains in arms and legs. This happens because the bones grow faster than the muscles can stretch to keep up with them. When puberty is over we are at our adult height.

In addition to all the physical changes to our body, both boys and girls may find that their feelings, emotions and interests change during puberty as well as physical changes to their bodies. The changes in attitudes and behavior may include: struggling with a sense of identity and questions about oneself; moodiness, anger and depression (being rude, self-centered); need for more independence and privacy; experimentation (taking risks, using drugs, having sex); identification with peers and forming strong relationships with friends (the opinions of peers and friends become more important than parents or other adults); more concern or worry about appearance and body; worry about the future (school, family, job etc.); new

"crushes" on movie stars, pop artists, teachers, friends or classmates; curiosity about sexual organs; feeling sexually attracted to people; and better ability to reason (can learn quickly, can plan, more dependable).

It is difficult, even impossible, to generalize when puberty starts and finishes. People are different, so everyone starts and goes through puberty at their own pace. However, we can say that puberty typically starts between the ages of 8 and 13 for girls and 10 and 15 for boys. However, some young people start puberty a bit earlier or later than that. We can say that puberty is finished when the skeletal growth is complete; and this typically happens between the ages of 16 and 17 for girls and in late teens or early twenties for boys.

2.3.1. Physical Changes in Boys

Boys will experience that their shoulders grow wider and their bodies becomes more muscular. Some boys experience swelling underneath their nipples, which looks like the start of breasts. This is caused by hormones and will go away with time. Other bodily changes in boys include:

- Testicles and penis grow larger.
- Pubic hair begins to grow.
- The voice begins to change and deepen, usually gradually but sometimes suddenly.
- About a year after the testicles begin to grow, a boy may begin to experience ejaculation (the release of a white milky fluid called semen from the penis).
- Underarm hair grows and sweat changes scent to adult body odor. Facial hair develops.

Erections: Erections occurs throughout life. An erection is caused by blood filling the spongy tissue in the penis as a result of lifting or straining, dreaming, being cold, wearing tight clothing, feeling fear or excitement, having a full bladder when walking or from sexual stimulation. An erection during puberty can often have no apparent cause, and boys can often get sudden or spontaneous erections, sometimes many times a day, resulting from high or changing levels of the male hormone testosterone. Having an erection without ejaculation may cause a temporary feeling of "heaviness" but it is not harmful in any way. If an erected penis is not touched, the erection will subside (go down) on its own.

Ejaculation: During puberty, the testicles grow and boys will eventually be able to ejaculate. Once a boy can ejaculate, he can cause a pregnancy. Full ejaculation involves the release of semen, which typically contains hundreds of millions of sperms in a teaspoon of fluid (in addition to sperm, semen also includes fluid from the prostate glands and the seminal vesicles). Usually, but not always, ejaculation comes with a wave of pleasurable release known as orgasm.

Prior to ejaculation, the Cowper's glands release a drop or two of fluid through the tip of the penis called the *pre-ejaculate*, which cleans the urethra. The pre-ejaculate alone does not contain sufficient number of sperm that are strong enough to cause pregnancy (however, if sperm from a recent ejaculation are still present in the urethra this can cause a pregnancy). HIV and other STIs may be present in the pre-ejaculate.

Wet dreams: men regularly have erections during sleep, and some men occasionally ejaculate during sleep. Ejaculating during sleep is called *nocturnal emission* or "*wet dream*". Wet dreams are common during puberty, but some men can still experience wet dreams after they finish puberty. A boy or a man that masturbates or has sex regularly is less likely to experience wet dreams. Wet dreams are not harmful in any way. It may release tension and be a source of pleasure. At the same time, wet dreams does not "waste" sperm. The male testicles are continuously making new sperm, and wet dreams are one way for the body to get rid of stored sperm.

2.3.2. Physical Changes in Girls

Girl's bodies usually become rounder and more womanly. Girls gain weight on their hips, and will generally notice an increase in body fat. Weight gain is part of developing into a woman. Although the changes may vary in timing, sequence and speed, girls' bodies goes through these changes:

- Breast starts to grow, starting with just a little swelling under the nipples (often only on one side at first – full development takes about 2 years).
- Pubic hair begins to grow.
- Inside a girls' body, the surface of the vagina thickens, and the uterus and ovaries increases in size.
- The first menstrual bleeding, called *menarche*, usually occurs two to three years after breast development starts. Many girls have irregular periods for the first couple of years. Once a girl ovulates, she can become pregnant. When her period is stable and her skeletal growth is complete the female body is getting physically ready to carry a pregnancy and go through birth. However, being psychologically ready is a different matter.
- Underarm hairs grow and sweat changes, resulting in an adult body odor.
- The cervix starts producing mucus that is discharged from the vagina. The mucus is normal and is a sign of natural changes related to fertility and menstruation.

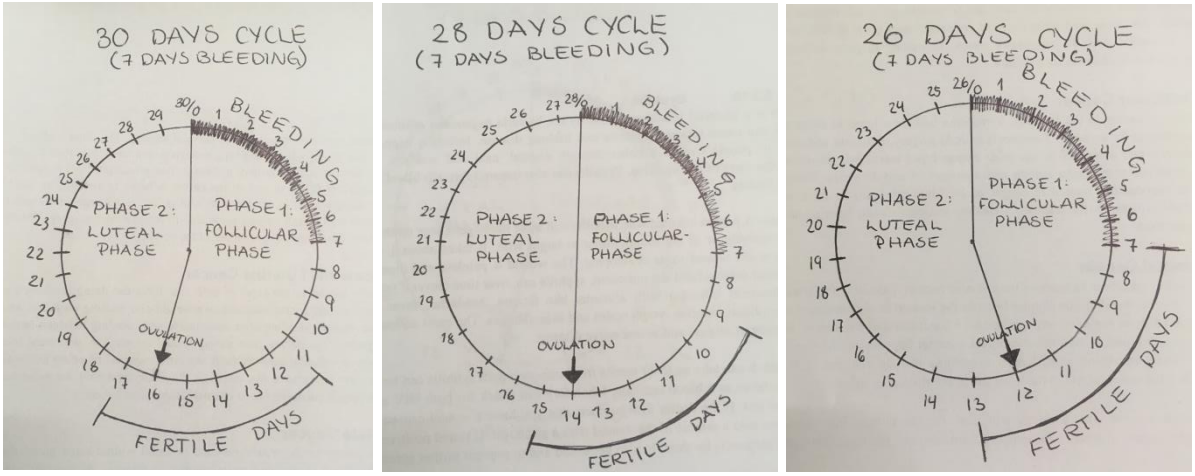
2.4. The Menstrual/Ovulatory Cycle

At puberty, girls begin to experience cycles of fertility. Different from males, who are fertile continuously from puberty onwards, females can only become pregnant during certain days of the cycle (about 6 days). The length of the cycle varies from female to female. It is most common to have a cycle that lasts from 25 to 30 days; however, many women have shorter or longer cycles than that. When you know the length and regularity of your own cycle you can predict when you will get your next period and when your fertile days are. ***If you want to find out how long your cycle is you have to count the number of days between the first day of your period to the next first day of your next period.***

During puberty, your menstrual cycle is often irregular (the length of time from one period to the next, and the number of days and amount of blood may vary), and it can take a couple of years for it to stabilize. A healthy woman is a woman with a regular menstrual cycle. However, even adult women can experience irregular periods. Travel, stress, depression, malnutrition, illness and trauma can all affect a woman's menstrual cycle.

During each cycle, the female body goes through many changes as a way of preparing for a potential pregnancy. Menstruation is just one part of the changes that takes place during a cycle (and which signs the start of a new cycle) and is a sign that pregnancy did not occur during the last cycle. In addition to menstruation, the mucus of the cervix (vaginal discharge) changes, an egg is matured and released (ovulation) and the lining of the uterus grows (and sheds if there is no pregnancy) during each cycle. The changes are controlled by the female hormones estrogen and progestin. Knowing how hormones influences our bodies through the menstrual cycle can give a girl or a woman a sense of greater comfort and control regarding her own body.

We can divide the menstrual cycle into two phases; the period before ovulation (*follicular phase)* and after ovulation (*luteal phase*). The part of the cycle before ovulation may vary a great deal. Most commonly, it lasts between one and three weeks. In contrast, the part of the cycle from ovulation to the next menstrual period does not vary; it is always close to 14 days.



Before Ovulation:
The menstrual bleeding signals the beginning of a new cycle and the bleeding usually lasts between four and seven days (however, many women also bleed less or more days than that). During menstruation, the uterus is shedding the *endometrium* (blood and tissue lining of the uterus) which flows out through the vagina and vaginal opening. After the menstrual bleeding ends, the vagina may feel dry because hormone levels are low and the cervix is producing little or no mucus. After a few days, however, as the body starts to release more hormones, the woman may notice a vaginal discharge which is cloudy-white or yellowish and may feel sticky. At the same time, the lining of the uterus (endometrium) begins to thicken and an egg matures inside the ovary. All these change happens inside the female body and women cannot detect what is going on.

Ovulation:
Towards ovulation, the vaginal discharge becomes clearer and slippery (often similar to raw egg white) and it can be stretched between two fingers. This clear mucus nourishes sperm and helps them to move towards the egg. The release of an egg from one of the ovaries into the fallopian tube is called ovulation. The two ovaries switches to release an egg every other cycle. During this time, a woman's sexual desire might increase. Some women may feel a slight discomfort on one side of the abdomen about the time the egg pushes out of the ovary.

After Ovulation:
After ovulation, the egg can stay alive for up to one day in the fallopian tube. It is in the fallopian tube the sperm penetrates the egg and causes fertilization which eventually may lead to pregnancy. The cervical mucus will again become thicker and creamy or sticky. For the remaining days of the cycle (14 days), hormones keep the thickened lining of the uterus in place. If no pregnancy has occurred at the end of the 14 days, the hormone level falls. The lining of the uterus is again shed (menstruation), marking the beginning of the next cycle. If a pregnancy has occurred, the body continues to produce hormones to keep the thickened lining of the uterus in place for nine months.

Fertile Days:
The fertile period include the day of ovulation and the five previous days. Sperm can survive in the female reproductive system for as long as five days, and the egg (if it is not fertilized) only survives for as long as 24 hours. Predicting the fertile days is difficult because the first phase of the cycle (from menstruation to ovulation) is the part that may vary widely in duration. Some women learn how to observe the changes in their mucus (and in their body temperature) so that they can tell when they are likely to be ovulating. Some women also feel a slight pain when they ovulate. Many women and girls use such "fertility awareness" techniques to have a better sense of when their menstrual period is due. Knowing which days are the fertile ones can be useful for women who are trying to become pregnant (read more in chapter 4.3. "*Natural Methods of Fertility Awareness*"). Fertility awareness techniques are not, however, recommended as a contraceptive.

Menopause:
As women enter mid-life, their hormone levels change. Eventually they stop releasing eggs and menstruation also ceases. This phase, called *menopause*, also signals the end of fertility. The age of menopause varies by women and differs in different settings, but usually occurs when a woman is in her late 40s and 50s.

2.4.1. Menstrual Health Management (MHM)

When you know what to expect, having your first menstrual period can be an exciting event. Unfortunately, many girls worry or gets afraid when their first period comes because no one has explained to them what it means and requires. Some parents may feel embarrassed to talk about it. Or the girl may have absorbed messages from culture or religion suggesting that menstruation is somehow unclean. Menstruation, however, is a natural part of being a female and it is the body's way of renewing itself and maintaining fertility.

A few days before the menstrual period begins, some girls and women may experience one or more kinds of discomfort. These include sore breasts, constipation, tiredness, pimples, and strong feelings/emotions that are harder than usual to control. Other months they may experience, some, other, or none of these.

Menstrual Sanitary Products:
During menstruation a girl can engage in all of her regular activities. Bathing during menstruation is important, and having a private place to change sanitary products and bath (both at home and outside the home) is important. The vulva should be washed with water

and mild soap to remove any blood that is left. The amount of menstrual blood varies from day to day and from person to person. Bleeding may be heaviest during the first days of the period. Different sanitary products are used by different women, ultimately chosen based on comfort, accessibility and price. You have to adopt what kind of sanitary product and how often to change based on your flow.

What kind of sanitary products women use varies in different settings. Many women use ***pads***. There are many different brands and sizes of *disposable pads*. Disposable pads are wrapped and thrown away after use. There are also reusable pads made from cotton material. Other women use *folded cloths/rags* as a pad. Both the reusable pads and cloths/rags have to be washed thoroughly after each use with soap and water. A tip is to soak these products in cold water for a while (cold water removes blood), and then you just wash the pad or cloth with soap and remember to rinse properly. Pads should be changed every 4-6 hours or more often if needed. Do not wait until the pad is full before changing.

Many women and girls use ***tampons*** instead of (or in addition to) pads. A tampon is a small mass made of compressed cotton, often shaped like a finger to fit into the vagina to absorb the menstrual blood. Tampons must be changed at least every 4 to 6 hours. Leaving a tampon in for too long can cause serious infections (and can also, in rare cases, also have deadly outcomes[2]). Inserting any unclean object into the vagina can also cause a serious infection.

The newest product on the market is ***menstrual cups*** which is placed inside the vagina to collect the blood. The cup is made of latex or other plastic material. You can use the menstrual cup for up to 12 hours before emptying it. After emptying you just rinse it in cold water before inserting it back in. After your period you boil it in water to sterilize it. Keep it in a fabric bag between periods.

Pads, tampons and the menstrual cup can be bought in the supermarket, pharmacy or from specific manufacturers. Not all women have access or can afford to buy these products. Instead they are using cloths/rags, cotton wool, leaves, toilet paper or other tissue to manage their periods.

Menstrual Cramps:
Some girls and women experience pain – abdominal cramping – during these days. In some cases, these cramps are strong and include nausea. For the uterus to be able to prepare for a new cycle, all the lining of the uterus have to be shed. The uterus is contracting to push the blood out through the cervix so that it can flow out through the vagina and the vaginal opening. It is these contractions that causes menstrual cramps. A mild painkiller such as ibuprofen helps against menstrual cramps. Taking a bath, or placing a plastic bottle or hot water bottle filled with warm water on the lower belly or lower back may also help. Many girls and women find that their premenstrual discomfort and their menstrual cramps tend to decrease if they exercise regularly throughout the month.

[2] Toxic Shock Syndrome (TSS) is a rare but life-threatening complication of certain bacterial infections that in some cases is related to the use of tampons. TSS can have flu like symptoms like a sudden high fever, vomiting, diarrhea, headache, sore throat, fatigue, dizziness, red and warm skin, and muscle pain. Otherwise healthy women/girls who suddenly feel bad during menstruation should first of all remove the tampon immediately and contact a doctor or hospital as soon as possible.

3. Reproduction and Pregnancy

If a woman has sex during her fertile days (as described in chapter 2.4) there is a high chance she will become pregnant. Sometimes pregnancy is desired, sometimes not. It is your right as a couple and as an individual to choose if, when, with whom and how often you want to have children. The right to information and access of contraceptives helps individuals and couples to fulfill that right. However, sometimes women become pregnant without any plan or desire to do so. Other times a couple wishes to become pregnant but fail to do so. This chapter will include everything related to pregnancy and childbirth.

3.1. Fertilization

Before pregnancy can occur, an egg and sperm must join. This event is called *fertilization*. Fertilization can only occur only during the fertile days of a woman's menstrual cycle. When a woman ovulates, one of her two ovaries releases an egg. Within minutes, fingerlike projections (called fimbria) at the end of the fallopian tube begin to move to surround the egg and draw it into the fallopian tube. At the same time, the woman's cervix moves into a position that eases the sperm's entry from the vagina. The cervix secrets a large amount of clear cervical mucus which provides nourishment (which enables sperm to survive for several days) and also provides an environment that helps sperm swim upward toward the fallopian tube, to reach the egg.

During sexual intercourse, the sperm are ejaculated near the cervix. They enter the cervix within seconds. If the woman is fertile, some sperm may reach the egg in the fallopian tube within five minutes, while other sperm can survive in the mucus in the cervix. In this way, for up to five days after ejaculation, sperm continue to exit in the woman's cervix and are available to fertilize an egg. It is therefore possible to become pregnant several days after having unprotected sex since she is likely to have sperm remaining in her cervix, and these sperm may still be able to reach the fallopian tube and fertilize the egg. Once ovulation occurs, however, fertilization must occur within 24 hours because the egg can survive for only that long. Fertilization takes place in the fallopian tube. Once a sperm has fused with the egg, it creates a barrier to other sperm.

In the fallopian tube, the fertilized egg (now called *zygote*) begins to divide and grow as it moves towards the uterus. This journey takes about five days. After it has divided once, it is called an *embryo*. Within two days of reaching the uterus, the embryo attaches or implants itself in the lining of the uterus (called *endometrium*). This implantation is the beginning of pregnancy.

Early signs of pregnancy may include: a missed period, tender or swollen breasts, sensitive nipples, frequent urination, unusual fatigue (exhaustion), nausea and vomiting, cramps, feeling bloated, and feeling unusually emotional. However, a pregnancy can only be confirmed with a pregnancy test which can be performed by a health care provider or by you at home using a home-test purchased at a pharmacy.

3.2. Infertility

Infertility is referring to the condition of not being able to become pregnant. A couple is said to be infertile if they do not become pregnant after having unprotected sex regularly for a year, even if they have had children before. About one in ten couples has trouble becoming pregnant.

Although infertility is often blamed on the woman, about half the time the man is infertile, or both partners may contribute to the problem. The main causes of female infertility include hormonal problems or blocked tubes (for example, from an untreated sexually transmitted infection (STI) which has developed into a pelvic inflammatory disease (PID) or another condition, such as endometriosis). Other health issues related to female infertility can be linked to her general health (especially thyroid or pituitary disease, Polycystic Ovarian Syndrome (PCOS) or if you are obese or underweight). The main cause of male infertility is problems with producing enough healthy sperm. To protect against infertility caused by STIs, use a condom when a pregnancy is not desired. Age may also be a factor. Particularly women, become less fertile with age as the number of eggs reduces. Women's fertility declines significantly beyond the age of 35.

If a couple desires to become pregnant, the first thing they should do is to determine the woman's fertile days and have sex when her mucus is abundant, clear, slippery, and stretchy[3]. They should treat any health problems, eat and rest well, and avoid tobacco, drugs, alcohol, and caffeine. If a couple has failed to become pregnant after one year of persistent trying it is normal to categorize them as infertile. The next step is to do a medical checkup. The man's semen can be examined at a clinic to determine if he has sufficient sperm, and his scrotum can be examined for presence of a varicose vein that may affect sperm production. The women can be examined to see is he has a condition or an infection that can be treated.

Other treatments depend on the cause of infertility. If the woman is not producing eggs, fertility drugs may help. If a tube is blocked or if there is other conditions, surgery may help. If a man has a varicose vein in his scrotum that is affecting his sperm, surgery may correct the problem. Assisted reproduction is the use of various advanced techniques to aid fertilization. *Artificial insemination* involved inserting male semen into the women's vagina when she is ovulating. *In-vitro fertilization* involves joining eggs and sperm in a laboratory dish, and inserting the resulting fertilized egg or eggs in the woman's uterus. Another practice is *surrogacy* in which couples arrange with a surrogate mother that she will carry a pregnancy for the woman (usually by means of in-vitro fertilization), when the woman is unable to do so herself. Such complicated techniques of assisted reproduction are extremely expensive.

3.2.1. Endometriosis

Endometriosis is a condition affecting 5-10 percent of women. The condition is caused by the cells that make the endometrium (the lining that grows inside the uterus) is growing and striving in other parts of the body besides the uterus. Most commonly, it grows on the ovaries, in the abdomen, around the intestines or in the bladder. Sometimes it can grow even further away from the reproductive system.

[3] Read more in chapter 4.2. (Natural Methods of Fertility Awareness)

The problem with endometriosis is that the cells behaves as if they are still inside the uterus; meaning that they grow during the menstrual cycle and bleed when there is no fertilization. You therefore have a bleeding inside your body when you are on your period, but the blood does not exit the body the way the menstrual blood does through the vagina. This bleeding is not dangerous, but it is causing an inflammatory response that irritates the surrounding cells. Long term, this can cause scar tissue which can cause problems even beyond the menstrual period.

Some women have no symptoms and therefore are not aware that they have the condition. Others do experience symptoms, and pain during menstruation is the most common symptom. Such severe menstrual cramps make daily life difficult. If the endometrial cells are located around the intestines or bladder you can also experience pain when going to the toilet. Some experience pain during sex, especially when the penis or something else is penetrating far into the vagina.

No test can confirm if you have endometriosis. The diagnosis is set based on your symptoms. Therefore, many women go undiagnosed. Endometriosis can make it hard to become pregnant without help, especially if the cells grow on the ovaries or fallopian tubes and have caused scaring in these areas.

Treatment can relieve the pain, but there is no cure. The most common treatment is hormone contraceptives and trying to reduce the number of bleedings. Severe cases should be referred to a specialist on endometriosis who can choose other drugs to tackle the pain.

3.2.2. Polycystic Ovarian Syndrome (PCOS)

Polycystic ovarian syndrome (PCOS) is characterized by many small cysts on the ovaries. The cysts disturb the functions of the ovaries and leads to an increased level of male hormones (androgen hormones). Classic symptoms includes: abnormal hair growth (associated with male hair growth; facial hair, chest hair and hair from the pubic hair towards the navel), acne, missing or sparse menstruations (however, 20 percent of women with PCOS still have normal periods), childlessness and overweight.

The change in hormones causes the ovulation to disappear and irregular bleedings. The missing ovulation leads to the women not being able to conceive (childlessness).

The diagnosis is set after symptoms have been checked through a general and gynecological examination. The examinations are done to rule out any other causes of the symptoms. Blood tests reveal abnormal hormone levels and give a picture of the body's sugar metabolism, fat and cholesterol. The condition is chronically, but treatment and weight reduction decreases the symptoms. Since there is an increased risk of developing diabetes and heart disease, the prognosis also depends on you being able to control your weight and sugar and fat intake.

The actual cause of PCOS is unknown, but it is believed to be related to genes and lifestyle. Two thirds (2/3) of women with PCOS are overweight, but the condition can also affect women of normal weight. The weight often worsens the other symptoms. The weight gain is

associated with changes in the metabolism. The effect of insulin (that controls the sugar in the body) decreases and many women also develop diabetes. In addition, many women also get high cholesterol and high blood pressure. This again increases the risk of heart disease later in life.

All research suggests that the most important treatment is done by the women itself. Controlling your weight, make sure you don't gain any additional weight, stop smoking and physical activity. Diet changes are most important. Exercise is important to stay healthy, but most people struggle to lose weight from exercise. A 5-10 percent weight loss is often enough to increase your chances of a successful pregnancy. Weight loss also reduces the risk of heart disease. The weight loss should come from lifestyle changes. Eating more wholegrain products, fruits and vegetables, reduce fat and sugar intake and cut down on high calorie drinks like soda and juice.

Further treatment includes various drugs. Diabetes drugs increases the effect of the body's insulin. This can lead to increased control of blood sugar, some weight reduction, reduced production of androgen hormones, normal menstruation and increased chances of pregnancy. It is advised to stop this treatment during a pregnancy. Other drugs can promote ovulation, which also increases the chance of pregnancy. But it can also slightly increase the chance of having multiples. Finally, birth control pills can reduce many of the symptoms caused by male hormones, but it can take up to 8 months before you see a change in the unwanted hair growth. In addition, birth control pills also provide contraception and normalize the menstruation. Further meditational treatment, hair removal and smaller surgical procedures is also available.

3.3. Pregnancy

We start calling it a pregnancy when the embryo had attached to the endometrium in the uterus (implantation). At this time, the embryo also gives rise to an amniotic sac and a placenta. The sac provides a protective fluid environment for the growing fetus. The placenta provides the fetus with nutrients and oxygen from the mother, and carries out waste products. An umbilical cord connects the placenta to the fetus.

We count the number of weeks of pregnancy from the first day of your last period (because it is very difficult to establish exactly when fertilization happened). Human pregnancy lasts 38 weeks after fertilization (about 40 weeks from the last menstrual period). Pregnancy is divided into three periods of about three months each, called trimesters[4].

(1) During the first trimester (from last period to week 12) all of the major organs and structures of the body are formed: the brain, heart, lungs, eyes, ears, arms and legs. After week 8, the embryo is called a *fetus*. Women commonly feel nauseous ("*morning sickness*") during the first trimester.
(2) During the second trimester (from week 13 to 28) the fetus grows rapidly, and usually around the week 19, the woman can feel fetal movement. Most women begin to put on weight during the second trimester.
(3) In the third trimester (from week 28 to birth), the fetus continuous to gain weight, and it movements become stronger and more frequent.

[4] For more information on the specific stages of a pregnancy see appendix 3: Pregnancy – Week by week.

Each cell in the human body contains a genetic code consisting of 46 chromosomes. Half of our chromosomes are inherited from our mom and the other half from our dad. 22 chromosome pairs (44 chromosomes in total) decide the mental and physical features of the baby. The last chromosome pair decides the sex of the baby. XY-chromosomes will be a boy and XX-chromosomes will be a girl. The egg from the mother always contains an X (since this is the only type of chromosome a female has) and the sex of the baby is determined if the sperm that penetrates the egg contains an X or Y chromosome.

3.3.1. Promoting a Healthy Pregnancy

During a pregnancy there are things you can do to promote a healthy pregnancy. You should especially avoid taking unnecessary medications, drugs and alcohol. Many medications and herbs lack the proper documentation stating if they are safe to use during pregnancy (especially during the first part of the pregnancy). Be careful and always consult a doctor and/or the pharmacist about the necessary drugs you can or should take. The use of illegal drugs (narcotics) is associated with high risk of injuries to the fetus and total abstinence is recommended. With alcohol as well, total abstinence is recommended to avoid any disruptions of the development of the brain and other organs of the fetus. Smoking is also not recommended as it is associated with low birth weight. Small babies have an increased risk of complications during pregnancy, birth and after birth.

Taking the recommended vitamins and mineral supplements (especially iron and folate) is very important (including before pregnancy, if possible). Green vegetables (like broccoli, kale, Brussels sprouts and spinach) contain a lot of vitamins, including folate. Supplements can also be bought in the pharmacy.

Pregnant women should also visit an antenatal-care provider, from whom to get medical checkups and to learn about pregnancy, potential danger signs, and childbirth. Women infected with HIV should take anti-HIV medication to prevent the fetus from becoming infected and to maintain their own health. Treatment with anti-HIV medicines during labor and delivery is critical for reducing the risk of transmitting HIV to the baby.

Having sexual intercourse during pregnancy is not associated with any negative consequences as long as the pregnancy proceeds as normal. You can have sex as often you want, but sometimes the sexual desire is low or absent. The sexual desire usually decreases with hormonal changes, feeling tired and nauseous and, later in the pregnancy, weight gain, back pain and other ailments also influences the sexual desire.

Some workplaces can be less suitable for pregnant women. Especially work that requires long periods where the woman has to stand or being exposed to chemicals are associated with complications in the pregnancy.

To travel by plane is not a problem until about 4 weeks before the expected birth. Longer plane rides can be associated with blood cloths in the legs. Consult your doctor before any travels.

3.3.2. Pregnancy Related Diseases/Problems

Some women can go through their pregnancy without any ailments, while others experience one or more pregnancy related diseases or problems.

Morning sickness, also known as *nausea gravidarum*, affects around 80 percent of all pregnant women. A woman with morning sickness often feels tired and nauseous, and may also vomit. For many women, the symptoms of morning sickness are the first signs of pregnancy. In the vast majority of cases, morning sickness has no health risk for the baby and treatment by a doctor is not commonly needed. However, morning sickness is an unpleasant experience and there are some things that might alleviate the symptoms.

Rest (tiredness makes nausea worse), liquids (fluid intake should be regular and in small amounts, rather than less often and in large quantities), food (consuming more meals per day, with smaller portions may help), avoiding having an empty stomach, identify nausea triggers, ginger (as some research show that ginger have a positive effect), medical treatment (if symptoms are still severe despite self-care measures, the doctor may recommend a short course of anti-sickness medication which is safe to use during pregnancy) can all help.

Preeclampsia is a condition where the pregnant woman has elevated blood pressure and proteins in their urine. The diagnosis is set by measuring the woman's blood pressure. Additional tests includes checking the blood count, platelets and uric acid. This is caused because of tight veins in the placenta resulting to the placenta and fetus getting less blood supply than they should have. It is the reduced function of the placenta that causes preeclampsia, but we are not sure what causes the reduced function of the placenta.

This condition most commonly develops after week 20 of the pregnancy and increases in incidence towards the time of birth. The pregnant woman can experience headache, eye symptoms, nausea and abdominal pain as a result of having preeclampsia. However, some women have no ailments (especially early in the course of the condition).

Chances of experiencing preeclampsia increases with: having too high blood pressure; first-time pregnancies; preeclampsia in earlier pregnancies; chronic kidney disease; multi-pregnancy (more than one fetus); diabetes; disease or abnormalities of the fetus; and connective tissue disease. If your mother had preeclampsia the chances of you experiencing it also increases.

Women with preeclampsia should go for checkups and follow-up with a specialist. In most cases of preeclampsia, the course of the pregnancy proceeds as normal with no complications. However, with preeclampsia there is a risk of reduced birth-weight and premature birth. Ultimately, birth is the only event that will cause preeclampsia to retreat. If you suffer from a mild form of preeclampsia, resting at home and frequent checkups (1-2 times a week) at the hospital should be sufficient treatment. If you experience elevated blood pressure or increased protein excretion in the urine you have to be admitted to hospital to start blood pressure treatment with drugs. If your preeclampsia has developed into eclampsia or HELLP-Syndrome, the baby has to be delivered as soon as possible.

Eclampsia is characterized with headache, unrest, visual disturbances, irritability, feeling sleepy and having a sparse urination. When the woman experiences cramps, she has developed eclampsia. *HELLP-syndrome* (Hemolysis, Elevated Liver Enzymes, Low Platelet Count) is a condition that destroys red blood cells (H), increased amounts of liver enzymes in the blood (EL), and the number of platelets go down (LP). This form of preeclampsia entails high risk of serious complications for both the mother and the child. In addition to the symptoms of preeclampsia, symptoms of HELLP also includes abdominal pain (in 90 percent of cases), nausea and vomiting (50 percent of cases) and changes in blood samples. Diagnosis is made from laboratory findings related to blood count, platelet count and sign of liver failure. Cases of HELLP-syndrome is difficult to deal with because the high risk of organ failure and maternal death has to be considered in relation to the risk the baby is facing by an early delivery. Delivery and full removal of any placental tissue is the only cure. Most women see an improvement after only 48 hours after delivery. Caesarean is the preferred delivery technique of women with severe preeclampsia or HELLP-syndrome.

The only way to prevent preeclampsia and HELLP-syndrome is to avoid pregnancy. However, this is often not an option for most women (neither for those who have experienced preeclampsia before). Trying to minimize the risk of preeclampsia recommendations is to maintain a general healthy lifestyle both before and during pregnancy. This should include sufficient physical exercise, a healthy diet and having a normal body-weight.

Pelvic Joint Pain is pain in the joint of the pelvic during pregnancy. The pelvic consists of several bones joint close together with little movement between the bones. During a pregnancy, these joints are affected by pregnancy hormones, making them more moveable. This is a natural process which prepares the pelvic for the upcoming delivery. However, some women experience the movement of the joints as painful. These pains can make it difficult to walk, stand and sit still for a long period at a time. It can be difficult to accomplish the daily chores like cooking and cleaning the house. The pain usually increases during the course of the day and the pain can come a little while after an activity. This is a condition which is associated with the later stage of a pregnancy. Most women start experiencing pain in month 5-8 of the pregnancy but some women experiences pain as early as in the first trimester. Going from being a healthy woman to having to deal with constant pain can be mentally tough on many women.

It is believed that pelvic joint pain is connected to asymmetric movement at the back of the pelvic and/or lack of stability in the lower back or pelvic contributes to the cause of the pain. Pelvic joint pain is the leading cause of pregnancy related sick leave. Customizing everyday life is the most important strategy for tackling pelvic joint pain. It is individual how much and what kind of activity that will result in pains. If the pain appears from standing, sit more. Sit when you are cooking, doing dishes or washing clothes. It is important to have an even strain on your legs. Stand with your weight evenly distributed on your feet and with a small distance between the legs. Walk with short steps. Many women will benefit from placing a pillow between her thighs, knees and ankles and maybe also in front of her belly to be able to rest properly when lying down on her side. When you carry something it should be evenly distributed in both arms and you should carry things close to your body. Adjust physical activity to within your pain threshold. It is important that you are able to relief the pain and

that you have opportunities to rest. Some women contact a physical therapist for advice on their condition. Some women benefit from using a corset that tightens the pelvic together. Use of crotches is not recommended as they can lead to weakened muscles in your back and pelvic. Acupuncture treatment has also shown to have a positive effect.

The risk of experiencing pelvic joint pain increases with number of births, high body mass index (BMI), young age, hard work, depression, previous back pain and trauma to the pelvic. Hard physical exercise (up to 5 times a week) before pregnancy has shown to have a preventative effect on this condition. Most women will experience that their pains disappear after birth. Some may develop back pains if they have has a particularly severe case of pelvic joint pain during their pregnancy.

Gestational Diabetes (Diabetes during Pregnancy):
Diabetes is when the blood sugar level is higher than normal because the body does not produce enough insulin. Blood sugar comes from what we eat and drink, and acts as fuel for the body. The blood sugar us lowest is lowest when it is long since the last meal (often in the morning) and highest 1-2 hours after meal. Insulin is a hormone produced in the pancreas and which lower the blood sugar.

During pregnancy, the need for insulin is higher. If the body cannot increase the production of insulin, the blood sugar level will be too high. Gestational diabetes is diabetes that is detected or occurs during pregnancy. The diabetes can lead to increased risk of preeclampsia and may lead to birth complications.

Gestational diabetes rarely gives any symptoms, but is diagnosed after sugar is found in the urine during pregnancy checkups. If a woman does experience symptoms it is the normal diabetes symptoms of extreme thirst and frequent urination.

Some women have higher risk to develop gestational diabetes and is connected to high age of mother, diabetes type 1 or 2 of the mothers parents, overweight and gestational diabetes in earlier pregnancies. Gestational diabetes is more common for women from South-Asia and North-Africa.

Gestational diabetes usually disappears after birth and the woman should take a test 6-12 weeks after birth to control that the blood sugar has normalized. Gestational diabetes increases the risk for the woman to develop diabetes type 2 later in life. You can reduce that risk by following the diet advice, keep a healthy lifestyle and exercise. Diet advice includes:

- Avoid food and drinks with lot of sugar.
- Choose wholegrain.
- Choose fish, chicken and vegetables (peas, beans and lenses are especially healthy).
- Milk products are an important source of nutrients, vitamins and minerals and should be included in the diet. However, reduce milk products that contain added sugar. And remember that lactose also affects the blood sugar.
- Eat fruits, but only one at a time and maximum 3 a day.
- Drink water when you are thirsty.

3.4. Birth and After Birth

During pregnancy the woman's uterus (womb) nourishes and protects the growing fetus. When the fetus is mature and the birth is imminent, the baby undergoes a series of movements that help it get through the birth canal. In the vast majority of cases, birth occurs normally (vaginal birth), but sometimes there are challenging situations that leads to assisted deliveries or caesarean delivery.

3.4.1. Vaginal Birth

A (normal) vaginal birth starts by itself and consists of three phases:

(1) The *opening phase*, where the uterus begins to contract, causing the cervix to open and pushes the unborn baby towards the cervix.
(2) The *expulsion phase*, where the cervix is now completely open and ready for the baby to pass through. Contractions push the child down through the mothers' pelvis and through the vaginal opening.
(3) The *postpartum phase* where the uterus expels the placenta and the birth is over.

The first sign of birth is *contractions* in the uterus muscles. In the beginning, these contractions are experienced as irregular outbreaks of common stomach ache or back pain. As soon as birth is approaching, the contractions will become more regular and there will be shorter time between each one. However, contractions does not always indicate that the birth has started. Throughout the pregnancy the uterus has exercised itself to tighten the muscles. These contractions are called false labor pain, and some pregnant women notice these relatively early in the pregnancy but for most women they become noticeable only in the last weeks of the pregnancy. If you notice a contraction that is not accompanied by other signs of birth, nor do they increase in intensity, the birth has probably not started.

When the birth do starts, a mucus plug that forms a barrier between the vagina and the uterus where the baby is will be squeezed out. This appears like a modest mucus based bleeding. Another sign of birth is that the amniotic sac breaks. When this happens, it feels like a flow (sometimes slowly and other times suddenly) of clear fluid from the vagina. We say that "the water broke". When this has happened you can contact the maternity ward and prepare to go there. When you arrive at the hospital, the midwife or doctor will do a vaginal examination to assess: how far the birth has come; the position of the baby; and if the heart of the baby is beating satisfactory.

The first stage, ***the opening phase***, starts with the contractions which helps open the cervix so that the baby can pass through. For each contraction the cervix opens slightly. The vagina is getting shorter and wider. The doctor/midwife can confirm this through a vaginal exam. A full opening is about 10 centimeters, and when the cervix has reach this opening the baby's head will start to push down through the birth canal (vagina). This first stage lasts approximately 12 hours (but can take up to 24 hours) for a first time mom and about 4-8 hours (but can be as fast as just a few minutes) for a woman that have given birth before.

When the cervix is fully open, a transition period occurs when it can seem like the birth stops. Then the second phase, ***the expulsion phase*** starts. The contractions are now accompanied with an urge to push the child out and down the birth canal. As the baby moves downwards, it

presses on the rectum and it feels as if you have to go to the toilet. You should only push with the contractions. This allows you use the strength of the uterus' contractions together with your own strength at the same time, and you can rest between the contractions. Towards the end of this phase, it is common for the midwife/birth attendant to cut the outer vaginal opening (episiotomy) to make a larger opening. The cutting is done to avoid uncontrolled raptures/tares in the vaginal wall, which can be difficult to repair and which also can cause future problems (obstetric fistulas). The expulsion phase ends with the baby being born and the umbilical cord is cut. This phase can last up to 2-3 hours for the first child and up to 1-2 hours for the second child.

The last phase, ***the postpartum phase***, is when the uterus contracts and expels the placenta. This can cause some bleeding. This part of the birth takes about 15 minutes. After the placenta is out you are most often given some medications to prevent serious bleeding. Episiotomy and any tearing are cleaned and stitched.

3.4.2. Assisted Vaginal Birth

If the delivery does not start or proceeds as planes, the midwife, doctor or birth attendance has to assist in getting the baby delivered. The assistance can either be to initiate the birth or to assist in delivery.

Birth initiating assistance includes hormonal birth initiate and breaking the amniotic sac. Hormonal birth initiate is being applied to women who have gone too long past their due date (usually 14 days) or if there are medical or social conditions that make one want the child to be delivered before the natural birth has started. The most common medical conditions includes preeclampsia and diabetes. Hormonal treatment is the insertion of an agent near the cervix that will assist in causing contractions. The amniotic sac is punctured if it is still intact and the hormone oxytocin is given. If birth does not start after two attempts of hormonal birth initiate has been given, most cases will be solved by delivery through caesarean (see next chapter).

Puncturing the amniotic sac is a method used to induce a birth or to rush a slow birth. When the amniotic fluid is emptied, contractions will often start spontaneously and the birth is starting. If the birth has not started after 1-2 hours, the hormone oxytocin is often also administrated intravenously to further stimulate the birth. If this method is used and birth still has not started after 12-24 hours, caesarean is being considered.

Assisted deliveries can be caused by the baby getting stuck in the birth canal, if the baby is not rotating into the right position, if the birth stops, the baby gets too little oxygen, or if the baby is too big to pass through the birth canal. In these situations, *pliers* or a *suction cup* can be used. Pliers is used by the midwife, doctor or birth attendant to assist in the process of pushing (now also pulling) the baby out. The suction cup is placed on the baby's head using vacuum, and the suction assists in the birth process until the point where the head has emerged from the birth canal. Then the cup is removed and the birth proceeds as normal. A third way to assist a vaginal birth is through *episiotomy* ("cutting"). This is a method used by the midwife to make the vaginal opening larger which helps the baby to be born faster and which prevents uncontrolled tares or raptures that can cause future problems for the woman.

The midwife can decide to cut if the baby is on its way out but is getting too little oxygen. Other reasons might be that the mother is exhausted or the tissue around the vaginal opening is not elastic enough. If pliers are used to assist the birth, episiotomy is often also applied.

3.4.3. Caesarean

In some cases, vaginal birth might not be the best option and caesarean is used as delivery method. There is a difference between planned and rushed caesareans. Caesarean can be planned for mothers with a specific medical condition, but you cannot demand to have a caesarean without proper medical argument. The rushed caesareans are usually scheduled if there are complications during vaginal birth.

Common causes of caesareans include:

- If the woman has a narrow pelvis and if there is a large baby; babies with hydrocephalus ("water-head"); malformations in the birth canal, the placenta blocks the birth canal (*placenta previa*) or the placenta is being delivered early (*abruption placentae*).
- If the woman has had previous caesareans (if there is an increased risk that the uterus will not be able to withstand the strain of a vaginal birth).
- If the woman suffers from any kind of disease or illness that can reduce the chances of her being able to withstand the stress of the birth.
- Preeclampsia can in some cases lead to delivery through caesarean (especially severe preeclampsia, eclampsia and HELLP-syndrome can demand this technique).
- Special cases where the woman is particularly anxious about the birth (this is usually the case with women that has frightening experiences from earlier births).
- If the baby lacks oxygen supply or the birth stops in the earlier stages of vaginal birth.
- If the functions of the placenta fails and the birth is slow; incompatible blood types with mother and child (in some cases the mother can develop antibodies towards the fetus which can cause anemia and harmful accumulation of abnormalities in the fetus, and caesarean is chosen earlier than normal – in week 32-36).
- If the umbilical cord or the baby is located in an unfortunate position.
- If it, for some reason, becomes necessary to deliver the baby long before due date.
- If assisted delivery (pliers or vacuum) fails.

Most caesareans are performed using local anesthesia in the back (either epidural or spinal). With this type of anesthesia, the woman is awake during the procedure and can see the baby as soon as it is delivered. A partition will do so that the woman cannot see the procedure. In some cases, full anesthesia (making the woman sleep during the procedure) is chosen. This is particularly common if the procedure is rushed and there is no time to put the local back anesthesia.

There will be made a 20 cm long cut across the stomach lust above the pubic hair over the pubic bone. The scar remaining from this procedure is often small and almost invisible. The procedure in itself lasts for about 45 minutes, and most of the time is used to close and stich the incisional. To make the cut and deliver the baby usually takes only 5 minutes.

After the procedure, the woman is sent to the recovery ward where she has to stay for at least 5 hours before she can be transferred to the maternity ward where the baby is waiting (the baby can also visit the mom when she is in recovery). Most women who deliver through caesarean are ready to go home after 4-7 days after the delivery. The woman should take it easy for about 4-6 weeks (especially avoiding any heavy lifting) to prevent the wound from reopening (as everyone should after any surgery).

There is a slight higher chance of complications from a caesarean than from a vaginal birth, especially with acute caesareans. The complications are related to all surgical procedures – bleedings and infections. The chance of blood cloths is also slightly higher with caesarean than vaginal birth. You are most likely able to give birth vaginally later even though you have delivered through a caesarean before. If the doctor concludes that there is a chance that the uterus will not handle the stress of a vaginal birth, any future deliveries have to be performed as a caesarean.

In rare cases it is necessary to open the uterus with a longitudinal cut. This implies a higher risk of bleedings, and requires any future deliveries having to be done through caesareans as well (because the uterus will not be able to handle the strain of a vaginal birth). This type of caesarean can be necessary if the lower part of the uterus is especially narrow (which can be the case of the baby is in an unwanted difficult position).

The production of breast milk and other hormonal processes in the woman's body will remain as normal regardless of whether the baby is delivered through a vaginal birth or through caesarean.

3.4.4. Breastfeeding

The production of breast milk will start a few days after birth. The baby will survive on reserves from before it was born until breastfeeding starts. It will also take some time for you and the baby to find the right technique for the breastfeeding to be as effective as possible. The first milk the mother produces (during the first 72 hours) is called *colostrum* and is especially nutritious and valuable to the newborn. Breastfeeding soon after delivery also leads to the uterus contracting, and thus stopping the bleeding in the uterus more easily. A mother should always get used to picking up signs that her baby is hungry. She should not wait until the baby cries. By waiting you teach your child to cry to get your attention. It will also make the baby upset and crying faster the longer you wait to react to its signals.

It is important to find a good nursing technique. Many issues related to breastfeeding/nursing can be solved by using the right techniques. Make sure you have a good sitting or lying position. Build up with pillows so that neither you nor the baby must strain during breastfeeding. Particularly early in the baby's life, skin-to-skin contact is creates security for the baby. The baby should be lying as straight as possible, avoiding having to twist and turn to reach the nipple. You should experience with different positions as babies may find it difficult to get hold of the nipple, and often it can be corrected by switching position. Feel free to squeeze some drops of milk to moist the nipple before you present it to the baby. You can also relieve by holding up your breast, making the weight of the breast does not become a strain on the baby. As the child grows bigger, this becomes less important. When the baby

opens its mouth to take the nipple, move the baby a little closer so that its lips surrounds the dark area around the nipple and not just the nipple itself. If the lips only surrounds the nipple itself the breast easily gets sore. When finishing, do not pull the nipple out while the child is still sucking. Sneak one of your fingers into the baby's mouth to stop the suction before pulling out the nipple. This also avoids strain and soreness in the breasts.

If you do experience sore nipples you should make sure that your breasts gets enough air. Wash your breasts only with water – no soap or wet wipes containing alcohol as this contributes to drying out the nipples. Any creams you apply should be perfume free. Another breastfeeding challenge is *indented nipples*. You can check if this implies to you by using your thumb and forefinger to squeeze the dark area surrounding the nipple together. If the nipple withdraws into the breast or becomes flat, this can mean that your baby can find it difficult to get hold of the nipple. You should ask at the hospital or friends and family any question you might have about breastfeeding. You can also experience clogged milk channels and breast inflammation. If you struggle with this you should nurse more often and use a breast pump for any remaining milk in the breast. Stopping breastfeeding can make your condition worse and is not recommended. Some women feel relief by placing a moist warm towel on the breast. If the pain is unbearable you should contact your health care provider.

3.4.5. Postpartum Depression

It is common for a woman to experience feeling depressed in the period after giving birth. The condition reaches from milder symptoms to severe depression. The depression is considered to be related to the birth if the depression starts less than four weeks after birth. However, women have an increased risk of depression up to 6 months after giving birth. Some women also develop depression even during their pregnancy. The symptoms are similar to other forms of depression and include: feeling down, crying, lack of ability to enjoy things, having trouble sleeping, eating disorders, suicidal thoughts and recurrent thoughts about death. Postpartum depression is slightly more common in young mothers. It is important to distinguish between postpartum depression and the more normal low feeling many women experience immediately after giving birth. This is a feeling that will go away after a few weeks. You can check for yourself by using a questionnaire[5], but final diagnosis should be made in consultation with a doctor.

The purpose of treating postpartum depression is to contribute to a rapid normalization of the woman's mood, prevent relapses and to improve the relationship between the mother and child. With mild forms of depression, drugs are not recommended. Support and relief from family and health-care providers are usually sufficient in these cases. With severe depression, especially depression with suicidal thoughts and thoughts related to harming the child, require immediate psychiatric attention. This condition will often require treatment with antidepressant drugs. Proper follow-up of skilled psychiatric healthcare professionals are important with severe or repeated postpartum depression. Many women avoid postpartum depression if the follow-up, check-ups and support is provided for her.

[5] Find the questionnaire attached in Appendix4

3.4.6. Obstetric Fistula

Obstetric fistula is one of the most serious and tragic childbirth injuries. It is an opening between the birth canal (vagina) and bladder, urinary tract or rectum. The opening or hole is caused by prolonged, obstructed labor, without access to timely, high-quality medical treatment. The condition leaves women leaking urine, stool or both, and this often leads to chronic medical problems, depression, social isolation and deepening poverty.

Without emergency intervention, obstructed labor can last for days, resulting in death or severe disability. The obstruction can cut off blood supply to tissues in the woman's pelvis. When the dead tissue falls away, she is left with a hole (*fistula* in medical terms) in the birth canal. Tragically, there is a strong association between fistula and stillbirth. Research indicates that approximately 90 percent of women who develop obstetric fistula end up delivering a stillborn baby.

Obstetric fistula is preventable, and can largely be avoided by: delaying the age of first pregnancy; stopping harmful traditional practices; and timely access to obstetric care. Preventing and managing obstetric fistula contribute to the Sustainable Development Goal (SDG) number 3; improving maternal health.

Fistulas are a sign of global inequality and an indication that health systems are failing to protect the health and human rights of the poorest and most vulnerable women and girls. Obstetric fistula has been eliminated in industrialized countries through the availability of timely, high-quality medical treatment for prolonged and obstructed labor (caesarean in particular). Today, obstetric fistula occurs mostly among women and girls living in poverty, and especially those living far away from medical services. It is estimated that more than 2 million women in sub-Saharan Africa, Asia, the Arab region and Latin America and the Caribbean are living with fistula. Some 50,000 to 100,000 new cases develop annually. Yet, fistulas are almost entirely preventable.

Prevention is key to ending fistula. Ensuring skilled birth attendance at all births and providing timely and high quality emergency obstetric care for all women who develop complications during delivery is essential. Additionally, providing family planning to those who want it could reduce maternal disability and death by at least 20 percent. The underlying factors that contribute to women's and girls' marginalization (including lack of access to quality health services and education, persistent poverty, gender and socioeconomic inequality, child marriage, adolescent pregnancy, and failure to protect human rights) must also be addressed.

Childbearing in adolescent girls before the pelvis is fully developed, as well as malnutrition, small stature (growth) and generally poor health conditions are among physiological factors contributing to obstructed labor. However, any woman may experience obstructed labor, including older women who have already had babies.

Left untreated, obstetric fistula causes chronic incontinence and can lead to a range of other physical ailments, including frequent infections, kidney disease, painful sores and infertility. Fistulas can also lead to social isolation and psychological harm. Women and girls with

fistula are often unable to work, and many are abandoned by their husbands and families, being community outcasts.

The continued occurrence of obstetric fistula is a human rights violation, reflecting the marginalization of those affected and the failure of health systems to meet their needs. The isolation of victims means they often go unnoticed by policymakers, and little action is taken to address or prevent their condition.

Reconstructive surgery usually repairs a fistula. However, many women and girls with fistulas are not aware that treatment is possible, cannot afford it or cannot reach the facilities where it is available. There is also a shortage of highly trained and skilled surgeons to perform the repairs.

Counseling and other forms of support (such as livelihood skills, literacy, job training and health education) may also be necessary to help women reintegrate into their communities, rebuild their lives, and regain their dignity and hope after surviving fistula. Follow-up is also crucial for all women and girls who have had fistula repair surgery, helping to ensure they do not develop the injury again during subsequent births, and helping to protect the survival and health of both mother and baby.

3.5. Abortion

Abortion is a debated topic and it varies between countries if abortion is legal or not. In many countries abortion is legal and the woman is able to decide for herself if she wants to go through with the pregnancy or have an abortion (most often the decision has to be made before the end of week 12 of the pregnancy[6]). In other countries, abortion is strictly illegal. And some countries allows abortion if the woman's life is at risk[7]. The human rights state that abortion should be legal and self-decided.

Among the 208 million women estimated to become pregnant each year worldwide, 59% (or 123 million) experience a planned (or intended) pregnancy leading to a birth or miscarriage or a stillbirth. The remaining 41% (or 85 million) of pregnancies are unintended. Some of these pregnancies end in abortion (either safe or unsafe abortion). Almost all unsafe abortions occur in developing countries, where maternal mortality rates are high and access to safe abortion is limited.

Abortion is the termination of a pregnancy. Abortions can be *spontaneous* or *induced*. Most abortions occur spontaneously (naturally) in the first 12 weeks of pregnancy. An abortion that happens by choice, before the fetus is big enough to live outside the uterus (before 22 weeks), is called an induced abortion. An induced abortion is a pregnancy that is ended for medical reasons (to save the mother's life) or is done voluntarily for different personal reasons. The safest way to induce an abortion is to have it performed by a trained health provider (safe abortion), however, many women undergo unsafe abortions to terminate unwanted pregnancies.

[6] Norwegian Law allows self-decided abortion before the end of week 12.
[7] Kenyan Law allows abortions if a trained health care professional considers the mother's life to be at risk.

A girl or woman who has recently had an abortion needs to consider contraception options. She should make a plan for getting contraception immediately after the procedure. If the abortion was not carried out by a skilled provider, she may not have access to contraceptives. Someone who is aware of this situation can help the girl or woman seek medical care and contraceptive cancelling.

3.5.1. Miscarriage (Spontaneous Abortion)

A pregnancy that ends on its own before week 22 of the pregnancy is called a spontaneous abortion or a miscarriage. About one in five pregnancies ends in miscarriages (often before the woman is even aware that she is pregnant). The risk of experiencing a miscarriage decreases with the length of pregnancy. The woman's age also influence the rate of miscarriages as older women more frequently experiences miscarriages.

Most miscarriages occur during the first 12 weeks of pregnancy and are called early spontaneous abortions. A miscarriage that happens from week 13 is called late spontaneous abortions. There is three types of spontaneous abortions: (1) *Threatening abortion* is not actually an abortion but women that experience some vaginal bleeding before week 22 of the pregnancy is diagnosed with a threatening abortion. Treatment includes the women to take a few weeks sick leave to rest and being advised not to have sexual intercourse during this time. (2) *Inevitable (unavoidable) abortion* is related to abundant fresh bleeding from the vagina with sometimes additional cramps or pain in the lower abdomen area. With this condition, an abortion cannot be avoided. (3) *Complete abortion* is when experiencing heavy bleeding that suddenly stops and the woman loses the feeling of being pregnant.

Miscarriages occur, most often, because the fetus is not developing normally or it has a chromosomal abnormality. This is why many people claim that miscarriages can be nature's way of preventing births of non-viable babies. Other reasons for miscarriage includes, but are not limited to: hormonal problems, infections or maternal health problems (such as infection of the uterus' mucosa, earlier treatment of cervical cancer or malformations of the uterus); lifestyle (i.e. smoking, drug use, malnutrition, excessive caffeine and expose to radiation or toxic substances); implantation of the egg into the uterine lining does not occur properly; maternal egg dysfunction; or maternal trauma.

If a woman has more than three miscarriages consecutively, the doctor will, or should, start an investigation to try to figure out what is causing the repeated miscarriages. Experiencing a miscarriage is emotionally tough, and it can be advised to wait 2-4 months before trying to become pregnant again to be physically and mentally prepared.

3.5.2. Safe Abortion

There are two primary methods of induced abortion. Both methods are effective if performed under proper conditions. When performed under proper conditions, an abortion is a simple and safe procedure. The procedure must be conducted by a trained health care provider using proper equipment, technique, and sanitary standards. Abortion is safest early in pregnancy.

The first method is a brief procedure during which a health care provider uses medical instruments (surgical abortion). The instruments are used to suction or remove the content of

the uterus (the endometrium that holds the embryo or, in later abortions, the fetus). *Vacuum aspiration* is the recommended technique for surgical abortion of pregnancies up to 12 to 14 weeks.

The second method involves taking one or more pills that trigger uterine cramping and the start of menstrual bleeding (medical abortion). Using this method, a woman expels the lining of her uterus and with it, the embryo. The recommended method for medical abortion is the drug *mifepristone* followed by *misoprostol*. The dose of drug and when to take it depends on the gestational age of the pregnancy. Occasionally, part of the lining remains in the uterus, and in such cases, the health care provider uses medical instruments to complete the procedure (as described above).

There is no medical need for a routine follow-up visit following uncomplicated surgical abortion or medical abortion using mifepristone followed by misoprostol. However, women should be advised that additional services are available to them if needed or desired. If the woman experiences an incomplete abortion or abortion complications she should of course always seek medical attention. Women may start hormonal contraception at the time of surgical abortion, or as early as the time of administration of the first pill of a medical abortion.

3.5.3. Unsafe Abortion

Unsafe abortion is defined by the World Health Organization (WHO) as a procedure for terminating an unintended pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both. Three out of four induced abortions in developing countries (excluding China) are carried out in unsafe conditions. Evidence shows that major physiological, financial and emotional costs are incurred by women who undergo unsafe abortion.

Unsafe abortion procedures may involve insertion of an object or substance (root, twig or catheter or traditional concoction) into the uterus; dilatation and curettage (surgical abortion method) performed incorrectly by an unskilled provider; ingestion of harmful substances (such as quencher, millet chuff, tea leaves and washing powder); herbal medicine; and application of external force. In some settings, traditional practitioners vigorously pummel (strike repeatedly, typically using fists) the woman's lower abdomen to disrupt the pregnancy, which can cause the uterus to rupture, with high risk of bleedings which eventually can lead to killing the woman.

The health consequences of unsafe abortion depend on the facilities where abortion is performed; the skills of the abortion provider; the method of abortion used; the health of the woman; and the gestational age of her pregnancy. The burdens of unsafe abortion and of maternal deaths due to unsafe abortion are disproportionately higher for women in Africa than in any other developing region.

Complications of unsafe abortion include hemorrhage, sepsis, peritonitis, and trauma to the cervix, vagina, uterus and abdominal organs. Bleedings and infections after abortion can lead to death. About 20–30% of unsafe abortions cause reproductive tract infections and 20–40%

of this result in infection of the upper genital tract. One in four women who undergo unsafe abortion is likely to develop temporary or lifelong disability (not being able to get pregnant again or being in constant pain) requiring medical care.

There is a growing consensus (when looking at the number of declarations and resolutions) that unsafe abortion is an important cause of maternal death that can, and should, be prevented through the promotion of sexuality education, family planning, safe abortion services to the full extent of the law, and post-abortion care in all cases. The consensus also exists that post-abortion care should always be provided, and that expanding access to modern contraception is critical to the prevention of unplanned pregnancy and unsafe abortion.

4. Contraceptives and Family Planning Methods

When we talk about *contraceptives*, we are talking about all methods that can reduce the chance of pregnancy. However there are some contraceptives that are safer and that we recommend over others. Contraceptives enables you to decide if, when, with whom and how many children you want. This is a human right, and contraceptives will help you to execute this right.

Most contraceptives only prevent pregnancy but some also protects against contracting sexually transmitted infections (STIs). Most contraceptives or family planning methods is used by women, but men should be equally responsible for making sure that they protect themselves and others against STIs and unwanted pregnancy. Young people often lack information and knowledge about contraceptives. In addition, young people often do not plan to have sex and therefore do not have contraceptives with them. It is important that you find the type of contraceptive that works for you, your health and lifestyle.

We can categorize contraceptives into two groups:

(1) Contraceptives with hormones:

Hormone contraceptives contain a very low dosage of a synthetic version of the female hormones (estrogen and progestin) which controls the menstrual cycle. All types of hormone contraceptives include progestin, and some also includes estrogen. Hormone contraceptives include birth control pills, injections, vaginal ring, contraceptive patch, implants and hormone IUDs.

(2) Contraceptives without hormones.

Contraceptives without hormones prevent pregnancy in other ways. Male and female condom, IUD with copper, sterilization and natural methods of contraception is all contraceptives that fall under this category.

Following is a short introduction to all contraceptive methods categorized as modern contraceptives, natural methods of contraception, natural methods of fertility awareness, permanent methods, and finally emergency contraceptives.

4.1. Modern Contraceptives

Some contraceptive methods are temporary and user-controlled methods that block the sperm from reaching the egg (condoms, cervical cup, spermicides). Other methods are long-acting methods working inside the body's system (oral contraceptives/birth control pills, injections, vaginal ring, contraceptive patch, implants and intrauterine device). Both these categories are considered *modern contraceptives*.

4.1.1. Male Condom

Condoms are a temporary contraceptive method using during sexual intercourse to prevent sperm from reaching the egg. The male condom covers the man's erected penis and therefore prevents the sperm from entering the vagina. Most condoms are made of latex material (but you can also find condoms made of other rubber materials) and is covered by a lubricant. Some people can be allergic to latex and should choose condoms made from other rubber

materials. Some people may react to the lubricant which can cause a slight itching, but is not harmful in any way.

- ✓ Male condoms also protects against STIs.

Condoms are the only contraceptive method that also protects against sexually transmitted infections (STIs) and are therefore considered one of the best contraceptive methods. Another advantage with the male condom is that it is easy to buy and access, it is easy to use and easy to carry, and it works immediately. Limitations includes that the condom has to be put on during sex and some men claims it reduces sexual feeling.

Correct condom use is essential for the condom to work optimally. You have to use the condom throughout the intercourse, and you can only use one condom once. It is also important to hold on to the condom when pulling out of the vagina after intercourse to prevent the condom from remaining inside the vagina or for semen to be spilled.

Guide to correct condom use:

1. Check the expiry date (an old condom can break more easily).
2. Open the wrapping carefully (mind long nails, teeth and jewelry so that you do not scratch the condom).
3. Squeeze the tip of the condom between your fingers to squeeze out the air (air in the condom can make it burst).
4. Thread the condom onto the erect penis the right way so that the condom easily rolls on. If you placed it the wrong way just throw that condom away and use another one (infections can already be transferred to the condom).
5. After intercourse, hold on to the condom when you pull out to prevent semen to escape the condom and to prevent the condom of remaining inside the vagina.
6. Pull the condom off the penis, tie a knot (so that the semen remains inside the condom) and throw it in a bin. Do not throw a used condom in a flushing toilet; condoms have a way of float back into the toilet.

4.1.2. Female Condom

Female condom is a temporary method only used during sexual intercourse. The female condom has the same functions as the male condom, but the appearance is different. The female condom is a lubricant plastic sheath with two rings. One ring (the one with the opening) remains outside the vagina, covering part of the labia (inner and outer lips). The other is placed inside the vagina, covering the cervix. The semen is collected inside the condom so make sure that the penis is inserted inside the outer ring. The female condom can be inserted hours before sexual activity begins and should be inserted 30 minutes before intercourse to be able to settle inside the vagina.

- ✓ Female condoms also protects against STIs.

Another advantage is that the female condom gives women control and enables them to protect themselves. The disadvantages are that it requires to be inserted some time before intercourse, it is noticeable during sex and it is expensive to buy.

4.1.3. Cervical Cap / Diaphragm

Cervical cap is a temporary method only used during sexual intercourse. The cervical cap is a small rubber cap that fits over the cervix (the opening between the uterus and vagina) inside the vagina. The cap should be used with a spermicide. The cap must initially be fitted by a health care provider.

- Cervical cap/diaphragm does NOT protect against STIs.

The advantage of this method is that is controlled by the woman and that it can be placed hours before sex. It can be difficult to insert and remove. The spermicides may irritate the vagina or the penis. It is not widely available and was more common earlier.

4.1.4. Spermicides

Spermicides are a temporary method used during sexual intercourse. Spermicides are creams or gels that immobilize and kill sperm. The spermicide has to be inserted into the vagina before intercourse. This is a method that is recommended to be used in combinations with other contraceptive methods. In addition, frequent use is also not recommended. Spermicides may kill sperm but it does not kill bacteria or virus and, therefore:

- Spermicides does NOT protect against STIs.

4.1.5. Oral Contraceptives / Birth Control Pill

Oral contraceptives are a long-acting hormonal method that you use daily to prevent pregnancy. There are a variety of different birth control pills; some contains different hormones and others are just different brands. Some pills use a combination of estrogen and progestin, others contains progestin only. Birth control pills, like all hormone contraceptives, stop the ovulation and change the cervical mucus, making it difficult for the sperm to enter the uterus.

(1) Birth control pills containing a combination of estrogen and progestin:

Most birth control pills create an artificial menstrual cycle which lasts for a given number of days (most common is 28 days). For the pills using a cycle of 28 days, you take the hormone pills for 21 days of the cycle (you will not bleed during these days), and the final 7 days you do not take any pills containing hormones (either you don't take any pills or your brand of birth control pills includes 7 days of pills that does not include any hormones, only some sugar). During these last 7 days, the endometrium inside the uterus will normally be shed, giving you a menstrual bleeding. Some birth control pills follows a principle of 24+4 days. You can skip your period by jumping straight from one tray to another without having 7 (or 4) days break, or skip the pills only containing sugar.

(2) Birth control pills containing only progestin:

The progestin only pills you take every day, but you don't take a break to get your period. The dosage of progestin is less than in the combination pills so it is very important that you take the pill at the same time every day. You have a window of 3 hours. This makes it easier to use these pills in the wrong way which increases the risk of pregnancy.

Taking the birth control pills correctly is essential for preventing pregnancy. When taken correctly you are safe at all times (even during those days you are not taking the pill). If you forget to take one or more pills, however, the protection will be weakened and you may experience contraceptive failure. The weakened effect depends on in which brand you are using. It is therefore very important to read the information on the leaflet following the pills and follow the instructions from your service provider who prescribed you the pill.

- Birth control pills does NOT protect against STIs.

Severe side effects of birth control pills may include blood cloths, heart attack, stroke and high blood pressure. It is therefore very important to consult a trained health care provider before starting to use birth control pills. Women starting using the pill may experience weight changes, moodiness, spotting (uncontrolled small vaginal bleedings) and more vaginal infections (candidiasis and bacterial vaginosis). The advantages of birth control pills is that they are simple and easy to use (as long as you remember to take it every day), it does not interfere with sex and many women experience less bleeding during menstrual periods and it may also reduce menstrual cramps. Fertility resumes within a few months after you stop using this method.

4.1.6. Injections

Injections are a long-acting hormonal method to prevent pregnancy. Hormones are being injected by a clinician. As all hormone contraceptives, the injections stops ovulation and thicken the mucus of the cervix, making it difficult for the sperm to enter the uterus. An injection is being given at regular intervals (usually every 1 or 3 months). It is very important that you go back for your re-injections at the time you were given. If you postpone you are no longer protected.

- Injections does NOT protect against STIs.

Hormones can cause various side effects and should not be used by women with liver disease, hearth disease, and breast cancer or blood cloths. Injections can also cause irregular menstrual bleeding, amenorrhea (bleeding stops) and weight gain. The advantages are that it does not interfere with sex and can last up to 3 months before requiring a refill. For many women, the biggest advantage is that they can use this method without the knowledge of others. Fertility resumes within a few months after you stop using it.

4.1.7. Vaginal Ring

The vaginal ring is a long-acting hormonal method. The vaginal ring is a thin, soft and flexible ring made of rubber that is placed inside the vagina by the woman herself. It slowly releases estrogen and progestin into the mucus in the vagina and eventually into the bloodstream. As with all hormone contraceptives, the vaginal ring also stops the ovulation and thickens the cervical mucus making it difficult for sperms to enter the uterus. As with (most) birth control pills, you are supposed to use the vaginal ring continuously for 21 days (3 weeks straight). You can use the same ring for 3 weeks before you take a break for 7 days

to be able to shed the endometrium (get a bleeding). If you want to skip the bleeding you just insert a new ring right away without a break.

When you are inserting the ring into the vagina, you squeeze the ring together between your fingers and push it far into the vagina. Since the ring is very elastic it will pop back into its original shape (placed against the walls of the vagina) when you let go of it. When you want to take it out you retrieve it with your finger. When the vaginal ring is placed correctly you are not supposed to feel that it is there. However, it is likely that your sexual partner may feel the ring when you are having vaginal sex. You can therefore take it out during the time you have sex and then place it back in when you are done. It is perfectly safe to take the ring out for up to 3 hours at the time, but remember to place it back in so that you will not lose the protection against pregnancy. In addition, even though this doesn't happen often, it can happen that the vaginal ring can fall out into the toilet when you have to go.

- Vaginal ring does NOT protect against STIs

4.1.8. Contraceptive Patch

The contraceptive patch is a long-acting hormonal method. The contraceptive patch is a patch containing hormones that is placed straight on the skin. The hormones travel from the patch, through the skin and into the bloodstream. As with all hormone contraceptives, the hormones stops ovulation and thicken the mucus of the cervix, making it difficult for sperm to swim through.

You use one patch for one week before you change it with a new one. You are supposed to use patches for 3 weeks (21 days) before you take a break for 7 days. If you want to skip the bleeding you just continue by placing a new patch without taking a break. If you forget to change the patch in time or it loosens, the protection decreases and you may experience contraception failure which can lead to pregnancy.

- Contraceptive patch does NOT protect against STIs.

The contraceptive patch does not require the woman to insert or apply anything at the time of sexual relations. And after the woman stops using it, fertility returns quickly. In addition, the patch is less effective for women weighing more than 90 kilos (198lbs) than for other women.

4.1.9. Implants

Implants are tiny capsules containing progestin hormone. The capsules are inserted under the skin of the arm by a trained clinician during a minor surgery and work as a long-acting method. It remains there for up to 3 years. The capsule slowly releases the hormone into the bloodstream. As with all hormone contraceptives, the hormone causes the ovulation to stop and the mucus of the cervix thickens, making it difficult for sperms to swim into the uterus. The implant is the most effective contraceptive because as long as it has been placed on the right place by a trained professional you cannot make a mistake that will decrease its protection.

- Implants does NOT protect against STIs.

During the first few months after inserting the implant women may experience irregular periods. The upfront cost is high, but the implant can stay in for up to 3 years and it can also be removed anytime. Fertility returns quickly after removal.

4.1.10. Intrauterine Device (IUDs)

Intrauterine device (IUD) is a small T-shaped device that is placed inside the uterus by a trained service provider. The IUD is a long-acting method containing the progestin (hormone) or copper (the metal). Both types have antifertility effects. The IUD is an old, well established, form of contraceptive, and it has become smaller and more secure with time. You can use an IUD even though you have never given birth or if you are young.

- IUDs does NOT protect against STIs.

(1) Hormone IUD:

Some IUDs containing the progestin hormone you can use for up to 3 years, other for up to 5 years. Some women lose their ovulation temporarily with this contraceptive method, but not everyone. It is more common with IUDs lasting for 5 years because the hormone level is higher. The most important effect of the IUD is the local effect: the hormone makes the mucus of the cervix impossible for sperm to swim through and the endometrium will be thin making it difficult for fertilized egg to attach and grow. The hormone IUD is the second most effective contraceptive method (following the implant).

(2) Copper IUD:

The copper IUD is a contraceptive alternative that does not contain any hormones. The copper IUD has small threads of copper twisted around the device. It can be used up to 5 years and protects against pregnancy at all times. There are different types of copper IUD and the difference is not in quality but in price. We are not actually sure how and why the copper IUD prevents pregnancies. However, we do know that the copper changes the environment inside the uterus because it causes small inflammations in the uterus. This IUD has only a local effect inside the uterus and therefore it will not affect the ovaries (ovulation) or the brain. A common side effect is heavier menstrual flow and increased period pain than before. Because of this, copper IUDs are not recommended for women already suffering from these ailments.

The IUD has to be inserted through the cervix. This can feel unpleasant since the opening of the cervix is very tight. Many women experience the insertion as short, strong menstrual cramps. It can help to take some painkillers before the procedure and relax when it is being inserted. If an infection is present during insertion, or if the conditions for insertion are not sterile, insertion may lead to pelvic infection and increased risk of infertility. There are two small threads that is attached to the IUD which is visible through the opening of the cervix. You can use these threads to check if the IUD is in place and the health care provider will use them to remove the IUD. If these threads suddenly disappear you have to contact your health care provider as it can mean that the IUD has been rejected by the uterus. If that happens you are no longer protected against pregnancy. This happens to about 5-10% of women using IUDs. In very rare cases this can also mean that you are pregnant.

4.2. Natural Methods of Contraception

Natural methods of contraception (abstinence, lactating amenorrhea method and withdrawal) are used all over the world as a cheap alternative to modern contraceptives. However, many women and couples fall pregnant despite pregnancy not being the desired outcome.

4.2.1. Abstinence

Abstinence is avoiding penetrating vaginal intercourse to avoid pregnancy. To avoid STIs you have to avoid vaginal, anal and oral sex. Holding hands, hugging, kissing, massaging and masturbation (using hands) are allowed. This is the most effective method for preventing pregnancy and STIs. Even though you have already engaged in sexual intercourse earlier it is possible for you to practice abstinence. This method requires high level of motivation and self-control.

- ✓ STIs can be avoided with this method.

4.2.2. Lactating Amenorrhea Method

This is a temporary method following the first 6 months after childbirth. Women who have not started their period again after giving birth and that are fully breastfeeding can use this method. Breastfeeding causes the body to produce hormones that can prevent ovulation. And when you do not ovulate, you cannot get pregnant. As contraception, this method is only effective during the first 6 months of fully breastfeeding (the baby is fed only breast milk on demand) or until the woman resumes her menstruation (whichever comes first).

- Lactating amenorrhea method does NOT protect against STIs.

The advantages of this method are that it has no cost and no side effect. Breastfeeding provides proper nutrition for the baby and it also has positive health effects on both the mother and the baby. This method is limited to a temporary period and it is difficult for women who need to be away from their baby regularly to follow this method.

4.2.3. Withdrawal

Withdrawal is when the man interrupts the intercourse and withdraws penis from the vagina before ejaculation. This is supposed to prevent sperm from entering the vagina. This is not a safe method. Sperm from a previous ejaculation can still be present in the urethra of the man and can enter the vagina through the pre-ejaculation[8]. In addition, withdrawal is difficult to practice as it depends on the man's self-control and ability to predict ejaculation. Women have no control with this method and it interrupts sex and may lessen the pleasure. However, withdrawal is always a backup contraceptive available for free. You can never trust withdrawal, but it is considerably more effective than not withdrawing.

- Withdrawal does NOT protect against STIs.

[8] Pre-ejaculation is a fluid emitted from the urethra during sexual arousal that function as a lubricant and acid neutralizer. The pre-ejaculate can include HIV and other STIs.

4.3. Natural Methods of Fertility Awareness

The methods are more commonly used by couples that wish to become pregnant to identify the fertile days in a woman's cycle. Natural methods of fertility awareness are NOT recommended as contraceptive methods. The reason why these methods are not recommended as contraceptive methods is because you can never know for sure when you ovulate. People that use these methods as contraceptive methods are taking a high risk.

- NOT any of the fertility awareness methods does protect against STIs.

4.3.1. Cervical Mucus Method

It is possible to use changes in your discharge (cervical mucus) to estimate when you are ovulating. For this method to work you have to check your discharge daily to look for changes. Just before ovulation the discharge will become glossy and slimy, and you should be able to stretch it between your fingers. Just after ovulation, the discharge becomes white and creamy. This method requires that you spend time getting to know your own discharge and get knowledge on how it changes throughout the cycle. When you have identified your fertile days you can abstain from sexual intercourse or use a barrier method these days to prevent pregnancy.

It is important to remember that there can be other things (other than the course of the cycle) that can cause a change in the discharge. Different infections can change the discharge, making it difficult to consider where you are in the cycle.

This method increases a woman's awareness and understanding of her own body. It allows women to predict when they will begin their next period (menstruation). The biggest advantage is that it can help couples that are trying to become pregnant. It is also acceptable to religious groups that oppose the use of other methods. On the other hand, this method requires time to learn the method, discipline to maintain daily observation of mucus and the cooperation of the woman's partner.

4.3.2. Temperature Method

A woman's body temperature changes slightly (0.3 Degrees Celsius) throughout the menstrual cycle, and your body temperature increases slightly between 2-4 days before ovulation. This method requires a special thermometer called a *basal body thermometer*, which enables the user to notice slight differences in body temperature. This method requires you to measure your body temperature every day for a longer period of time to find out when in your cycle you normally ovulate. Knowing when you ovulate you are able to calculate your fertile days. Again, this method is most helpful to couples who are trying to become pregnant. But if used as a contraceptive method, abstaining or a barrier method should be practiced during the fertile days to prevent pregnancy.

4.3.3. Calendar/Standard Days/Cycle Beads Method

Many women have fairly predictable menstrual cycles. That means that the woman is able to predict when a new cycle starts. This method requires a regular cycle, which enables the woman to predict her fertile days. You need to know your own menstrual cycle. Ovulation normally occurs 14 days before the beginning of the next menstrual period. This method is

very risky as a contraceptive method. It is better used by couples who are trying to become pregnant to identify the most fertile days of the cycle. Again, this method is only practical for women with regular cycles.

4.4. Permanent Methods

There are only two forms of permanent methods to prevent pregnancies. One is male sterilization (vasectomy) and the other is female sterilization (tubal sterilization). Permanent mean that when performed, this method implies that the person will never be able to reproduce again. In other words, these procedures make you infertile.

- Permanent methods does NOT protect against STIs.

4.4.1. Vasectomy / Male Sterilization

Vasectomy is a simple, outpatient operation in which the vas deferens (the tubes carrying sperms, leading from the testicles to the urethra) is cut and ties. Since the sperm now is blocked from being ejected with the semen through ejaculation, it is then harmlessly reabsorbed into the man's body. The procedure does not change a man's ability to have sex, feel sexual pleasure or ejaculate. Vasectomy is only effective after three months after the procedure.

4.4.2. Tubal Sterilization / Female Sterilization

Tubal sterilization is a surgical procedure where the fallopian tubes are cur and tied (tubal ligation) or blocked. Both methods prevent sperm and egg from meeting. It does not change a woman's ability to have sex or feel sexual pleasure.

4.5. Emergency Contraceptives (EC)

Emergency contraception is something women can use to avoid pregnancy after having unprotected sex (including rape), after experiencing contraceptive failure[9] or after misuse of a contraception method. A general rule is that you should use emergency contraceptives only if something else went wrong, it shall not replace other contraceptive methods (that's why it is called *emergency* contraceptive). Emergency contraceptives are not as effective as other contraceptive methods and it has more side effects. Emergency contraception is not abortion; emergency contraceptives only delays ovulation. It does not work if you are already pregnant.

- Emergency contraceptive does NOT protect against STIs

There are two types of emergency contraceptives:

(1) Emergency Contraceptive Pill:

Pills containing progestin are the most common method of emergency contraception. The *emergency contraceptive pills* work by preventing ovulation, preventing an egg and sperm from joining, or preventing implantation, whereby a fertilized egg attaches to the uterus. The effectiveness of emergency contraceptive pills depends on the type of pill that is used and

[9] Contraceptive failure depends on what type of contraceptive you use. It can be that you forgot to take your birth control pill, your vaginal ring fell out or the condom broke. If you are unsure about the rules on contraceptive failure you should contact your doctor or a trained professional with knowledge about contraceptives and family planning.

how soon it is taken after having unprotected sex. The sooner the pills is taken after unprotected sex, the more effective they are. Emergency contraception does not cause an abortion, because it does not work if the woman is already pregnant. In Kenya, the EC pills are called Postinor2 (or goes under the names of its generic forms; Ecee2, Emcon, P2, Option2).

(2) Intrauterine Device (IUD) with Copper:

Another emergency contraceptive method is the *copper-IUD*. When used as an emergency contraceptive, the copper-IUD is inserted by a trained health care provider within five to seven days after the woman has had unprotected sex. Copper-releasing IUDs works as an emergency contraceptive by interfering with implantation by preventing a fertilized egg from settling in the womb. In some countries, the copper-IUD, has not been approved for emergency contraception.

5. Reproductive Tract Infections (RTI)

Infections are caused by microorganisms; either bacteria or virus. These microorganisms are tiny living organisms that cause diseases when they enter the body. Many bacteria are useful to us. However, many do also cause diseases. This happens because they produce toxins or break down cells and tissue. Different from bacteria, viruses do not have any metabolism and are therefore unable to multiply before entering a cell. The virus is therefore dependent on finding a home inside a living organism (like a human cell). This is why we cannot use medication against viruses without also affecting the cell. As a rule, treatment of viral infections (virus) is left to the patient's own immune system.

Reproductive tract infections (RTIs) are caused by either bacteria or virus and have three main causes:

(1) When bacteria are accidently introduced or spread to the uterus during medical procedures.
(2) Overgrowth of bacteria normally present in the vagina (*endogenous infections*).
(3) Sexually transmitted infections/diseases (STI/STDs).

Infection caused by medical procedures is most often related to insertion of intrauterine device (IUD) or childbirth. You can try to prevent these infections by always using good health care services that practice safe and sterile procedures.

5.1. Endogenous Infections

Girls and women can experience itchy or smelling genitals even though they bath regularly and have never had sex before. Infections that are not sexually transmitted (endogenous infections) occur when there is an overgrowth of "bad" bacteria in the female reproductive system. Sometimes you cannot do anything to prevent these infections, but if you want to try to avoid it there are some preventative measures you can try. Women should avoid vaginal douching; the use of internal vaginal "drying" or "tightening" herbs, agents, or products; and the unnecessary use of antibiotics. After using the toilet, women should always wipe from front to back to avoid spreading germs from the anus into the vagina or urinary opening. Synthetic (polyester) underwear and tight pants that restrict air circulation should also be avoided. The two most common endogenous infections are *candidiasis* and *bacterial vaginosis*.

5.1.1. Candidiasis (Fungus)

Candidiasis (also called yeast infection, candida, or thrust) results from an increase in yeast bacteria naturally present in the vagina. Symptoms include a thick white discharge, intense itching or redness of the vulva and vagina, and vaginal irritation during sex. Sometimes a woman may have candidiasis but have no symptoms. Women whose immune systems are weak, who are pregnant, or who are taking antibiotics are more likely to develop candidiasis. Men can occasionally experience itching and discomfort from candidiasis. People can also have candidiasis in other moist parts of the body. Candidiasis can be treated. Contact a doctor, health care provider or a pharmacy to get more information.

5.1.2. Bacterial Vaginosis

Bacterial vaginosis is also caused by an abnormal increase of 'bad' bacteria in the vagina. The most common symptoms are thin gray, white, or yellow/green discharge; a bad odor/smell, especially after sex or during menstruation; or vaginal itching and soreness. More than half of women with bacterial vaginosis, however, do not have any symptoms at all. Although it usually causes no complications, it can be serious, leading to increased susceptibility to HIV and other STIs, pelvic inflammatory disease (PID), and, among pregnant women, increased risk of preterm delivery or low birth weight. Bacterial vaginosis is treatable. Contact a doctor, health care provider or a pharmacy to get more information.

5.2. Sexually Transmitted Infections/Diseases (STI/STD)

Sexually transmitted infections/diseases occur when bacteria, viruses or other disease-causing organisms passing primarily by sexual contact (vaginal, oral, and anal intercourse). Some STIs can be transmitted by skin-to-skin contact, others through the exchange of bodily fluids. In addition, some STIs can be transmitted from the mother to the child during pregnancy, birth and breastfeeding. STIs can have devastating health consequences, including infertility, chronic abdominal pain and cancer. It is possible to become infected with an STI even after only one sexual intercourse with an infected person. Changing sex partner, having many sex partners, having a sex partner that has or may have other sex partners, or a sex partner who lives elsewhere or travels often increases your risk of acquiring an STI.

The only way of knowing for sure you have an STI is to ***get tested***. It is important to test regularly and recognize the signs of an STI and to visit a doctor as soon as possible if you experience any symptoms or suspect that you have been exposed to an STI. Early (and regular) testing is essential as it reduces the consequences of most STIs. A couple should not resume sexual activity until both partners have been tested and have completed any necessary treatment. If you find out you have an STI you should make sure that your partner also get tested and goes for treatment as well.

Prevention is essential as several of the STIs cannot be treated and some also have devastating consequences. You should always get tested regularly, practice abstinence or safe sex, maintaining mutually faithful relationships, obtaining a vaccination for the Hepatitis and HPV viruses.

Following is information about all sexually transmitted infections and diseases.

5.2.1. Cancroid

Cancroid is a sexually transmitted infection caused by the bacteria *hemophilus ducreyi*. The bacteria transfer trough skin to skin contact during sexual activity, and enter the body though small tares in the skin. Cancroid cannot be transferred between mother and child during childbirth. People living with HIV have a higher chance of also having cancroid.

Symptoms: Open genital sores that may produce pus and may be painful, swollen lymph nodes in the groin. In women, symptoms are less obvious and may include pain when urinating, pain when intercourse, rectal bleeding, and unusual vaginal discharge.

How to test: Pus examined via microscope (swab test), culture of a sore or through a blood test. You must see healthcare provider because cancroid symptoms are difficult to differentiate between symptoms of more common STIs.

Treatment: Cancroid is treated with antibiotics. The patient usually becomes painless within 48 hours and wounds recovery is visible within 72 hours. If no improvement achieved after 7 days, the diagnosis should be reassessed or other simultaneous infection (often syphilis) should be considered.

5.2.2. Chlamydia

Chlamydia is an infection caused by the bacteria *chlamydia trachomatis*. The bacteria are transferred through the exchange of bodily fluids (semen and vaginal discharge) during sexual activity (vaginal, anal and oral sex) and settle and grow in the mucosa of the urethra (men) and on the cervix (women).

Symptoms: Chlamydia infections often have no symptoms. However, if symptoms do occur, it is usually in the form of a burning sensation when urinating, discharge from the urinary opening, women may experience abnormal vaginal discharge and/or irregular bleedings, and men can also experience itching in the urinary opening.

How to test: Women test for chlamydia with a swab test or a gynecological examination. Men tests through a urine sample. Both men and women practicing anal sex should also do a swab test of the anus. Chlamydia should be tested 14 days after suspected transmission (for the infection to be detectable on the test).

Treatment: Chlamydia is cured by an antibiotic. If you have tested positive for chlamydia, your partner should also be treated even if he or she has a negative result. You have to wait 7 days after finishing treatment before having unprotected sex. This is because it takes some time to be certain that you got rid of all of the bacteria.

NOTE: A chlamydia infection can spread from the urethra to the prostate and epididymis (men) and from the cervix to the uterus and ovaries (women). This can lead to infertility in both men and women. In addition, an infection that has caused scaring in the fallopian tubes increases the risk of pregnancy outside the uterus. Some women also develop chronic abdominal pain or a liver inflammation as a result of a chlamydia infection. If an infection is present during pregnancy it can cause miscarriages, premature birth and low birth weight. The infection can also be transferred to the baby during birth, but will rarely result in severe birth defects.

5.2.3. Gonorrhea

Gonorrhea is a sexually transmitted disease caused by the bacteria *neisseria gonorrhoeae* that can be present in the vagina penis (urethra), throat and anus. The bacteria transmit through body fluids (semen and vaginal discharge) during sexual activity (vaginal, anal and oral sex).

Symptoms: Men often experience symptoms of a gonorrhea infection in the urethra. These symptoms includes a burning sensation when urinating; itching in the urethra or under the

foreskin; discharge from the urethra (often yellow-ish puss or mucus); itching, rash or a sore feeling under the foreskin or on the head of the penis. Only half of infected women experience symptoms of a gonorrhea infection in the vagina. The symptoms include a burning sensation when urinating; a change in vaginal discharge (increased amount, change of color and/or thicker consistency); bleeding after intercourse or between periods; and pain during intercourse. People infected with gonorrhea in the throat or anus rarely experience symptoms, but if symptoms do occur, it is usually in the form of pain and inflammation in the throat and itching or burning sensation in the anus. Symptoms usually occur 2-7 days after transmission.

How to test: Women are tested for gonorrhea with a swab test from the vagina. Men tests through a urine sample. People (both men and women) practicing anal sex should also do a swab test of the anus and people practicing oral sex should do a swab test of the throat. It is common to test for both gonorrhea and chlamydia at the same time as it is common for people with gonorrhea to also be affected by chlamydia. Gonorrhea should be tested 14 days after suspected transmission (for the infection to be detectable on the test). A follow-up test should also be taken two weeks after a completed treatment.

Treatment: Gonorrhea is treated with antibiotics. However, it is important to do a culture test to look for antibiotic resistance as the number of gonorrhea bacteria that are resistant towards antibiotics are increasing. In some countries, all gonorrhea bacteria are resistant. Since gonorrhea is treated with antibiotics but many bacteria's are resistant, one can therefore not expect that the treatment will have any effect. This is a great cause for concern. If tested positive, your partner should also be treated even though he or she has a negative test result. You should not have unprotected sex before the follow-up test has given a negative result.

NOTE: The disease can spread to the woman's uterus and fallopian tubes and to the men's epididymis and testicles, which ultimately can cause infertility in both men and women. Signs that the infection has spread to the uterus and fallopian tubes may include: abdominal pain; increased vaginal discharge (often yellow-ish and often containing blood); fever; and a general feeling of being sick. Signs that the infection have spread to the epididymis and testicles includes: pain in the scrotum; redness, tenderness and soreness on one side of the scrotum; some experience pain when urinating; fever and a general feeling of being sick.

5.2.4. Hepatitis

Hepatitis is the inflammation of the liver. Different viruses cause Hepatitis (Hepatitis A, B and C). Especially Hepatitis B transmits through sexual activity. Hepatitis B can be dangerous, but most people get healthy within four months. However, for a few percent of infected people, hepatitis will remain in their bodies throughout their lives, and they risk developing a severe liver disease. Hepatitis B transmits through body fluids (vaginal discharge, semen, blood, breast milk and, in rare cases, saliva) during sexual activity (vaginal, anal and oral sex) and through sharing needles. Infection may also transmit from mother to child during childbirth and breastfeeding.

Symptoms: One in three infected people do not have any symptoms at all. One in three has flu like ailments, skin rashes, joint pain, drowsiness and stomach ache (but no liver inflammation). One in three will also have liver inflammation.

How to test: Hepatitis B is tested with a blood test. It can take up to 6 months after the time of infection before the virus is detected on the test, so you should test 6 months after suspected transmission. If you test positive it is important to notify your sex partner(s) over the past 6 months so that they also can get tested.

Treatment: Treatment and follow-up is performed by a specialist. It is important to abstain from sex until the specialist treating you telling you that you are no longer contagious.

There is a vaccine against hepatitis B (here is also a combination vaccine for hepatitis A and B). The vaccine consists of 3 dosages. The second dosage should be injected one month after the first and the third after six months (0, 1 and 6 months).

5.2.5. Herpes

Herpes develops after you have been infected with the *herpes simplex* virus (HSV). Herpes is very common and there are two types of herpes: HSV-1 and HSV-2. The virus is transmitted through saliva, skin and mucus. Both types of the Herpes virus can cause outbreaks both on your mouth and genitals. However, most infected people will never experience an outbreak. Some have only one outbreak during their whole lifetime, while others have outbreaks more often.

It is difficult to say when a person with the herpes simplex virus is contagious. In theory, an infected person is contagious for the rest of its life, but in practice, you are only considered contagious when you have an outbreak (however, transmissions between outbreaks are also possible, especially just before an outbreak). Using a condom reduces, but does not eliminate, the risk of infection.

The outbreak you experience on your mouth is more commonly called “cold sores”. Many people are infected by this already at an early age as the virus transmits via saliva and can therefore be transmitted when sharing food and drinks with infected people. If you have HSV-1 in your mouth you are immune from getting the same type on your genitals.

Herpes on your genitals are called genital herpes. It transfers through unprotected vaginal, anal and oral sex. The virus can also transmit from the mouth to the genitals or vice versa through oral sex.

Symptoms: painful sores on your genitals. A typical outbreak usually starts as itching and a tickling sensation in the skin. After a few days, blisters and wounds appear. The blisters usually breaks relatively quick and the wounds are most noticeable. The wounds are extremely painful and you feel a burning sensation when urinating if the urine comes in contact with one of the wounds. After a while the wounds will crust, and eventually the outbreak will pass and the skin will go back to normal without any scars. Herpes is not dangerous, but the wounds are very painful. Herpes can transmit from mother to child during

childbirth if the mother has an outbreak. The virus can have serious consequences for a newborn.

How to test: Everyone that experiences painful sores on the genitals or around the anus should see a doctor. The doctor will quickly be able to tell if it is herpes or not. If the doctor is unsure, he or she can take a swab test from the wound.

Treatment: Herpes has no cure, but treatment can prevent further outbreaks or make them shorter. The first outbreak should be diagnosed and treated as soon as possible (preferably the same day as you detect the outbreak). You can treat the outbreaks with pills (taken orally) and/or an anesthetic ointment/cream (applied to the sores). Without treatment an outbreak can last 2-6 weeks, but with treatment it can last 5-7 days.

5.2.6. HIV and AIDS

Human Immunodeficiency Virus (HIV) is a virus that attacks and breaks down a person's immune system (the body's defense against infections). As the immune system weakens, the person gets more easily infected with diseases and infections that are usually harmless, but for a person with HIV, these diseases and infections can be serious and even deadly. Without treatment HIV can develop into *Acquired Immune Deficiency Syndrome* (AIDS).

HIV transmits through bodily fluids (blood, semen, vaginal fluid and breast milk). The virus is most commonly transmitted through the exchange of semen and vaginal secretions during sex. Having another STI can increase the risk of acquiring or passing HIV during sex. HIV can also passed to others by transfusion of infected blood or by sharing needles with an infected individual for drug or steroid use, body piercing, or tattooing. HIV can also be passed from an HIV-positive mother to her baby during pregnancy, delivery, or breastfeeding. Oral sex also carries some risk for HIV transmission. HIV does not transmit from saliva, tears, sweat, feces or urine (unless the urine or feces contains blood). HIV cannot be transmitted by touching, kissing, sneezing, coughing, or by shearing food, drink, or utensils, or through everyday contact at work, school, or home. It is not transmitted by using swimming pools, public toilets, or through insect bites.

Symptoms: Symptoms are rare, but if symptoms do occur, it is in the form of flu like ailments approximately 3-6 weeks after transmission. Other symptoms include fever, fatigue, headache, nausea and diarrhea. These early symptoms disappear again after 2-4 weeks and it can often be several years before new symptoms occur.

How to test: People are diagnosed with HIV through a blood test, and if the blood test shows that their cells fighting diseases (immune system) have fallen below a certain number the person is diagnosed with AIDS. The blood test will be able to detect HIV 12 weeks after transmission.

The HIV test detects special cells (called HIV antibodies) that are present if the person is infected. Tests can usually detect HIV antibodies within six to eight weeks of exposure. In rare cases, it may take as long as six months for the antibody level to be detected by a test.

- A positive HIV test means that the person has HIV antibodies and is infected with the virus. If the first test is positive, a second, different test is conducted to confirm the results.
- A negative HIV test means that the person is not infected with HIV. Or it may mean that he or she is infected but has not yet made enough HIV antibodies to test positive. Someone who tests HIV-negative but suspects that he or she was recently exposed to the virus should take the test again in a few months.

The only way to be sure if you are infected or not is to get tested. The only way to know if your sex partner is HIV-positive is if he or she takes an HIV test and shares the results with you. Millions of HIV-positive people feel and look completely healthy, have no symptoms, and have no idea that they are passing the virus to others.

Being tested for HIV is important for many reasons. Obtaining a negative test result can bring enormous relief to a person. It can also encourage that person to practice safer sexual behavior in the future. Those who test HIV-positive can begin to seek care and treatment.

Treatment: HIV cannot be cured, but it can be treated. The current HIV treatment is called antiretroviral therapy (ART). ART is a combination of drugs that reduces the level of HIV virus in the blood and slows down the destruction of the immune system. ART improves the quality and length of life for many individuals living with HIV. Those who are tested can also inform and protect their sex partners. For a woman who is – or would like to become – pregnant, knowing her HIV status is important so that she can take action, if necessary, to reduce the risk of transmission to her baby. ART also reduces illness and death due to AIDS. Not all people respond equally to the drugs. But without treatment, a person infected with HIV generally progress to AIDS within one to ten years after becoming infected. Without treatment, a person with AIDS may live less than a year.

When people find out that they are HIV-positive, they may feel frightened, confused, and depressed. Being infected with HIV is life-changing, and it takes time to adjust to the knowledge. People living with HIV need a strong emotional support system, which may include parents, their spouse or partner, other family members, friends, counselors, social workers, other people living with HIV or AIDS, or religious or spiritual leaders. They need to find a doctor who is caring, respectful, and knowledgeable about HIV and AIDS, and to have access to medical treatment when they need it. They need to learn as much as possible about HIV and AIDS, and how to protect their own health and that of their sex partners. To stay as healthy as possible, they need to eat well, exercise regularly, rest adequately, avoid smoking and drinking too much alcohol, and avoid using recreational drugs. Most important, by always practicing safe sex, they can protect themselves from other sexually transmitted infections and avoid infecting others with HIV.

Prevention: There is no vaccine or cure for HIV. Prevention is therefore essential. You can prevent from being transmitted or transmit the virus though others by abstaining from unprotected sexual intercourse or by using male or female condoms for every intercourse. Another prevention method is to be faithful to only one partner (monogamy). This approach, however, only works if both partners are truly monogamous and if both partners are HIV

negative. For men, circumcision offers some protection against HIV, but it does not eliminate the risk of infection. For women there are currently no known direct benefits of male circumcision. Therefore, circumcised males should still use condoms. You can also prevent transmission by not sharing needles. This is done by making sure you only use new or sterile needles for all injections, skin piercings and tattoos. Mother-to-child transmission is prevented by using drugs during pregnancy (antiretroviral therapy of the mother in addition to preventative treatment of the child), deliver though caesarean and to learn appropriate feeding options for their newborn. You can also prevent being infected with HIV by taking PrEP (Pre-Exposure Prophylaxis) and PEP (Post-Exposure Prophylaxis). PrEP is a daily pill for HIV-negative people that can help prevent HIV infection before exposure to the virus (i.e. for partners of HIV-positive people). PEP is an emergency medication for HIV-negative people that can help prevent infection after exposure to HIV (i.e. in rape cases).

5.2.7. Human Papilloma Virus (HPV) / Genital Warts

Genital warts come from a strain of viruses called *human papilloma virus* (HPV) present in the skin and that infect through skin-to-skin contact. Genital warts transmit easily when you have an outbreak. The risk of transmission goes down when there are no outbreak. If you have a regular partner, he or she is most likely also already infected even though they have no symptoms. It usually takes between 1 and 8 months from infection to warts occur on the skin.

Symptoms: Warts on the genitals. Not all people infected with the virus will experience outbreaks. Genital warts may vary in size and appearance. Some are small, skin-colored and flat, others are bigger and white. The number of warts also vary. In addition to the warts it is common to also experience ailments like itching, burning and small tares in the skin and mucous membranes. This can cause pain during intercourse and when urinating. Also people with the virus without warts can experience these ailments.

How to test: There is no test that can tell you if you have genital warts. However, a doctor or another trained health care provider is able to identify genital warts through looking at the skin during an examination.

Treatment: The body's immune system will most often eradicate the virus and any genital warts on its own within 12-18 months. However, visible warts can be treated. With treatment, the warts usually disappear faster. There are different treatments for genital warts, but most common is to brush a liquid agent on the warts or to use a cream. Genital warts are not dangerous.

Today, hundreds of different strains of the HPV virus is known and discovered. Only some strains cause genital warts. Other strains can cause warts on the rest of the body such as fingers, feet and face. Only warts on the penis, around the vaginal opening or in the skin around the genitals and anal opening are called genital warts. Some strains of the HPV virus can also lead to cancer. Most commonly, cervical cancer, but it can also lead to cancer in the vagina, penis, anal opening and throat. The strains of the HPV virus that causes cancer is different from the ones causing genital warts. That means that genital warts do not increase the risk of cancer.

There is a vaccine for HPV which provides immunity and protection against several different types of HPV strains that can cause cancer. As a bonus, it also provides protection against some of the most common HPV virus strains causing genital warts. The vaccine is taken in 3 dosages (0, 2 and 6 months).

5.2.8. Pubic Lice

Pubic lice are a parasite that live and grow on body hair. The lice lay eggs on the hair. The eggs hatch after a week and become new lice. Pubic lice transmit though close body contact (i.e. during sexual activity or other nude body contact). Pubic lice can, in rare cases, also transmit via towels, sheets and clothes.

Symptoms: Lice are not dangerous but it causes annoying and intense itching. The itching is an allergic reaction to a bite from the lice. When you examine the skin you can see that it is red and irritated. Sometimes you can also see tiny red bites on your skin (red dots on your skin). It is also possible to see the tiny lice and eggs attached to the hair.

How to test: There is no test that can establish if you have pubic lice, but if you experience these symptoms you can contact a doctor or another health care provider for them to assist you in setting a diagnosis.

Treatment: You can easily treat pubic lice using different ornament bought in the pharmacy. Your partner(s) and other family members should also be treated to prevent you from transferring the lice between each other after one undergoes treatment.

5.2.9. Scabies

Scabies is a parasite that can take habitat in human skin. It lives and lay eggs in tunnels under the top layer of the skin. Scabies is common in the skin between the fingers, on the underside of the wrists, on the penis, between the thighs, on the vulva, on the nipples and around the waist. Scabies transmits through close body contact (i.e. sexual contact or other naked body contact). Scabies can, in rare cases, also transfer through towels, sheets and clothes.

Symptoms: Symptoms include an intense itching which is the result of an allergic skin reaction that occurs about one month after being infected. The itching increases with heat (i.e. when lying in bed under a warm blanket or in warm weather). Typical symptoms are itching at night. Scabies can also cause skin rashes, redness and small lumps on the skin.

How to test: It is often difficult to set a diagnosis. There is no test that can tell you if you have scabies, but if you experience rash and itching (usually between fingers, wrists or in the genital area) you should get an appointment to see a doctor or another health care provider that can examine you.

Treatment: The treatment of scabies is simple, using a cream you put on the affected area. Scabies dies when it is not in contact with skin, and when exposed to extremely high or low temperatures. Sheets can be washed in a washing machine on 60 degrees or put in the freezer overnight.

5.2.10. Syphilis

Syphilis is a bacterial infection caused by the bacteria *treponema allidum*. If left untreated, syphilis can cause serious problems and lifelong disease. Infection happens through direct contact of people's mucosa either through vaginal, anal and oral sex. Condom protects against this form of transmission. Syphilis can also transmit through blood, and, in rare cases, through kissing.

Symptoms: A person infected with syphilis will most likely get a sore on the genitals, close to the anal opening or in the mouth/throat to begin with. It takes about 1 to 10 weeks from infection to the wound starts developing. The wound is painless and disappears after a few weeks. If not detected and left untreated, syphilis can, over time (several years) develop into a serious bacterial infection with ailments like fatigue, headache, fever feeling, impaired general condition, swollen lymph nodes and skin changes. The most serious cases of syphilis can lead to heart disease and severe nerve disease.

How to test: It can take up to 12 weeks from infection until syphilis can be detected on a test. The test is taken as a blood test. The laboratory can check for both HIV and syphilis on the same blood test. If the doctor also suspects that you have a wound caused by syphilis, he or she may also take a sample of the wound with a swab test. If tested positive you should notify any sexual partner(s) for them to also get tested and to prevent further spread of the disease.

Treatment: Syphilis is curable with penicillin (an antibiotic). You should not engage in sexual intercourse before the doctor or provider treating you is giving you the "all clear".

5.2.11. Trichomoniasis

Trichomoniasis is a sexually transmitted infection caused by the microscopic single-celled parasite *thrichomonas* (or *thrichomonas vaginalis*). It can infect the vagina or urethra during sexual intercourse.

Symptoms: Most people infected with trichomoniasis in the penis/urethra experience no symptoms. Unfortunately, this leads to many people being infected without knowing and then unknowingly infects others. Most people infected in the vagina experience symptoms. The most common symptom is a change in vaginal discharge. Women often experience large amounts of thin-flowing yellow or greenish discharge with a foamy consistency. It can also cause a burning sensation when urinating.

How to test: Men test for trichomoniasis through a urine test. Women use a swab test. It is recommended to notify any sexual partner(s) if you test positive to make sure they also get tested and to prevent further transmission.

Treatment: Trichomoniasis is treated with antibiotic.

6. Reproductive Cancers

Cancer is a disease in which abnormal cells divide uncontrollably and destroy body tissue. Cancer can develop in all cells and has the ability to spread to other parts of the body, and some cancers are connected to the reproductive system. In addition to the six most common reproductive cancers (breast, cervical, endometrial/uterine, prostate, testicular and colorectal cancer) mentioned in this chapter, other types include penile and ovarian cancer. For all types of cancer, early diagnosis and treatment make a cure more likely.

6.1. Breast Cancer

Breast cancer is a cancer that forms in the cells of the breast. Both men and women can get breast cancer but women are most often affected. Breast cancer can occur at any age, but the risk increases with age. Breast cancer is the most common and deadliest cancer among women in both developed and developing countries.

The best defense is to detect breast cancer early (when it is small, has not spread and is easier to treat). Screening for breast cancer is performed using examinations and mammography. Guidelines for breast cancer screening vary widely however and depend on a woman's risk factors and on local resources. Women older than 20 years should self-examine their breast every month to look for changes[10]. Symptoms of breast cancer include a lump in the breast, bloody discharge from the nipples and changes in the shape and texture of the nipple or breast. If you detect any changes or abnormalities that worry you, you should go for further testing and consult a doctor for medical advice.

Treatment depends on the stage of cancer. Breast cancer can be treated with chemotherapy, radiation and surgery.

6.2. Cervical Cancer

Cervical cancer is a malignant tumor of the cervix. Cervical cancer is the second most common cancer among women. Most cases and related deaths occur in developing countries and are due to limited screening.

Most cases of cervical cancer are caused by certain strains of the Human Papilloma Virus (HPV). HPV can be prevented by an HPV vaccination and by practicing safe sex[11]. Precancerous cells or lesions on the cervix can be detected using a PAP-smear test during a pelvic exam. The test will determine if you have no, some, medium or high cell changes in the cervix. Women who are sexually active should be screened regularly. Contact a doctor for further medical advice.

There are different treatment methods available and they depend on the level of cell changes or the stage of the cancer. There are three different surgical methods. One removes only a small part of the cervix and is performed if the cancer screening show high levels of cell changes. If there is a cancer tumor in the cervix, removing the cervix, uterus, supporting tissue and lymph nodes in the pelvic is an option (the ovaries are usually not removed). This

[10] See Appendix 5: "Breast Self-Examination".
[11] The Human Papilloma Virus is considered a sexually transmitted infection (see p. 48).

surgery is the most common treatment of cervical cancer. The final surgery is done to maintain fertility and is only offered to young women with a tumor less than 2 centimeter and that is limited to the cervix. The surgery is done in two procedures: (1) lymph nodes in the pelvic are removed; and (2) large part of the cervix is being removed. The final treatment method is chemotherapy often in combination with radiation. Chemotherapy can reduce the size of a tumor, making it small enough to be able to remove with surgery. This is the most common treatment if the tumor has grown out of the cervix.

6.3. Endometrial / Uterine Cancer

Most uterine cancer begins in the layer of cells that form the lining (endometrium) of the uterus. Risk factors of this cancer includes overweight and starting period at an early age. Symptoms include vaginal bleeding after menopause and bleeding between periods. People may experience pain in the pelvis, pain during sexual intercourse, abnormal menstruation, heavy menstruation or irregular menstruation, abnormal vaginal bleeding and weight loss is also common. Surgery to remove the uterus is the main treatment for most women with uterine cancer. Advanced cases may need chemotherapy or radiation.

6.4. Prostate Cancer

Prostate cancer is cancer in the man's prostate (a small walnut-sized gland that produces seminal fluid that nourishes and transports sperm). Symptoms of prostate cancer include difficulty with urination, but sometimes there are no symptoms at all. Prostate cancer most commonly affects older men, and some types of prostate cancer grow slowly. In those cases, monitoring is recommended. In aggressive cases, radiation, surgery, hormone therapy, chemotherapy or other treatments are required.

6.5. Testicular Cancer

Testicular cancer is cancer in the testicles. Symptoms include a lump in either testicle or a feeling of heaviness in the scrotum. Treatments include surgery, radiation and chemotherapy. Testicular cancer is rare compared to the other cancer types mentioned; however, testicular cancer is the most common cancer among men between 15 and 35 years. Testicular cancer can usually be successfully treated if caught early. Men can learn to do a self-exam to identify abnormal growths in the testicles[12]. Healthy testicles should have a smooth surface and not be bigger than

6.6. Colorectal Cancer

Colorectal (or colon) cancer is a cancer of the colon or rectum, located at the lower end of the digestive tract. It is included in this chapter because the rectum is included as a sexual organ for many people (it does not have any reproductive function) and because it is one of the most common cancer types. Symptoms of colorectal cancer depends on the size and location of the cancer. Some commonly experienced symptoms include changes in bowel habits, changes in stool consistency, blood in the stool and abdominal discomfort.

Treatment depends on the size, location and how far the cancer has spread. Common treatments include surgery to remove the cancer, chemotherapy and radiation therapy.

[12] See Appendix 6: "Testicles Self-Examination".

7. Gender-Based Violence

According to The United Nations Commissioner for Refugees (UNHCR), gender-based violence is "any act that is perpetrated against a person's will and which is based on gender norms and unequal power relations [between the genders]". It is important to differ between gender-based violence (GBV) and violence against women (VAW). When we talk about gender-based violence we have to remember that it is not only women that are victims. It is a fact that violence based on gender norms and unequal power relations most often happen to females, however, it is important not to forget that the term *gender-based violence* also includes violence against men perpetrated against them on the basis that they are men.

Violence against women and girls are widespread, posing a major public health and human right issue. Globally we are working with a number stating that one-third (1 of 3) of women has been beaten, forced into sex or abused in some other way, most often by someone they know (UNFPA). And according to a report by the World Health Organization (WHO, 2014), one in five women is sexually abused as a child. Around 140 million women and girls worldwide have undergone female genital mutilation (FGM) and another 3 million are at risk annually in Africa. 100 million girls in developing countries will continue to marry as children. And violence against women, including systematic rape, has been reported during and after armed conflicts in all war zones.

Severe injuries, intentional homicide, and suicide related to violence all contribute to female mortality rates. In a community, violence against women can perpetuate the false belief that men are better than women. Gender-based violence creates a climate of fear and insecurity in families, schools, communities and workplaces. Women who experience violence (and their children) need access to various services, and ideally these services should be provided to them in one place. These women may need hotlines, cancelling, support networks, shelters, legal services and health care. Trained health care providers can help detect abuse and assist victims by offering medical, psychological and legal support and referrals. It is important to know you right and also knowing where you can get legal assistance.

To be able to stop gender-based violence and violence against women there is a need for attitude change and to establish other prevention efforts. Such efforts may include:

- Engaging men to change cultural attitudes about masculinity and violent behavior.
- Integrating gender education into formal and informal education, including information about gender-based violence.
- Introduce and support campaigns addressing these issues; such as the annual "16 days of activism against gender-based violence".
- Conduct activities to empower women and girls, and educate women and girls about their legal rights.
- Work towards ending harmful traditional practices; especially early/child marriage which puts many girls in relationships in which they are at risk of violence.

In addition, laws continue to allow gender-based violence:

- Demonstrating political commitment through statements from high-level government officials, backed by action and the commitment of resources.

- Enacting and implementing laws that address violence against women, and evaluating the application of these laws.
- Developing guidelines and protocols and providing systematic mandatory training for police, prosecutors, and judges.
- Establishing specialized courts and police units.
- Enacting vigorous arrest and prosecution policies and appropriate sentencing.

7.1. Forms of Gender-Based Violence

Gender-based violence can be divided into 4 categories: (1) sexual violence, (2) physical violence, (3) emotional (or mental) violence, and (4) economic violence.

- ***Sexual violence*** is all violence with a sexual character and includes, but are not limited to: sexual harassment, sexual assault/exploitation, rape and attempted rape, child abuse (sexual)/incest, forced prostitution and child prostitution, sexual trafficking, and harmful traditional practices[13] like female genital mutilation, early/child marriage, virginity testing etc.
- ***Physical violence*** is any violence causing physical harm to the victim and includes, but are not limited to: kicking, beating, biting, scratching, use of weapons (knives, guns, sticks etc.), killing, spouse beating (domestic violence) and assaults.
- ***Emotional (mental) violence*** is violence that influences/harms the victims' emotions and mentality, and includes, but are not limited to: verbal (emotional) abuse, humiliation, discrimination, denial of opportunities and/or services and spouse confinement (domestic violence).
- ***Economic violence*** includes all forms of violence that influences someone's economic ability and includes, but is not limited to: only allowing boys (sons) go to school, unequal pay for equal work and limited promotions for women and girls.

7.2. Root Causes and Contributing Factors of GBV

Gender-based violence is caused by some root causes that can be narrowed down to four points:

- Male and/or society disrespect or disregard towards women.
- Lack of belief in equality of human rights for all.
- Cultural or social norms of gender equality.
- Lack of value of women and women's work.

Numerous contributing factors contribute to the extent and intensity of the problem. These contributing factors may include, but is not limited to: alcohol and drug abuse; poverty; lack of availability of basic needs (food, fuel, income generation) may requires women to enter isolated areas; boredom, lack of services, activities and programs; collapse of traditional society/family support; religious, cultural and/or family beliefs and practices; design and social structures of place of residence (overcrowded, living with strangers etc.); design of services and facilities; general lawlessness; location (high crime area); lack of laws against forms of GBV (i.e. domestic violence), lack of police protection; legal justice system and laws allowing GBV to go unpunished; loss of male power or role in the family and

[13] Harmful Traditional Practices is discussed in chapter 8 and will not be further discussed here.

community (seeking to assess power); political motive (weapon of war/for power/control/fear/ethnic cleansing etc.); and retaliation (revenge).

7.3. Consequences of GBV

Any type of violence has consequences. Gender-based violence can cause physical/medical or psychological consequences on both individual and family/society level.

Medical and physical consequences (individual level) include, but are not limited to:

- Fatality: death, homicide, suicide, maternal mortality or infant mortality.
- Acute physical trauma: pain and injury (such as broken bones, burns, black eyes, cuts, bruises, headaches, abdominal and muscle pain), shock, diseases, infections etc..
- Chronic physical trauma: disability, chronic infections and pain, gastrointestinal problems, eating disorders, sleep disorders, alcohol and drug abuse etc.
- Reproductive trauma: miscarriage, unwanted pregnancy, unsafe abortions, sexually transmitted diseases/infections, infertility, gynecological disorders, sexual disorders (including painful sex, lack of desire, and fear of sex) etc.

Psychological consequences (individual level) include, but are not limited to:

- Post-traumatic stress disorder (PTSD).
- Depression, anxiety and fear.
- Anger.
- Shame, insecurity and self-hate.
- Self-blame.
- Mental illness.
- Suicidal thoughts/behavior/attempts.
- Lack of ability to function in society or community (i.e. lack of ability to earn an income, care for children etc.).

On the family and society level, the consequences often include (but are not limited to):

- Blaming the survivor.
- Stigma.
- Spouse/family rejecting the victim and family breakdowns.
- Divorce.
- Displacement.
- Social rejection and isolation of the survivor and its family.
- Further violation of the survivor.

8. Harmful Traditional Practices

If we are going to respect human rights and fundamental freedoms for all humans without distinction we also need to take a look at harmful traditional practices. Harmful traditional practices is a number of social and cultural practices, some rooted in traditional attitudes and others evolving around modern times. These practices have a direct impact on reproductive health activities and status of adolescents and young people – especially women and girls. Many international legal instruments on human rights reinforce individual rights, and also protect and prohibit discrimination against specific groups of people; women in particular. *The Convention on the Elimination of All forms of Discrimination against Women* is one such instrument.

Many harmful traditional practices put girls and women in a disadvantage situation. Harmful traditional practices are violence against women and girls which are defended on the basis of tradition, culture, religion or superstition by some community members. As with all forms of violence against women and girls, harmful traditional practices are caused by gender inequality, including unequal power relations between women and men, rigid gender roles, norms and hierarchies, and ascribing women lower status in society. Following is some of the practices that is considered harmful and discriminatory towards women.

8.1. Son Preference

Son preference refers to a whole range of values and attitudes which are manifested in many different practices. Most common is when the sons are preferred over daughters. This is one of the principal forms of discrimination is when the boys are preferred over girls. Son preference is universal and not unique to developing countries or rural areas. It is a practice enshrined in the value systems of most societies and dictates the value judgments, expectations and behavior of family members.

Neglect and discrimination of the girl's child is most common, but in some extreme cases son preference may lead to selective abortion or female infanticide. If the girls are neglected, it may determine the quality and quantity of parental care and the extent of investment in her development and it may lead to acute discrimination, particularly in settings where resources is scarce. Son preference denies the girl good health, education, recreation, economic opportunity and the right to choose her partner.

Son preference is often an outcome of family lineage being carried on by male children (the preservation of the family name is guaranteed through the son(s). It is most common for a woman to take her husband's family name after marriage, dropping her own parent's family name. The fear of losing a name prompts families to wish to have a son, and some men marry a second or third wife to be sure of having a male child. People in important roles like priests, pastors, sheikhs and other religious leaders are men of great status. Religious leaders have a major involvement in the perpetuation of son preference.

8.2. Early, Child and Forced Marriage

We earlier claimed that we all have the right to choose who we want as a partner and who we want to marry. Early marriage, child marriage and forced marriage are all practices that

violates this right. In addition, they also have a direct impact on our sexual and reproductive health.

Child marriage is a situation where marriage, cohabitation or any arrangement is made for such marriage or cohabitation with someone below the age of 18 years. Early and forced marriage likely leads to sexual activity for a girl at an age when she is neither physically nor sexually mature. Child marriage is also associated with dropping out of school, low labor force participation, increased risk of HIV infection, increased risk of gender-based violence, early childbearing and high fertility rate. There is also a risk of high infant mortality, as well as high maternal morbidity and mortality.

8.3. Female Genital Mutilation (FGM)

Female genital mutilation/cutting (FGM/FGC) comprises all procedures involving partial or total removal of the female genitalia or any other injury to the female genital organs or any harmful procedure to the female genitalia, for non-medical reasons and includes *clitoridectomy*, *excision* and *infibulations*. It does not include sexual reassignment or a medical procedure that has a genuine therapeutic purpose. FGM is a human, women's and child's rights violation. It is an age-old practice which is perpetuated in many communities around the world simply because it is customary. FGM forms an important part of the rites of passage ceremony for some communities, marking the coming of age of the female child. It is believed that, by mutilating the female's genital organs, her sexuality will be controlled; but above all it is to ensure a woman's virginity before marriage and chastity thereafter.

Health Consequences: FGM can cause physical and psychological harm throughout the woman's life. These complications includes hemorrhaging and shock at the time of the cut, problems with urination and menstruation, and obstetric complications. FGM persists because it is a social norm, linked with marriageability. This ensures that the practice continues, although the health consequences may be severe. FGM is associated with immediate and long-term social, physical, psychological and health consequence. In addition, girls who have undergone FGM as a rite of passage are likely to drop out of school, experience child marriage and early childbearing.

The practice of FGM violates, among other international human rights, the right of the child to the "enjoyment of the highest attainable standard of health". FGM imposes a catalogue of health complications and untold psychological problems.

The age at which FGM is carried out varies from area to area. FGM can be performed on infants as young as a few days old, on children from 7 to 10 years old, and on adolescents. Adult women can also undergo FGM at the time of marriage. Since FGM is performed on infants as well as adults, FGM can no longer be seen as marking the rites of passage into adulthood, or as ensuring virginity.

FGM is deeply rooted in cultural practice that remains prevalent in Kenya despite being outlawed in 2001 by the Children's Act and Prohibition of FGM Act 2011, and being a violation of rights.

Types of FGM:

(1) *Circumcision*: this involves the removal of the prepuce and the tip of the clitoris. This is the only operation which, medically, can be linked to male circumcision.
(2) *Excision* or *clitoredectomy*: this involves the removal of the clitoris, and often also the labia minora. This is the most common operation.
(3) *Infibulation* or *pharaonic circumcision*: this is the most severe operation, involving excision plus the removal of labia majora and the sealing of the two sides, through stitching or natural fusion of scar tissue. What is left is a very smooth surface, and a small opening (often not bigger than the head of a match) to permit urination and the passing of menstrual blood.

The operation takes between 10 and 20 minutes, depending on its nature. In most cases, anesthetic is not administered. The child is held down by three or four women while the operation is being done. The wound is then treated by applying mixtures of local herbs, earth, cow dung, ash or butter. If infibulation is performed, the child's legs are bound together to impair mobility for up to 40 days. If the child dies from complications, the excisor is not held responsible; rather, the death is attributed to evil spirits or fate.

FGM operations are mainly carried out by women (exisor) who have acquired their "skills" from their mothers or other female relatives. The same women often also the community's traditional birth attendants. The type of operation to be performed is decided by the girl's mother or grandmother.

The conditions under which these operations take place are often unhygienic and the instruments used are crude and unsterilized. A kitchen knife, a razor-blade, a piece of glass or even a sharp fingernail is the tools of the trade. The instruments are used repeatedly on numerous girls, thus increasing the risk transmitting diseases and infections.

FGM is a custom or tradition synthesized over time from various values, especially religious and cultural values. The reasons for maintaining the practice include religion, custom, decreasing the sexual desire of women, hygiene, aesthetics, facility of sexual relations, fertility etc. In order to be clean and proper, fit for marriage, female circumcision is a precondition. Circumcision is also performed to reduce sexual desire and also to maintain virginity until marriage.

The effects of FGM have short-term and long-term implications. Immediate consequences include hemorrhage, infection and acute pain. Later complications may include keloid formation, infertility caused by infections, obstructed labor and psychological complications. In some devastating cases, the complications from deep cuts and infected instruments can lead to death. Most physical complications result from infibulation, although hemorrhage can also occur during circumcision with the removal of the clitoris. Acute infections are common when operations are carried out in unhygienic surroundings and with unsterilized instruments. The application of traditional medicine can also lead to infection. Chronic infection can also lead to infertility and anemia. Another complication includes *haematocopos*, the inability to pass menstrual blood due to the remaining opening being too small. This can lead to infection and infertility. Obstetric complications are the most frequent health problem, resulting from

scars that open during childbirth. This often leads to hemorrhaging that is difficult to stop. Infibulated women have to be opened (deinfibulated) on delivery of their child. Then it is common for them to be re-infibulated after each delivery.

In parts of the world that does not practice FGM, severe forms of the practice present challenges to midwives and obstetricians in providing antenatal, delivery and post-natal care.

8.4. Widow Inheritance

Widow inheritance is the practice that in the event of your husband's death, you should marry one of his brothers or relatives to maintain status. This practice makes sure the man's resources stays in his family and is not inherited by his wife. This practice is considered harmful to women because women are often forced to obey this practice against their choice and will. In addition, it is discriminating against women because, if in the same situation, men are not expected to re-marry (especially not any of his wife's relatives).

8.5. Virginity Testing

Virginity testing is the practice and process of determining whether a person, usually a female, is a virgin (to determine that she has never engaged in, or been subjected to, sexual intercourse). This practice is considered harmful because it is discriminating against women and girls. In addition, some forms of virginity testing are a health risk to the girls/young women.

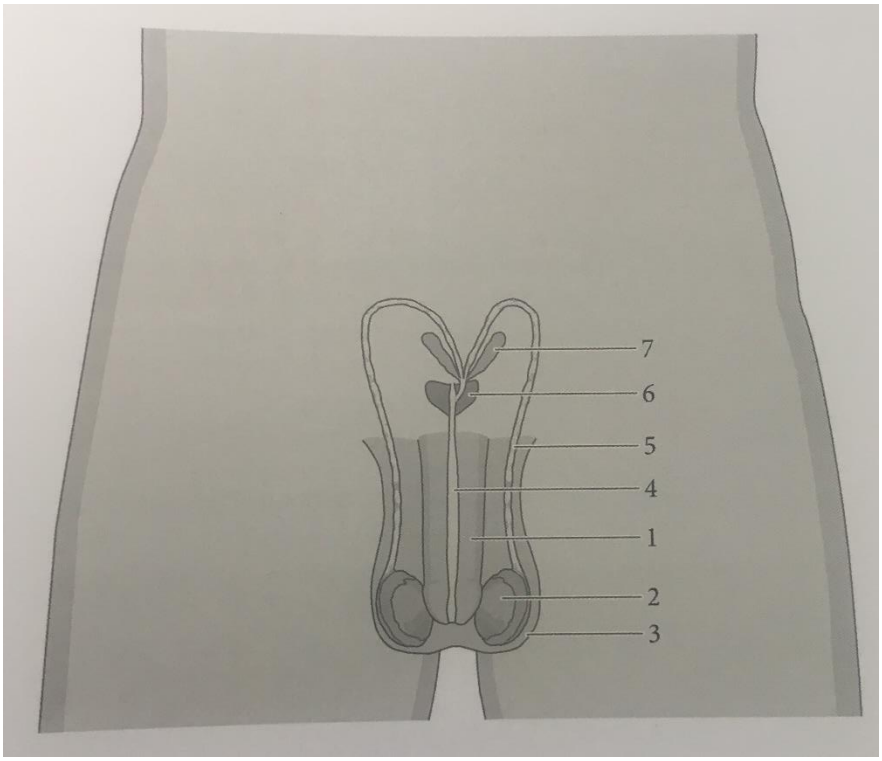
8.6. "Honor" Crimes and Dowry Abuse

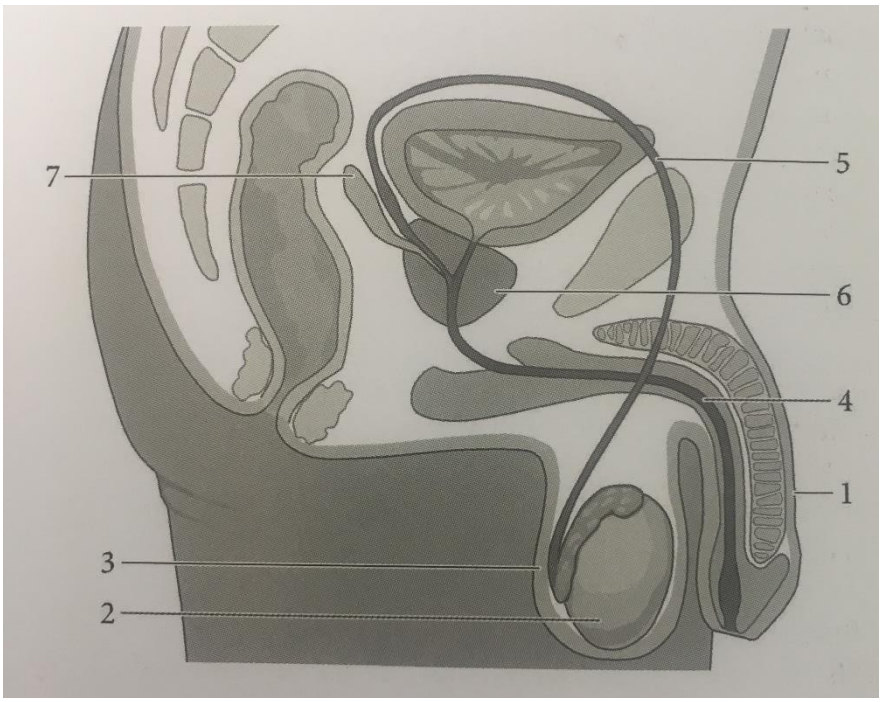
"Honor" crimes occur when a girl or woman is attacked or killed by, or on behalf of a family member, because of an actual or assumed transgression of certain gender social norms which are framed as sullying the honor of a partner, family member etc. Activities which have been framed in this way include being sexually active, pregnancy outside of marriage or even being victim of rape. "Honor" crimes can be seen as a way of protecting family reputation or tradition.

Violence or murder related to dowry payment happens when new brides are hurt or killed by in-laws as a result of conflicts related to dowry.

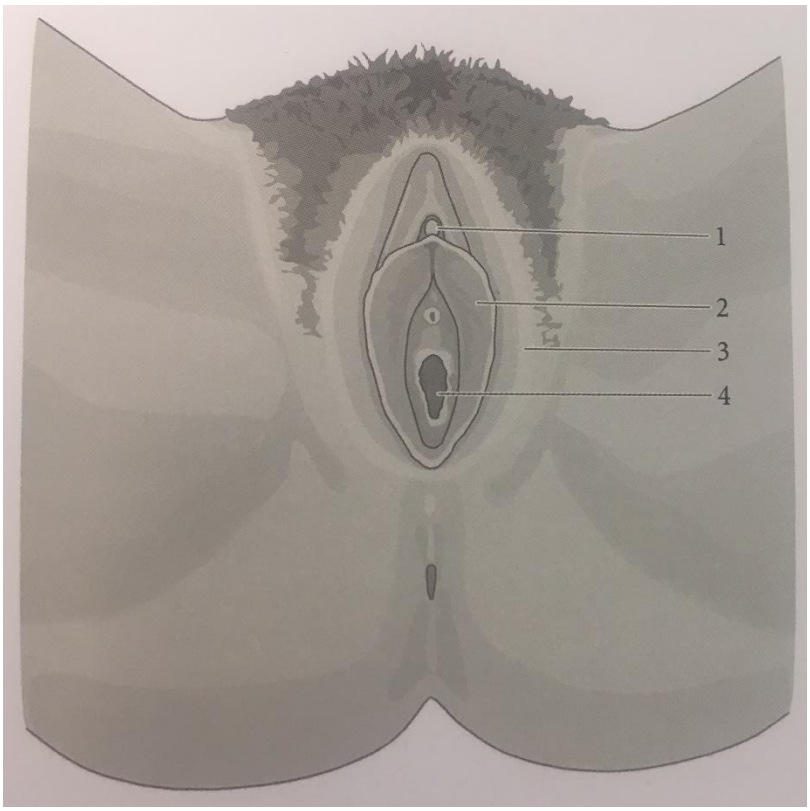
Appendix:

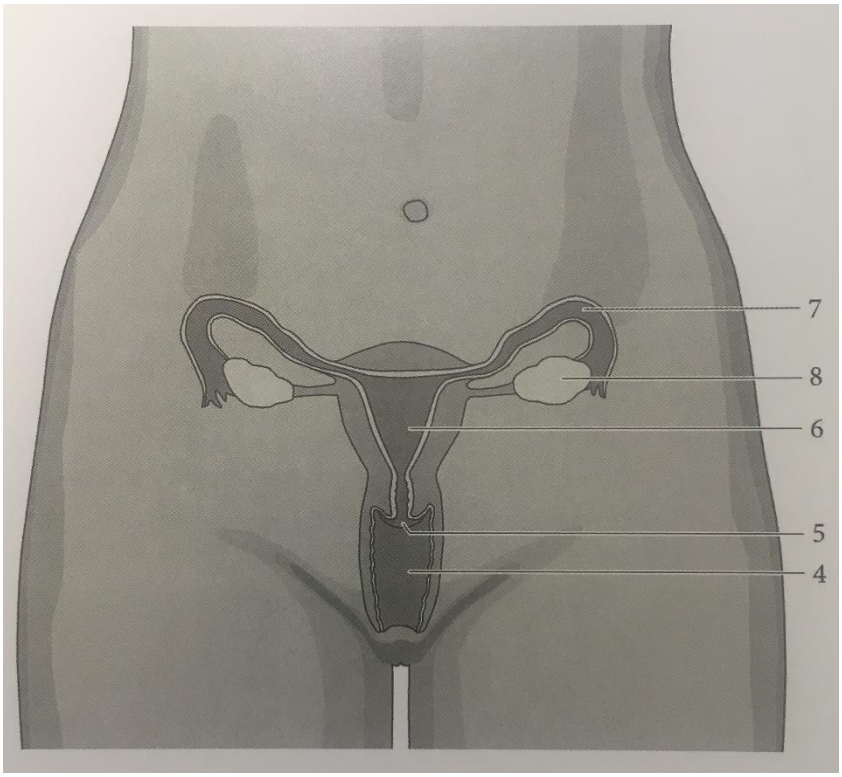
Appendix 1: Male Reproductive System and Organs





Appendix 2: Female Reproductive System and Organs





Appendix 3: Pregnancy – Week by Week

Child Development
FIRST TRIMESTER
Week 0, 1, 2 and 3:
Pregnancies are counted from the first day of the last period. This is because it is difficult to establish the exact fertilization (when sperm penetrates the egg). After fertilization, the egg divides several times before it is led down to the uterus. The egg attaches to the uterus 5-6 days after fertilization. When the egg attaches we can call it a pregnancy. The fertilized egg is called *morula* in this stage of the pregnancy.
Week 4 and 5:
The morula is at this time collected as a small lump of cells that creates the *embryo*. The embryo has grown into the endometrium and is now completely covered. The placenta is developed at this time, and a mucus plug is blocking the small opening in the cervix (opening between the uterus and the vagina).The embryo is a few millimeter long at this point. The lungs of the baby starts to develop. The spine develops and closes. Arms and legs starts to develop slowly. The first blood cells and blood vessels starts to develop. The heart starts to develop.
Week 6, 7 and 8:
Liver, lungs, pancreas and thyroid develops and the heart now has one chamber. The intestines are being formed and the umbilical cord is developed. Arms and legs continues to develop and fingers and toes starts to form. Slowly the embryo will start to look like a human. The length of the embryo is about 22 millimeter in week 8.
Week 9:
The embryo continuous to develop into a human shape. The face continuous to develop and the head is now about the size of the rest of the body. The body, arms and legs continuous to extend. The male or female genitals starts to develop at this point. The length is about 27 millimeters.
Week 10 and 11:
All organs have now started to form. Production of bone marrow has also started, and this marks the shift from embryo to *fetus*. The rest of the pregnancy contributes to the growth and maturation of the fetus.
SECOND TRIMESTER
Week 12, 13 and 14:
The fetus' organs are still growing, and most parts are now in place. The fetus' urine production starts, and nails are in place on fingers and toes. All nutrition goes through the placenta. The length of the baby is between 60 and 74 millimeter long.
Week 15, 16 and 17:
In the course of two weeks the fetus doubles its weight from approximately 80 to 160 grams.
Week 18, 19 and 20:
The fetus is now starting to make faces and sucks on its fingers. It can move after sound, can distinguish between light and darkness, and it has also started having hiccups. The hiccups occur because the fetus is producing urine and drinks the amniotic fluid as a part of cleaning it. The fetus is covered by a white layer of fat which is stuck to the body hairs. The fat protects the kin as long as the fetus is living in the amniotic fluid. The weight of the fetus is approximately 350 grams in week 20. At this time, almost all fetuses are the same size, which makes it favorable to set the term for delivery with an ultrasound at this time.
Week 21, 22 and 23:
Teeth construction in the gums develops, the eyelids cover the whole eye and the nails have grown fully. The lungs and airways develops. The pancreas have also started to produce hormones and insulin. The fetus have periods of being awake and periods of sleeping. The weight is usually about half a kilo.
Week 24, 25 and 26:
The fetus is now able to hear the heartbeat and breathing of the mother, in addition to voices "outside". The weight is about 650 to 900 grams.
Week 27, 28 and 29:
The weight of the fetus is between 1000 and 1400 grams. The eyes opens for the first time. The sight will

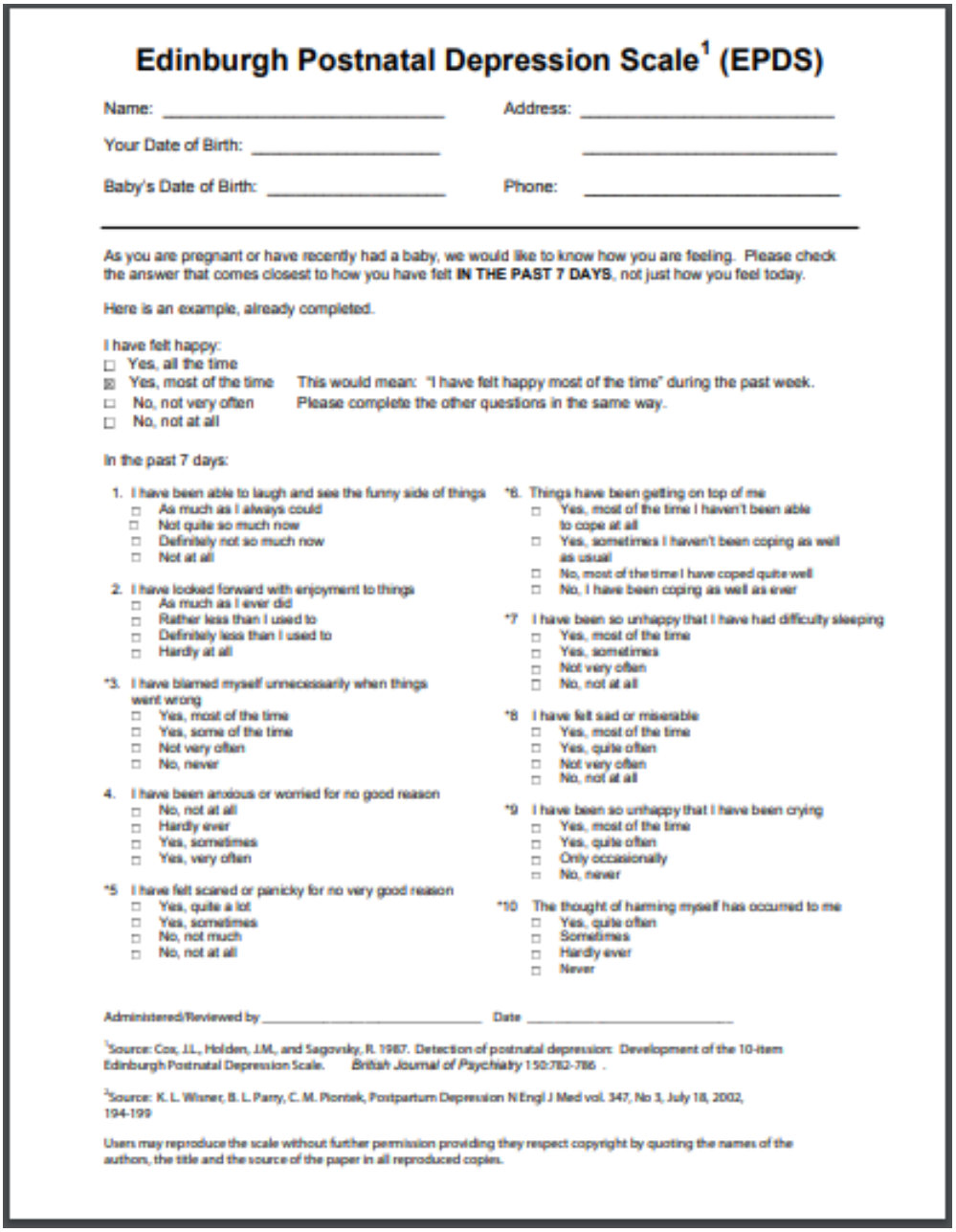
continue to develop both during the rest of the pregnancy and in the newborn period. Most fetuses will turn with the head down in the pelvis. For those who does not turn at this point, there is still more time to turn later.
THIRD TRIMESTER
Week 30, 31 and 32:
The fetus is now looking like an infant. It has also turned around facing down into the pelvic. The length of the fetus is about 40 centimeters, and the weight is 1600 to 2000 grams.
Week 33, 34 and 35:
The inner organs (except the lungs) of the fetus is now finished developed. The lungs still has to mature and the fetus will do regular breathing exercises. The length of the fetus is about 45 centimeter and the weight is around 2200 to 2600 grams.
Week 36, 37 and 38:
The brain is now finished developed. The weight is still increasing but the length is stagnating. The amniotic fluid is reducing gradually. The head is supposed to be facing down towards the birth canal. If the butt is facing down it is common to try to turn the fetus around. The length is about 45 to 50 cm and the weight is 2800 to 3200 grams.
Week 39, 40 and 41:
The fetus is now ready to be born. It takes up extra nutrition to go on during the birth. The weight is about 2500 and 4500. The length is from 45 to 55 centimeters.

Mother Development
FIRST TRIMESTER
Week 4 and 5:
This is the time for the nest menstrual period. A missed period is a sign of pregnancy.
Week 6, 7 and 8:
Many pregnant women will start to feel more signs of pregnancy (heartburn, constipation, tiredness, breasts enlarge, feeling dizzy when standing up for a long period) at this point. Pregnant women should make sure their body gets enough fluids, food, sleep and rest to minimize displeasures. Some women starts feeling disgusted by certain types of food. Some women may experience that their hair is more difficult to maintain than before, others get thicker and shinier hair. Increased vaginal discharge is normal as long as it is not itching, burning or you feel pain. It is not unusual to experience bleedings early in the pregnancy even though the pregnancy is developing as normal. However, bleedings when pregnant causes women to worry. If the bleeding is abundant and painful, the doctor or midwife should be contacted. The risk of miscarriage is highest the first 12 weeks of the pregnancy. You cannot influence a potential miscarriage. The most important thing the women can do is to try to have a regular and good diet, keep exercise/be active, and get enough sleep and rest.
Week 9:
Thought and feelings changes. Women may have thoughts can be about miscarriage, thought about the baby, relationship to the partner, your own childhood and upbringing, bodily changes etc. The hormonal changes will make the woman's mucosa more fragile than normal. This increases the risk of experiencing bleeding from the gums when you brush your teeth, have nose bleeds or some blood from the vagina after sexual intercourse. The uterus is still located in the pelvic and the pregnancy is not visible for others.
Week 10 and 11:
Both the breasts and the uterus if the pregnant woman continuous to grow. Some women may feel a slight aching in the lower part of the tailbone which is normal and nothing to worry about. Women that has struggled with pregnancy related nausea may experience that this might reduce at this time. The risk of a miscarriage is still present to a greater extent than later in the pregnancy, but by every passing day the chances decreases. For some women it is comforting to know that it is little they can do to influence this.
SECOND TRIMESTER
Week 12, 13 and 14:
If you experience morning sickness, this should have settled at this time. The uterus and baby is growing

(weight gain is between 1-4 kilos). The baby is moving, but at this time you can rarely feel it.
Week 15, 16 and 17:
Your stomach is growing and most women will experience that it will be visible to others at this point. Some women feel the movements of the fetus at this stage, but for others, it will take longer time. Many women experiences mood swings. Irrational dreams, thoughts and fantasies may occur. Because of swollen mucosa membranes you may experience that your nose is more clogged than normal. Because you have an increased amount of blood in your body you may experience that you also sweat more than normal. At the same time you lose your breath more often. This is because your heart is covering the oxygen need of two people. Fungal infections during pregnancy is very common. Look for symptoms like itchiness and a change in discharge. The infection can be treated but consult your birth attendant or doctor before starting any treatment.
Week 18, 19 and 20:
Your bodyweight may have increased with 3 to 6 kilograms at this point of the pregnancy. Your baby stomach is visibly larger. You will most likely feel the fetus' movements at this point. Women that has children from before tends to feel movement before women that are pregnant for the first time. The movements can be felt like flatulence or bowel movements. You can be uncertain about what you are feeling and what it is. After a while, the movements becomes clearer and you will not have any doubts that it is the fetus that is moving.
Week 21, 22 and 23:
The pregnancy is half way done. The women starts to prepare mentally and physically for the birth and to become a parent. The attention of the woman id directed towards the expected baby and less towards the rest of the world. The ligaments in the pelvis becomes more elastic and for some women this can lead to pain when standing or walking. It can also be painful or difficult to stand up and walk in stairs.
Week 24, 25 and 26:
You can now start to feel the movements of the fetus daily also outside the stomach. These movements is a sign that the fetus is developing normally and is doing ok. The ever growing uterus can put press on the bladder, nerves, blood vessels and the stomach. More frequent toilet visits, leg cramps and heartburn can be annoying. It is also common to feel dizzy when lying on the back because the uterus is pressing on the vein leading blood back to the heart. Turing to the side often helps. The breasts continues to grow and prepares to produce milk.
Week 27, 28 and 29:
The women starts experiencing changes in their skin. Red dots in the face, on the over arms and upper body is caused by changes in the blood vessels and will disappear after the pregnancy. Stretch marks, pigmentation and or a dark pigment stripe along the stomach is also common. These will most likely disappear or fade after birth. The nipples and the area around may also become darker. Pressure and movement from the fetus may affect your sleep quality, and getting enough sleep can be a challenge. Remember to rest when you have the opportunity to do so. Pregnancy itching can also occur. It is usually not dangerous, but you should notify your birth attendant or doctor for guidance and advice.
THIRD TRIMESTER
Week 30, 31 and 32:
The mother's lung capacity is increasing to ensure enough oxygen to herself and the baby. The heart beats faster to compensate the body's needs. It is common to feel out of breath fast. Your feet may be swollen due to extra water in the body. Some women feel constipation which can be because of being less physically active, hormones, lack of fiber or low fluid intake may influence the bowel movement.
Week 33, 34 and 35:
The body is starting to prepare for birth by having more frequent and clearer contractions in the uterus (this is called false labor pains and it doesn't mean that the birth has started). The false labor pains starts on the upper part of the abdomen and moves down over the whole uterus before it lets go. They usually lasts for about 30 seconds. In the beginning the false labor pains can be experienced as menstrual cramps in the beginning, and came more uncomfortable gradually. Women that has given birth before often experience these false labor pain earlier than women who are pregnant for the first time. They also experience them as stronger and more intense. It can be difficult to know the difference between the false labor pain and the birth contractions. The false labor pain usually passes after a short while and they can also change if you lay down, change position or move around. They are not regular and rarely increases

in intensity.
Week 36, 37 and 38:
Many women will have problems finding a comfortable sleeping/resting position. Since the uterus is pressing on the bladder, frequent toilet visits are common. Some women may experience that their breasts starts to leak breast milk even before the baby is born, Mood swings, feeling sad or irritable is also common.
Week 39, 40 and 41:
During this time the women are waiting for the birth. Some become inpatient. The body preparations are important. The consistency of the cervix is getting softer and the contractions (false labor pain) in the uterus is irregular and uncoordinated. At the end of the pregnancy, the activity increases which can be annoying.

Appendix 4: Postpartum Depression Questionnaires



Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, very often — Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Appendix 5: Breast Self-Examination

1. Start by standing in front of a mirror. Look at your breasts with your arms hanging down the side, with your arms raised behind your head and with your arms supported on your hip joint while tightening your chest muscles.
2. Then lay down with a small pillow under the left shoulder. Put your arm behind your head and feel your chest with your right hand with straight fingers and light pressure. Begin with the nipple and go beyond the chest in circles until the entire chest is examined. End up in the armpit. Finally, you squeeze the area around the nipple and see if some fluid is being discharged. Examine the right breast in the same way with a pillow under the right shoulder and the right hand behind the head.
3. You may want to examine your breast while you are in the shower as the soap on the skin makes your fingers slide easily over the chest. You do as above but in standing position.
4. The examination ends with you searching for lumps in the armpit and on the upper side of the collar bone.

Appendix 6: Testicles Self-Examination

Start your self-exam right after you have taken a hot shower or bath. At this time the scrotum is most relaxed and it is easier to examine the testicles.

- Stand upright and push the penis aside. Use both hands and examine one testicle at a time. Place the thumb on the top of the testicle and two fingers on each hand behind the testicle and roll it between your fingers.
- The testicles should feel solid, but not completely hard. Feel for lumps or unevenness in front or on the sides of the testicles. The lump can be on the size of a pea or a grain of rice. Pain, discomfort, lumps or other changes in color and size of the testicles should lead to a quick contact with a doctor.
- You should be able to feel the epididymis (the seminal pipe located at the top-back of each testicle). The epididymis may feel a bit sore when you put pressure on it. This is normal. It is also normal that one testicle (usually the right one) is larger than the other and that one hangs further down than the other.
- If you find a lump it does not have to mean it is cancer. It can be a benign tumor, hernia, swelling of the veins of the scrotum or other reasons.
- Sudden and severe (acute) pain in the scrotum and testicles lasting more than a few minutes requires immediate medical attention.

Appendix 7: Gender-Based Violence Factsheet

<table>
<tr><td colspan="4">Types of GBV</td></tr>
<tr><td>Sexual violence</td><td>Physical violence</td><td>Emotional/mental violence</td><td>Economic Violence</td></tr>
<tr><td>- Harassment
- Sexual assault/exploitation
- Rape and attempted rape
- Child sexual abuse/incest
- Forced prostitution, child prostitution
- Sexual trafficking
- Harmful traditional practices</td><td>- Kicking, beating, biting and scratching
- Use of weapons (such as knives, guns etc.)
- Killing
- Spouse beating (domestic violence)
- Assault and other physical violence (gender based)
- Harmful traditional practices</td><td>- Verbal, emotional abuse
- Humiliation
- Discrimination
- Denial of opportunities and/or services
- Spouse confinement (domestic violence)
- Harmful traditional practices</td><td>- Only allowing boys/sons to go to school
- Unequal pay for equal work
- Limited promotions for women and girls</td></tr>
<tr><td colspan="4">Root Causes of GBV</td></tr>
<tr><td colspan="4">- Male and/or society attributes of disrespect or disregard towards women
- Lack of belief in equality of human rights for all
- Cultural/social norms of gender equality
- Lack of value of women and/or womens work</td></tr>
<tr><td colspan="4">Contributing Factors to GBV</td></tr>
<tr><td colspan="2">- Alcohol/drug abuse
- Poverty
- Availability of food, fuel, wood, income generation requires women to enter isolated areas
- Boredom, lack of services, activities, programs
- Collapse of traditional society and family support
- Religious, cultural and/or family beliefs and practices
- Design and social structures of residence (overcrowded, living with strangers etc.)
- Design of services and facilities</td><td colspan="2">- General lawlessness
- Geographical location/environment (high crime area)
- Lack of laws against forms of GBV
- Lack of police protection
- Legal justice system/laws silently condones GBV
- Loss of male power/role in family and community, seeking to assess power
- Political motive, weapon of war, for power/control/fear/ethnic cleansing
- Retaliation</td></tr>
<tr><td colspan="4">Consequences of GBV</td></tr>
<tr><td colspan="4">Individual Level</td></tr>
<tr><td colspan="2">Psychological</td><td colspan="2">Medical/physical</td></tr>
<tr><td colspan="2">- Post-traumatic stress disorder
- Depression
- Anxiety and fear
- Anger
- Shame/insecurity/self-hate
- Self-blame
- Mental illness
- Suicidal thoughts/behavior/ attempts
- Lack of ability to function in society/community (e.g. Earn income, care for children)</td><td colspan="2">- Fatal (death, homicide, suicide, maternal mortality, infant mortality)
- Acute physical (injury, shock, disease, infection)
- Chronic physical (disability, chronic infections & pain, gastrointestinal problems, eating disorders, sleep disorders, alcohol/drug abuse)
- Reproductive (miscarriage, unwanted pregnancy, unsafe abortions, STIs, HIV/AIDS, menstrual disorders, pregnancy complications, infertility, gynecological disorders, sexual disorders)</td></tr>
<tr><td colspan="4">Family/Society Level</td></tr>
<tr><td colspan="4">- Blaming the survivor
- Stigma
- Rejection by spouse and family
- Family breakdowns
- Divorce
- Desplacement
- Social rejection and isolation (survivor/it's family)
- Family rejected by society
- Further violation of survivor</td></tr>
</table>