Reproductive Health

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■ Reproductive Health

Out lines:

- ■ Introduction.
- ■ Definitions.
- ■ Right of a client.
- ■ Reproductive health includes:
- ■ The improved reproductive health of society requires following factors:
- ■ Quality of care in Reproductive Health
- ■ The following are the elements of quality health care:
- ■ Quality of reproductive health care means:

Reproductive health

■ **Introduction**

■ The establishment of a reproductive health system provides not only a solution measure to the population problem, but also contributes to the improvement of individual health, and it is based on the definition of "health" as provided by the World Health Organization (WHO) in its Constitution. However, the range of reproductive health is wide and the definition and interpretation of its concept remain varied. Many people in the world have no chance to enjoy reproductive health due to various causes. Such causes include insufficient knowledge of human sexuality, inappropriate or low-quality information and service on reproductive health, the spread of high-risk sexual behavior, discriminative social customs, negative attitudes toward women and girls, and the limited empowerment of women and girls in relation to sex and reproduction, etc. Adolescents are in an especially vulnerable position. This is because there is little information available on reproductive health and few related services in many of the countries in the world.

■ **Reproductive Health**

■ Reproductive health simply refers to healthy reproductive organs with normal functions. According to the World Health Organization (WHO), reproductive health means a total well-being in all aspects of reproduction, i.e. physical, emotional, behavioral and social.

■ **(2) Reproductive Health Care**

■ In adherence to the above definition of reproductive health, "reproductive health care" is defined as "the entire set of methods, techniques and services that contribute to reproductive health and its well-being through prevention and solution of various problems related to reproductive health." Reproductive health includes health related to sex for the purpose of individual sex and the enhancement of human relationships (sexual health), and is not simply limited to counseling and care related to reproduction and sexually transmitted infections.

Reproductive health includes:

1-Reproductive processes, functions and system at all stages of life. (e.g., adolescence, preconception, antepartum, postpartum, premenopausal, postmenopausal) and their life circumstances (e.g., single or married, with children or without, post abortion, circumcised, infertile, or in a non-monogamous or abusive relationship).

2-Sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."

3-Right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law,

4- Right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

The improved reproductive health of society requires following factors:

(i) Better awareness about sex-related matters.

(ii) Increased number of medically assisted deliveries and better postnatal care leading to decreased maternal and infant mortality rates.

(iii) Increased number of couples with small families.

(iv) Better detection and cure of STDs.

(v) Overall increased medical facilities for all sex-related problems.

(iv) Successful implementation of action plans like providing medical assistance and care to reproduction-related problems, pregnancy, delivery, STDs, abortions, contraception, menstrual problems, infertility, etc., needs strong support and infrastructural facilities.

- Integrated" reproductive health care services provided by primary providers address the various life circumstances and life stages of individual clients and might include:

- Family planning education (including fertility awareness), counseling and services or referral

• Preconception counseling; pregnancy, safe delivery and postpartum care, including breastfeeding education and counseling about appropriate FP methods

• Newborn and child health services

• Prevention and treatment of STIs, reproductive tract infections (RTIs) and HIV/AIDS

• expanded counseling and education on a variety of reproductive health issues

• Services which reduce or treat gender-related abuses (e.g., female circumcision, domestic violence)

-Infertility management, counseling and services

• Sexuality education and health services for adolescents

• Nutrition services

• post abortion care, including counseling and education to reduce unsafe abortion

• Reproductive cancers detection and education

• Per menopause and menopause management

The Target Groups for Reproductive Health Services

The following populations are groups of priority concern in reproductive health services. These groups are:

• Women of childbearing age (15 – 49 years old)

• Adolescents (both male and female)

• Under five years old children

a. Women of child-bearing age (15 – 49 years old)

1. Women alone are at risk of complications from pregnancy and childbirth

2. Women face high risks in preventing unwanted pregnancy; they bear the burden of using and suffering potential side effects from most contraceptive methods, and they suffer the consequences of unsafe abortion.

3. Women are more vulnerable to contracting and suffering complications of many sexually transmitted infections including HIV/AIDS.

4. From the equity point of view this population group constitutes about 24% of the population; which is a significant proportion.

5. Deaths and illnesses from reproductive causes are highest among poor women everywhere.

b. Adolescents (Both sexes)

1. Adolescents lack reliable reproductive health information, and thus the basic knowledge to make responsible choice regarding their reproductive behavior.

2. In many countries around the world, leaders, community members, and parents are reluctant to provide education on sexuality to young men and women for fear of promiscuity.

3. Many adolescents are already sexually active, often at very young age.

4. The reproductive health status of young people, in terms of sexual activity, contraceptive use, child bearing, and STIs lays the foundation for the country's demographic feature.

5. During adolescence normal physical development may be adversely affected by inadequate diet, excessive physical stress, or pregnancy before physiological maturity is attainted.

6. Adolescents are at high risk to acquire infertility associated with STIs and unsafe abortion

7. Conditions of work are designed for adults rather than adolescents and put them at greater risk of accidental injury and death.

8. Current health services are generally not organized to fulfill the need and demands of adolescents.

a. Under Five Children

1. Children's health is a base for healthy adolescence and childbearing ages.

2. Proper health service for children serves to increase the opportunities of women to have contact with the health institution.

3. The health of children and women is inseparable

4. The morbidity and mortality of children in Egypt is one of the highest in the world.

5. Bearing high number of children has adverse consequences on health of the mother, the general income distribution and health status of the family.

Quality of care in Reproductive Health

Quality of care in RH refers to the overall effectiveness and appropriateness of health care. It is about providing services that clients want and includes effectively by the staff.

The following are the elements of quality health care:

- Promotion and protection of health
- Accessibility and availability of services
- Acceptability of services
- Technical competence
- Availability of essential supplies and equipment
- Quality of client provider interaction
- Adequate and relevant information and counseling for clients
- Involvement of clients for decision-making
- Comprehensiveness of care and linkages to other reproductive services
- Continuity of care and follow up

Quality of reproductive health care means:

- Care should be personalized

• Clients should be treated with dignity

• Privacy should be maintained

• Clients should not have to wait a long time before being served

• Health workers should inform about the available services

• Facilities for services should be clean

• Client flow should be well organized

• Routine services should be available at least during normal working hours, and labor and delivery services, and services for complications of reproductive health, which requires emergency care, should be available on a 24 hour a day basis

• An adequate flow of essential supplies and equipment should be maintained

• Supervision should involve working together with staff to solve problems related to provision of reproductive health care

Population problem in Egypt

Outline: -

1. Introduction
2. The causes of population problem in Egypt.
3. Hazards of over population.
4. Possible solution of the population problem in Egypt.
5. The axes of the National Population Policy in Egypt.

Introduction

Background & scope of the problem:

Population problem is one of the most prominent problems of the world. It is evident however, that although there is a higher rate of population increase in other countries they do not suffer from the problem of overpopulation. The example of these, are Saudi Arabia, the Gulf states, Sudan as well as Brazil and other Latin American countries. They are in need of manpower. No one will deny that Egypt is suffering from an acute population problem, to the extent that it affects socio-economic development and achievement of satisfactory standards of living conditions. Population problem affects everyone in the family and even in the country.

Egypt population is estimated at **102,334,404** people at mid-year of 2020 according to United Nations data. This new record means the population has more than doubled since 1981. If our population goes on increasing at the same rate, Egypt's population is expected to reach 160 million by 2050. However, if the current rate of reproduction diminishes, the population may be limited to 120 million by 2050.

■ Causes of population problem in Egypt:

I - Rapid population growth:

This is manifested by declining death rate, and a consistently high birth rate. About 70% of the population in Egypt is rural and favors high fertility and the total fertility rate in Egypt is 3.3. Moreover, increase infant mortality is contributing to compensatory excess in fertility.

a) Crude birth rate (C.B.R) =

No of live births in a certain year & locality x 1000

Mid-year population for the same year and locality

The current birth rate for Egypt in 2020 is **25.377** births per 1000 people, a **2.23% decline** from 2019 **(United Nations - World Population Prospects).**

b) Crude death rate (C.D.R) =

No of deaths in a certain year & locality x 1000

Mid-year population for the same year and locality In 2019, crude death rate for Egypt was **5.78** deaths per thousand population **(World Data Atlas, 2019).**

c) **Rate of natural increase (R.N.I):** It is the difference between the crude birth rate and the crude death rate. It is used to estimate the rate of annual growth of the population. Egypt rate of natural increase was at level of 19.93 persons per thousand population in 2019 **(World Data Atlas, 2019).**

d) Infant mortality rate: The current infant mortality rate for Egypt in 2020 is **14.629** deaths per 1000 live births, a **3.23% decline** from 2019 **(United Nations - World Population Prospects).**

II- The pattern of the distribution of the population in the country:

a) The population of Egypt overcrowds the Nile Valley. Egypt has area of some 1,001,449 square kilometers of which only about 38,000 at present habitable.

b) It may be thought that the high density of population is alone responsible for the population problem in Egypt, but this is not very accurate. Many countries witness a tremendous rise in the density of their population as Japan but do not suffer from the problem of overpopulation.

c) The growth of the population exceeds the growth in the resources.

Hazards of overpopulation:

A- On the Family level:

1. Children:

a) High morbidity
b) High mortality
c) Retarded growth (malnutrition)

2. Mother:

a) Malnutrition (maternal depletion syndrome)
b) Stress & worry

3. Husband:

a) Financial problems
b) Stress & worry

4. Family:

d) Bad housing
e) Increased prevalence of malnutrition
f) c) Low level of education or illiteracy

B- On the National level:

a) Low socio-economic development

b) High proportion of dependent non-productive groups below 15 years
c) Low quality of all services.

Possible Solutions of the population problem in Egypt:

A- Socioeconomic development:

1- Improving and increasing educational facilities specially girls education.
2- Providing more employment for women.
3- Increasing agricultural mechanization.
4- Increasing industrialization.
5- Increasing social security.
6- Reducing infant mortality.

B- Fertility Regulation:

1- Birth control is the imperative short-term solution of the problem:
2- Broadening family planning information through advocacy campaigns
3- Improving family planning services through availability of the methods, accessibility to the service & training of the medical & paramedical teams.

■ **Population Policy in Egypt**

The recent governmental effort in the field of population and family planning activities was manifested by establishment of the "Supreme Council for Population and Family planning" in 1973.

The first national population policy statement was issued by that time, emphasized the importance of socioeconomic development in fertility control, in addition of providing family planning services.

In 1975: this policy was developed to recognize the importance of the three dimensions:

- Rapid population growth
- Unbalanced population distribution
- Unfavorable population characteristics.
- **In late 1970s,** calculation of family planning acceptors was introduced in the family planning facilities and the information, education and communication (IEC) activities were improved.
- **In late 1980s,** "National strategy framework for population, human resources development and family planning program" was proclaimed and highlighted the three dimensions of population problem.
- **National population plan 2007 - 2017**

The national Council for population has developed a strategic plan for population from 2007 to 2017 to reinforce the national efforts in facing population increase. The population plan aims to achieve the total fertility rate to 2.4 children per woman in 2012 and 1.2 children per woman by 2017 which will contribute to rationalize the levels of population growth and redouble the community's ability to deal with the expected to deal the expected population rates of increase.

- **This is through adopting four main axes;** each of them includes a number of operational strategies which are as follows:

The axes of the National Population Policy in Egypt.

-The first axis:

Promoting standard of reproductive health and family planning and improving the accessibility within the context of primary health care:

This axis aims at providing reproductive health and family planning services to all who need them in quality, time and price affordable to them. Also aims to raise family planning practice to 67.3% in 2012. Thus make services available for about 8.6 million women. This could be achieved though:

- Integration of family planning and reproductive health services
- Promoting quality standards and availability of family planning and reproductive health services .

-The second axis:

Activating the role of leaders, decision makers as well as the private sector and religious scholars:

This axis is aiming at changing the citizens' attitude and behavior, by adopting the concept of small family, it also aims at activating the role of preaching, media, education and communication to adopt the concept of small family and upgrading women's health as well as the role of clergy, renewing the religious discourse and targeting young people of both sexes in order to influence their reproductive health behavior.

-The third axis

Support the link between population trends and overall development:

Throughout this axis, the plan aims to focus attention on all aspects of human development, especially health, through the ongoing programs of maternal and child care which will increase the chances of life expectancy in addition to education through the expansion of absorption in preliminary education especially for girls and supporting literacy programs. On the economic level, the program aims to support the social and economic development of women.

The fourth axis:-

Activation of the monitoring, evaluation and calendar system:

This axis includes upgrading the systems and mechanisms of coordination as well as database for population activities for all partners in this area, evaluating and analyzing the data and indicators on the situation of population to determine the progress achieved, as well as the application of the rules of transparency and access to information and indicators of demographic situation and formulate systems and mechanisms for redress.

Family planning health education

Outlines:

- **Introduction**
- **Definition of:-**
- **Family planning**
- **Contraception:**
- **Birth control:**
- **Objectives of family planning**
- **Family planning counseling**
- **Role of family planning nurse**
- **Timing of family planning counseling**
- ***Methods used for family planning and health education:**

a) Individual method

b) Group method

- Discussion

- Workshop

c) Mass Method =general

- Printed health education material

- Visual health education material

- Audio health education material

- Audio visual education material

Application methods on two family planning methods.

Family planning services during covid.1

Introduction:

The rapid increase of population has an adverse effect on the national economy. The benefits of improvement in the different sectors are being eroded by the growing population. At the level of families, the increasing number of births has a deleterious effect on the health of the mother and the child. Family planning enables individuals (women and men)to plan their families and achieve desired birth spacing and family size, and contributes to improved health outcomes for infants, children, women, and families**.**

Definition:

Family planning

It is the conscious process when a couple decided on the number of spacing children and the timing of birth .

Contraception:

It is voluntary prevention of pregnancy the decision to practice contraception has individual and social implication.

Birth control

It is any method used to prevent pregnancy.

Definition of health education:

Health education is a combination of learning experience designed to facilitates voluntary actions conducive to health. Health education has evolved in health promotion.

Objectives of family planning health education:-

1. To avoid unwanted births.
2. To regulate the interval between pregnancies.
3. To control the time at which births occur in relation to the ages of the parent.
4. To determine the number of children in the family
5. Healthier mothers and children
6. Fewer children means more time and money for each one
7. Helping to prevent sexual transmitted diseases
8. Slowing population growth

Ideal contraceptive methods should fulfill the following criteria

1. Widely acceptable
2. Inexpensive
3. Simple to use
4. Safe

5. Highly effective
9. Family planning counseling
Counseling is a client-centered interactive communication process in which one person (usually trained) helps others make free, informed decisions about their personal behavior.

The main elements of Family planning counseling
The provider must perform the six element of the information, education
and counseling process (GATHER):
• Great the client
• Ask client about herself and family (fill out necessary forms)
• Tell client about Family planning methods
• Help client choose a contraceptive method
• Explains how to use the method and teaches alarming symptoms and signs that necessitate immediate reporting to the clinic
• Return follow-up recommendations and make appointment if possible.
Return Visit:
• Nurse greets client
• Client presents permanent card with record number
• Medical record obtains
• Updates basic medical/demographic and social date
• Nurse asks if client has any questions or problems (General health and contraceptive method)
• If question or problem, nurse refers client to physician for examination
and or further action
• Reinforce method use with specific instructions and warnings
• Discuss follow-up visit appointment
• Complete medical record
Role of family planning nurse
1-She must able to facilitate client knowledge and choice.
2-Provide valid, current information in away which is easily understood
by the women.
3-She should be active listening.

4-Midewife should be aware of family planning services available in the
area where she practices
5-Know all methods of family planning.

Timing of family planning counseling:

1-During antenatal period:
-Ideally family planning counseling should start in antenatal period.
-During antenatal period begin discussing family planning methods with
the women particular during third trimester (at last visit of the pregnant)
-Pregnant women need to know that if they aren't exclusively breastfeeding they can get pregnancy as soon as four weeks after the birth
of their babies even if they have not get started their menstrual cycle
-Counseling mothers about methods of family planning that can started immediately after birth
-Advise mother about benefits of using breastfeeding as family planning
methods.

2-Counceling about family planning postpartum
[after delivery]
-Help new mothers decide how they will avoid pregnancy after birth.
-Discuses with the mother the duration between pregnancy to choose the
suitable method.
-Waiting until baby is at least 2years old before women tries to become pregnant again is best for the baby and good for the mother, too
-Tell mother to use family planning method if she not breastfeeding.
[Mechanical ,hormonal,barrier,Natural method]
-Discuss with the mother breast feeding methods of family planning (LAM)
3-Counseling about family planning methods after abortion[postabortion]
-Fertility returns quickly within 2weeks after first trimester abortion

and
4weeks after seconel trimester abortion.
-If women want to bcome pregnant again soon encourage her to wait at least for 6months to reduce preterm Labor.

***Methods and approachs for family planning and health education**:

1- **Individual approach**

Doctor and nurses,who are in direct contact with client and their relatives
EX: when a nurse give instruction about how to use of contra captive pills
Advantages & disadvantages of individual health education

Advantages

1-two-way communication
2-illiterate people can be taught
3-easy to make follow up
4-it is flexible (change topic according to recipient).

Disadvantages

1-time consuming
2-difficult to cover wide range of people
3-limited manpower
4-expensive

2- Group health Education

An effective way of education
Methods of Group Health Education:
1-Discussion method
2-workshop
3-seminar
4-symposium
5-Role play
1-Discussion method (group Discussion)
-Group discussion is considered a very effective method of health teaching. It is a tow-way teaching method. People learn by exchanging their views and xperiences.

Advantages

1- Improve critical thinking.

2- Grasp complex facts faster.
3- Enhance active participation and
interaction.
4- Working in group is fun.
5- Provide opportunities for sharing of ideas and concerns.

disadvantages

1- Time consuming
2- Shy learners may refuse may refuse to become involed
3- One or more member may domain the discussion
4- It require coordinate
5- Can be blocked due to side talking or interruption

2-workshop

-It consists of a series of meeting with emphasis on individual work within a group with the help of educator
-Workshop group may consist of about 15 participants

3. Mass Approach:

This technique is refereed to when a health education message is needed to be communicated to masses of people.

Types of mass approach:

1 - printed Health learning materials
2 - visual Health learning materials
3 - audio Health learning materials
4 - audio visual Health learning materials
1 - printed learning materials :

- Poster
- Newspaper
- Cards
- Hooklets

Advantages

1-can be carried easily from one place to another
2-can be saved for future use
3-illiterate people can learn easily

disadvantages

1-one way communication
2-color printing is very expensive

3- it can damage easily

2-visual Health learning materials:

Models Flipchart

Advantages

1- can easily arouse interest

2 - speed up and enhance understanding

3- create opportunities for active learning

disadvantages

1- require equipment's

2- some difficult transport if big

3-audio learning materials :

✓ Radio and audio cassettes are common audio aid

✓ Includes anything heard such as spoken, health talk, music.

Advantages

1- simple to operate and portable.

2- can be repeated more time.

3- high availability.

disadvantages

1- electricity required

2- difficult to update

3- can be time consuming

4- easily forgotten

4 - audio visual learning materials :

• T. V Projected material

• Films Videos

Advantages

1- easy to follow can be repeated more time

2- high availability

3- easier to remember

disadvantages

1- electricity required

2- can be time consuming

3- difficult to evaluate

4- One way communication

• Family planning services during Covid -19

1-Increased outreach to let patients know about current services

2-Sending messages to patients on health system's or cline's website

about services

3-Alternative models for providing services or access to contraception for their patients such as

A. Tele health /Tele medicine.

B. Pharmacist –prescribed contraception.

4-Goole play store app: to assess whether patients have any characteristics
or medical conditions for which use of specific contraceptive method

5-Give guidelines to most contraceptive methods can be started with no physical examination such as

Combined hormonal contraception

Diaphragms and cervical caps

Female Genital Mutilation

<u>Out lines:-</u>

- Introduction
- Definition
- Prevalence
- Types
- Why FGM is still practiced
- The age at which FGM is performed
- Complications of female genital mutilation
- Impact on health
- Cultural and Ethical Issues
- Recommendations for prevention FGM in Egypt

Introduction:

The term FGM (Female Genital Mutilation) is a phrase that has been presented to reference any form of the procedure that is performed on the genital areas of young girls and women that involves the removal of part or whole areas of the genitalia. The practice of FGM has been identified as being performed in many regions all across the world. The practice is; however, deeply rooted in the African continent and is heavily prevalent mostly in the countries that have a strong connection to the Islamic religion.

Definitions

Female genital cutting (FGC), also known as female genital mutilation (FGM), female circumcision comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

Incidence& Prevalence

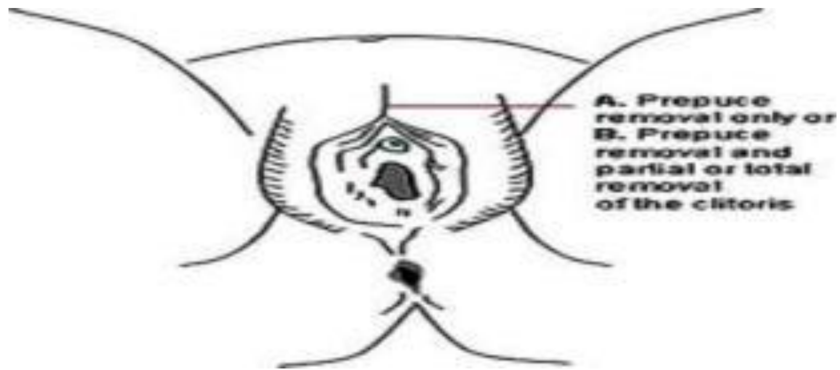
An estimated 100 to 140 million girls and women worldwide are currently living with the consequences of FGM.
In Africa, about three million girls are at risk for FGM annually.

Amnesty International estimates that over 130 million women worldwide have been affected by some form of FGM, with over 3 million girls at risk of undergoing FGM every year. FGM is mainly practiced in 28 different African countries. [9] It is common in a band that stretches from Senegal in West Africa to Ethiopia on the East coast, as well as from Egypt in the north to Tanzania in the south; see Map. It is also practiced by some groups in the Arabian Peninsula. FGM is most prevalent in Egypt, followed by Sudan, Ethiopia, and Mali. In 2007, Egypt passed a law completely banning FGM.

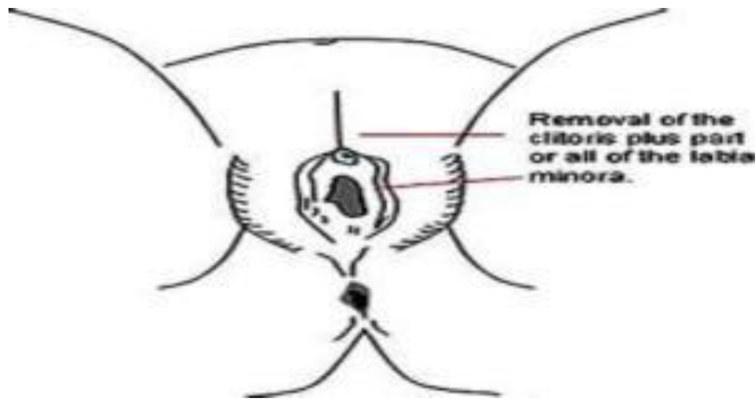
Types of female genital mutilation:

WHO which uses the term Female Genital Mutilation (FGM) divides the procedure into four major types:-

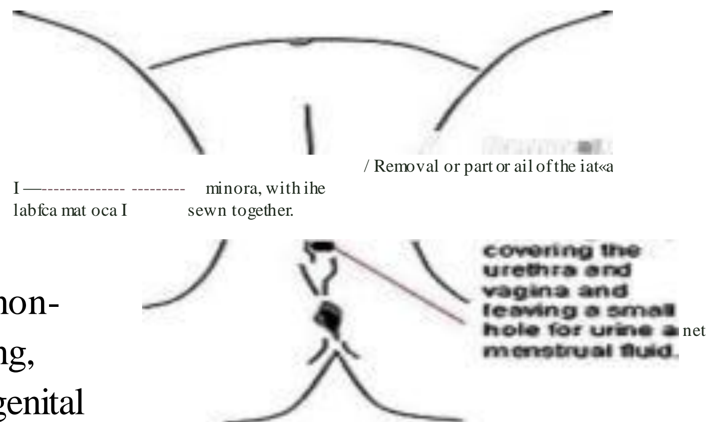
1. **Clitoridectomy (type I):** partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).



2. **Excision (type II):** partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).



3. **Infibulation (type III):** narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.



4. **Other (Type IV):** all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

The age at which FGM is performed:

It depends on the ethnic group or geographical location.

1. In Eritrea, for example, baby girls are excised around the seventh day after birth. However it is more common for children to be excised between the ages of 4 and 10 years.
2. Alternatively, FGM may be performed during adolescence, at the time of marriage (or subsequent marriages), during a first pregnancy or even during labour if it was not performed before.

Complications of female genital mutilation:

FGM has no health benefits, and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies.

Immediate complications can include severe pain, shock, hemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue.

Long-term consequences can include:

- Recurrent bladder and urinary tract infections;
- Cysts;
- Infertility;
- An increased risk of childbirth complications and newborn deaths;
- The need for later surgeries. For example, the FGM procedure that seals or narrows a vaginal opening (type 3 above) needs to be cut open later to allow for sexual intercourse and childbirth. Sometimes it is stitched again several times, including after childbirth, hence the woman goes through repeated opening and closing procedures, further increasing and repeated both immediate and long-term risks.

Impact on health:

1. The most common short-term consequences of FGM include severe pain, shock caused by pain and/or excessive bleeding (haemorrhage), difficulty in passing urine and faeces because of swelling, oedema and pain, as well as infections. Death can be caused by haemorrhage or infections, including tetanus and shock. A study from one country.

2. An update on WHO's work on Female genital mutilation (FGM) that practices Type I and II FGM, and in which 600 women were questioned about their daughters' complications after FGM Type I and II, reported a death rate of 2.3%.
3. FGM of any type is also associated with a series of long-term health risks.
4. The most common complications are dermoid cysts and abscesses. Chronic pelvic infections that can cause chronic back and pelvic pain, and repeated urinary tract infections have been documented in both girls and adults.
5. A recent WHO-led study showed that FGM is associated with increased risk for complications for both mother and child during childbirth.
6. Rates of caesarean section (29% increase for Type II and 31% increase for Type III FGM) and postpartum hemorrhage (21% for Type II and 69% for Type III FGM) were both more frequent among women with FGM compared with those without FGM.
7. In addition, there was an increased probability of tearing and recourse to episiotomies. The risk of birth complication increases with the severity of FGM.
8. FGM of the mother is also a risk factor for the infant. The study found significantly higher death rates (including stillbirths) among infants born from mothers who have undergone FGM than women with no FGM. The increase was 15% increase for Type I FGM, 32% increase for Type II FGM and 55% increase for Type III FGM.
9. FGM can also lead to negative psychological consequences. Documented effects include post-traumatic stress disorder,

anxiety, depression, and psychosexual problems. A recent study shows that women who have undergone FGM may be more likely than others to experience psychological disturbances (psychiatric diagnosis, suffer from anxiety, somatization, phobia and low self-esteem)

10. Research has shown that sexual problems are also more common among women who have undergone FGM. Women with FGM were found to be 1.5 times more likely to experience pain during sexual intercourse, experience significantly less sexual satisfaction and they were twice as likely to report that they did not experience sexual desire.

11. Further surgery is usually necessary later in women's' lives when infibulations (Type III) must be opened to enable sexual intercourse and further again in childbirth. In some countries this is followed by re-closure (reinfibulation), and hence the need for repeated defibulation later. For many women sexual intercourse is painful during the first few weeks after sexual initiation.

12. The male partner can also experience pain and complications. Type III FGM is also associated with infertility. Evidence suggests that the more tissue is removed, the higher the risk for infection.

Cultural and Ethical Issues:

FGM has been documented in individuals from many religions, including Christians, Muslims, and Jews. Some proponents of the practice claim that it is required by the Islamic faith. However, scholars and theologians of Islam state that female circumcision is not prescribed by their religious doctrine, emphasizing that the procedure

is almost never performed in many major Muslim countries such as Saudi Arabia, Iran, and Pakistan.

Female Genital Mutilation in Egypt:

- In Egypt 90% of girls who had undergone FGM were between 5 & 14 years old when subjected to the procedure. 50% of those in Ethiopia. Mali & Mauritania were under 5 years of age and 76% of those in Yemen were not more than two weeks old.
- The practice of female genital mutilation (FGM) is still widespread in Egypt, with 91% prevalence in 2008 (Demographic Health Survey (DHS).

The limited reduction in spite of many years of campaigns against the practice indicate a limited understanding of factors influencing decision making. Particularly there is limited understanding of sexual concerns influencing the continuation or abandonment of FGM.

- Support for FGM was deeply rooted in people's mind, and the major motivation was a belief that FGM was a necessary and effective way of ensuring women's virtue.
- It was believed that women's sexual desire resided in the clitoris, and that by cutting it, women's sexual desire would decrease. This was believed to be a necessary and useful measure to ensure premarital virginity and marital faithfulness.

Nursing role:

Competent, knowledgeable, and culturally sensitive nurses and other health care providers are essential to fight harmful cultural practices including FGM. They are also essential in the care and support of women and girls who suffer from the dire consequences of the procedure. Nurses and midwives need to be trained to open up Type III FGM (deinfibulation), to ensure that care is safe and effective, and

to prevent further complications. In addition, appropriate training is necessary to handle families who expect them to perform reinfibulation (stitching again to narrow the vaginal opening, sometimes performed after each child birth), which all health care providers are forbidden to do.

Antenatal care and reversal of infibulation (deinfibulation)

It is important to identify women who have been cut when they first seek pregnancy care, and find out what type of FGM has been performed.

Apart from the usual screening and antenatal care, it is important to provide pregnant women with support specific to their needs around FGM. They may need counseling, advice, information and social and psychological support.

Surgical reversal (deinfibulation) should be offered where appropriate. Partners should be involved in decision-making when the woman is willing for this. It is important to work out a care plan with the woman early in pregnancy, and to involve interpreters as necessary. Even fairly competent English speakers may have problems understanding medical terminology, and using a trained interpreter may be wise in order to avoid misunderstandings. Caesarean section is not indicated just because a woman has had FGM performed.

Reversal is best performed before pregnancy (commencing before the wedding night), or at least within the second trimester of pregnancy at around 20 weeks of gestation:

- This avoids the need to cut the scar tissue in labor.
- Reduces the possibility of extensive lacerations that can occur when the fetal head stretches the scarred or closed introitus and perineum. These may involve the urethra, bladder and rectum if uncontrolled and leave the woman with a fistula.

- Reduces the chances of fetal asphyxia or stillbirth if a woman progresses unaided to the second stage of labor.
- It helps to reduce the incidence of bacterial vaginosis that is associated with pre-term labor.

Care in labor

- Normal care is required during the first stage of labor
- Sensitivity is essential at all times
- There is no need to pass a catheter unless the woman is unable to pass urine
- Reversal may need to be carried out during the first stage of labor (see overleaf) midwives need to watch women who have undergone type 3 FGM closely during the second stage of labor even when the woman's introitus has previously been assessed as adequate for the birth. Unexpected problems may occur with descent of the fetal head or stretching of the perineum because the scar tissue around the vagina and perineum may be unstable
- A medio-lateral episiotomy should be performed in the second stage of labor only if unavoidable
- It is important to explain the requirements of the UK law. It is not permissible to reinfibulate or stitch the woman back closed after the birth.

Maternal Near Miss

Out lines:

1- Introduction.
2- Definition of maternal near miss.
3- Importance of maternal near miss.
4- The changing face of maternal morbidity.
5- Identification criteria.
6- Maternal near miss indicators.
7- WHO maternal near miss approach for maternal health.
8- The WHO set of severity markers (life-threatening conditions) used in maternal near miss assessments.
9- Causes of maternal near miss.
10- Correctable measures.
11- Benefit of settling the criteria for diagnosis of maternal near miss.
12- Management of near miss

Introduction

In any setting, women who develop severe acute complications during pregnancy share many pathological and circumstantial factors. While some of these women die, a proportion of them narrowly escape death. By evaluating these cases with severe maternal outcomes (both "near-miss" cases and maternal deaths), much can be learnt about the processes in place (or lack of them) for the care of pregnant women.

Maternal near miss is one of the important indicators used for the measurement of maternal health. Improvement of maternal health is one of the millennium development goals, MDG 5 with Target 5 that calls for the reduction of maternal mortality ratio by three quarters between 1990 and 2015. Since 1990, though maternal deaths world-wide have dropped by 47%, the number of maternal deaths in developing countries remains high. The global maternal mortality ratio is 210/100,000 births while it is about 240 in developing countries as compared to 14/100,000 in developed countries.

Definitions

Terms used in the WHO near miss approach: -

A maternal near-miss: Is defined as "a woman who nearly died but survived a complication that occurred during pregnancy, childbirth or within 42 days of termination of pregnancy".

Maternal death: is defined as "It is the death of woman during pregnancy or within 42 days of termination of pregnancy, irrespective of the duration and the site of pregnancy, due to obstetric complications and diseases in pregnancy".

Severe maternal complications: are defined as "potentially life-threatening conditions" This is an extensive category of clinical conditions, including diseases that can threaten a woman's life during pregnancy and labor and after termination of pregnancy.

Severe maternal outcomes: refers to a life-threatening condition (i.e. organ dysfunction), including all maternal deaths and maternal near-miss cases.

MNM ratio (MNMR): refers to the number of maternal near-miss cases per 1000 live births (MNMR = MNM/LB).

Maternal near-miss mortality ratio: refers to the ratio between maternal near miss cases and maternal deaths. Higher ratios indicate better care.

Importance of maternal near miss approach: -

Near miss cases occur more often than maternal mortality and may generate more information because the women herself can be source of data.

Morbidity ---------mortality continuum

Normal ____ ^ Morbidity ___ Sever morbidity
death

HWO maternal near miss identification criteria

According to the World Health Organization, if woman present any of these conditions during pregnancy, childbirth or within 42 days of termination of pregnancy and survive, she is considered as a maternal near miss case.

Severe maternal complications

- Severe postpartum hemorrhage
- Severe pre-eclampsia
- Eclampsia
- Sepsis or severe systemic infection
- Ruptured uterus
- Severe complications of abortion

Critical interventions or intensive care unit use

- Admission to intensive care unit
- Interventional radiology
- Laparotomy (includes hysterectomy, excludes caesarean section)
- Use of blood products

Life-threatening conditions (near-miss criteria)organ dysfunction

Cardiovascular dysfunction:

- Shock
- Cardiac Arrest
- Severe hypo-perfusion (lactate >5 mmol/L or >45 mg/dl)
- Severe acidosis (pH<7.1)
- Use of continuous vasoactive drugs
- Cardio-pulmonary resuscitation
- Respiratory dysfunction

Acute cyanosis

- Gasping
- Severe tachypnea (respiratory rate>40 breaths per minute)
- Severe bradypnea (respiratory rate<6 breaths per minute)
- Severe hypoxemia (O2 saturation <90% for >60min or PAO2/FiO2<20)
- Intubation and ventilation not related to anesthesia **Renal dysfunction**
- Oliguria non responsive to fluids or diuretics
- Severe acute azotemia (creatinine >300 ^mol/ml or >3.5 mg/dL)
- Dialysis for acute renal failure.

Coagulation dysfunction

- Failure to form clots.
- Severe acute thrombocytopenia (<50,000 platelets/ml).
- Massive transfusion of blood (> 5 units).

Hepatic dysfunction

- Jaundice in the presence of pre-eclampsia
- Severe acute hyperbilirubinemia (bilirubin>100 ^mol/L or >6.0 mg/dL).

Neurologic dysfunction

- Prolonged unconsciousness or coma (lasting >12 hours)
- Stroke
- Uncontrollable fit / status epileptics
- Global paralysis Uterine dysfunction
- Hysterectomy due to uterine infection or hemorrhage.

Maternal Near-Miss Indicators

-I- Certain maternal near-miss indicators have been suggested to evaluate the quality of care:

-I- **1- <u>Maternal near-miss ratio,</u>** which is the ratio of the number of maternal near-miss cases per 1000 live births (MNMR = MNM/LB).

2- **<u>Maternal near-miss mortality ratio</u>** which is the ratio of the number between maternal near miss cases and maternal deaths. Higher ratios indicate better care.

<u>Causes of maternal MNM: -</u>

- Poor antenatal care.
- Poor infrastructure.
- Lack of skilled personnel.
- Poor transport facilities.
- Delayed referrals.

<u>Correctable measures of MNM: -</u>

- Good antenatal care.
- Early identification of risk factors.
- Timely delivery.
- Magnesium sulphate for prophylaxis of eclampsia.
- Good blood bank facilities.

<u>Management of near miss: -</u>

- Admission to intensive care unit.
- Interventional radiology.
- Laparotomy (including, hysterectomy).
- Use of blood products.

<u>Standard care</u> postpartum
haemorrhage

Standard care All women should receive 10 IU of oxytocin just after delivery for the prevention of postpartum haemorrhage **Eclampsia**
Standard care All women with eclampsia should receive magnesium sulfate
systemic infections or sepsis
Standard care All women having a caesarean section should receive prophylactic antibiotics
Fetal lung maturation
Standard care All women delivering a live preterm fetus should receive corticosteroids for fetal lung maturation

Maternal mortality

Out lines:

- Introduction.
- Key facts.
- Definitions.
- Prevalence of Maternal mortality in Egypt.
- Egypt - Maternal mortality ratio.
- Indicators of Maternal Health.
- Risk factors for maternal mortality.
- Causes of maternal mortality.
- Measures to avoiding or reducing maternal death.

Introduction:

Maternal mortality is unacceptably high. About 830 women die from pregnancy- or childbirth-related complications around the world every day. It was estimated that in 2015, roughly 303.000 women died during and following pregnancy and childbirth. Almost all of these deaths occurred in low-resource settings, and most could have been prevented. The high number of maternal deaths in some areas of the world reflects inequities in access to health services, and highlights the gap between rich and poor. Almost all maternal deaths (99%) occur in developing countries. More than half of these deaths occur in Africa and almost one third occur in South Asia.

Women die as a result of complications during and following pregnancy and childbirth. Most of these complications develop during pregnancy and most are preventable or treatable. Other complications may exist before pregnancy but are worsened during pregnancy, especially if not managed as part of the woman's care. The major complications that account for nearly 75% of all maternal deaths are:

- severe bleeding (mostly bleeding after childbirth)
- infections (usually after childbirth)
- high blood pressure during pregnancy (pre-eclampsia and eclampsia)
- complications from delivery
- Unsafe abortion.

Definitions:

Definition of maternal mortality:

It is the death of woman during pregnancy or within 42 days of termination of pregnancy, irrespective of the duration and the site of pregnancy, due to obstetric complications and diseases in pregnancy.

Maternal Mortality Rate:

The number of maternal deaths in a given period per 100,000 live births during the same period. This measures the impact of maternal deaths on the population of women as a whole.

Prevalence of Maternal mortality in Egypt Egypt - Maternal mortality ratio

37 (deaths per 100,000 live births) in 2017.

In 2017, maternal mortality ratio for Egypt was 37 deaths per 100,000 live births. Between 1998 and 2017, maternal mortality ratio of Egypt was declining at a moderating rate to shrink from 70 deaths per 100,000 live births in 1998 to 37 deaths per 100,000 live births in 2017.

DATE	VALUE	CHANGE,
2017	37.0	-2.63 %
2016	38.0	-2.56 %
2015	39.0	0.00 %
2014	39.0	-2.50 %
2013	40.0	-4.76 %
2012	42.0	0.00 %
2011	42.0	-6.67 %
2010	45.0	0.00 %

Risk factors for maternal mortality:

1. **Maternal Age:** the safest age for childbearing is from 20 -24 years, so pregnancy before 20 years or above 30 years is associated with higher maternal mortality.
2. **Parity:** grand multiparity (5 or more delivers) is associated with higher maternal mortality.
3. Lack of adequate spacing between pregnancies increase the risk to the mother.
4. **Mode of delivery:** spontaneous vaginal delivery is safer compared to instrumental or caesarian deliveries.
5. **Place of delivery:** home deliveries in developing country are associated with higher maternal mortality, high risk patient should deliver at hospital.
6. **Education of the mother:** it has an influence on MM
7. **The use of contraceptive:** to avoid the risks of unsafe termination of pregnancy as hemorrhage & infection.

Causes of maternal mortality:

Women die as a result of complications during and following pregnancy and childbirth. Most of these complications develop during pregnancy and most are preventable or treatable.

1. **Hemorrhage:** caused by abortion, disturbed ectopic pregnancy, vesicular mole, ante & postpartum hemorrhage.
2. **Shock as** in rupture or inversion of the uterus.
3. **Infection:** septic abortion &puerperal sepsis.
4. Hypertensive disorders of Pregnancy.
5. Thrombosis &pulmonary embolism.
6. Amniotic fluid embolism.
7. Heart disease & other diseases which become aggravated by pregnancy.

8. Complication of anesthesia.

Maternal mortality includes both direct & indirect maternal deaths:

1. **Direct maternal death:** this includes death of the mother resulting from obstetrical complications of pregnancy, labor and Puerperium.
2. **Indirect maternal death:** this includes death of the mother resulting from disease which is aggravated by pregnancy.

Measures to reducing or avoiding maternal deaths:

❖ During premarital period:

- Access to adolescent reproductive health education and services.
- Stress on the importance of premarital counseling & premarital examination.
- Arrangement of classes to educate population about the importance of preventing early marriage.

During antenatal period:

- Proper antenatal care with regular follow up of the mothers during pregnancy.
- High risk women as diabetic & cardiac cases are seen more frequent.
- Correction of anemia & malnutrition.
- Hospitalization of cases of high risk.
- Ultrasound examination to diagnose cases.
- Provide immunization.
- Access to safe abortion.

❖ During intrapartum period:

Basic emergency obstetric care should be available at first-level facilities providing childbirth care.

- Delivery of all cases at the hospital if possible.
- Aseptic& antiseptic measures should be followed.
- Blood should be available for bleeding cases.
- Prevention of prolonged labor.
- General anesthesia if needed should be given by an expert anesthetist.
- Routine use of ecbolics in the third stage of labour to reduce the incidence of post-partum hemorrhage.

❖ During post-natal period:

- Infected persons or carriers should not come in contact with the puerpera.
- Maintain aseptic &antiseptic measures.
- Antibiotics if indicated.
- Health education about family planning information and services.
- Access to postpartum care.
- Early detection of postpartum hemorrhage and proper treatment

Safe Motherhood

Out lines:

1. Introduction
2. Definition
3. Goals and objectives
4. Important of safe motherhood
5. Component of reproductive health and The "Six Pillars" of Safe Motherhood:-
6. Essential Services for Safe Motherhood
7. Priorities for Safe Motherhood
8. Barriers to safe motherhood
9. Indicators of Maternal Health
10. Three delays model
11. How to Educate Others on the Importance of Safe Motherhood and Newborn Health
12. Nursing role in safe motherhood

Objectives:

At the end of this lecture, the student will be able to:

1. Define safe motherhood
2. Know goals and objectives

3. Enumerate the important of safe motherhood
4. Enumerate the services
5. List barriers of safe motherhood
6. Know the indicators of safe motherhood
7. Know what the component of reproductive health
8. Educate Others on the Importance of Safe Motherhood and Newborn
9. Health
10. Enumerate the nurse role

Introduction:-

Approximately 15 per cent of pregnant women will develop complications that require essential obstetric care, and up to five per cent of pregnant women will require some type of surgery

Safe Motherhood includes antenatal care, delivery care (including skilled assistance for delivery with appropriate referral for women with obstetric complications) and postnatal care

Definition:-

^ Motherhood is the concept or initiatives to ensure that women receive high quality care in order to achieve the optimum level of health of mother and infant.

Goals and objectives of safe motherhood;-

1. TO improving maternal and child health and eliminating the probable risk that can occur.
2. TO obtaining the desired outcome of pregnancy.
3. TO improve the maternal and neonatal health through preventive and promote activities as well as by addressing avoidable factors that cause death during pregnancy, childbirth and postpartum period
4. TO reduce maternal and neonatal morbidity and mortality

Important of safe motherhood:-

• Promoting women's health

- improves not only individual health, but also the health and survival of women's families
- **Improves well-being of communities and countries.**
- Component of reproductive health and The "Six Pillars"

of Safe Motherhood:-
Component of reproductive health

- Reproductive health.
- Adolescent health.
- Maternal health.
- Contraception.
- Sexually transmitted infection.
- Abortion.
- Female genital mutilation.
- Child and forced marriage.

The "Six Pillars"

1. Family Planning:
   Individuals and couples must have the information and services to plan the timing, number, and spacing of pregnancies.

2. Antenatal Care:
To provide vitamin supplements, vaccinations, and screen for risk factors to ensure that complications of pregnancy are detected early and treated appropriately.

3. Obstetric Care:-
To ensure that all birth attendants have the knowledge ,skills, and equipment to perform safe delivery.

4. Postnatal Care:-
To ensure that postpartum care is provided to mother and baby, including lactation assistance, provision of family planning services, and managing danger signs.

5. Post abortion Care:-
To ensure that complications of abortion are detected early and treated appropriately.

6. STD/HIV/AIDS Control:
To screen, prevent, and manage transmission to baby, to assess risk for future infection; to provide voluntary counseling and testing.

Essential Services for Safe Motherhood

1. Community education on safe motherhood
2. Prenatal care and counseling.
3. Care for obstetric including emergencies
4. Postpartum care
5. Post-abortion care .
6. Family planning services
7. Reproductive health education and services for adolescents

Priorities for Safe Motherhood

- Advance safe motherhood through human rights
- Safe Motherhood is a Vital Economic and Social Investment
- Delay Marriage and First Birth
- Every Pregnancy Faces Risks
- Ensure Skilled Attendance at Delivery
- Improve Access to Quality Reproductive Health Services
- Prevent Unwanted Pregnancy and Address Unsafe Abortion
- Measure Progress
- The Power of Partnership.
- Empower Women.

Barriers to safe motherhood

1. There are social/cultural norms related to gender that contribute to maternal mortality.

Poor nutrition

- Poor maternal nutrition is very common in many countries. Women who are underweight are also less likely to have healthy pregnancies.

Early first pregnancy

- Improvements in maternal weight can be achieved by delaying age of first pregnancy, an issue linked closely to marital age.

Early marriage

- Pregnancy-related deaths are the leading cause of mortality for 15-19 year-old girls worldwide.

2- Lack of education and information.

High rates of illiteracy/low rates of school attendance among women and girls, contribute to high maternal mortality.

3 Restriction of women's movement outside the home:

In some societies, limits their access to services or ability to seek services.

4- Gendered division of household labor

Rooted in social norms and values, means that women bear most of the domestic, farming, and childcare tasks.

5- Gender-based violence:

Female genital cutting, can complicate childbirth, leading to, for example, obstetrical fistula.

6- Lack of decision making power

- How many children to have?
- Spacing between pregnancies

Indicators of Maternal Health

Some of the parameters that help to see the effect of implementation of safe motherhood in the country include

A. Maternal mortality ratio (MMR):

Refers to number of maternal death per 100,000 live births.

B. Total Fertility rate:

Refers to the number of children that a woman can have in her reproductive life if she conforms to country's age specific fertility rate.

C. Contraceptive prevalence rate:

Refers to the number of women using any method of family planning per 100 women aged 15-49.

D. Perinatal mortality rate:

refers to the number of perinatal deaths per 1000 live Births

D. Antenatal Coverage:

Is the number of mothers receiving care during pregnancy per hundred women.

E. Attended Birth:
Is the percentage of pregnant mothers who receive delivery services by trained or skilled person.

F. Post natal care:
Is the percentage of mothers who receive health services after 42 days after delivery.

G. Birth spacing:
Is the percentage of mothers who deliver after two years of the previous delivery.

J. Infant Mortality Rate:
Is the number of deaths of infants up to the age of one year per 1000 live births in a given year .

K. Under Five Mortality Rate:
The number of deaths of children Under 5 years of age per 1000 children age 5 years in a year.

The Three D's (Delays)

There are three phases during which delays can contribute to the death of pregnant and postpartum women and their newborns.

These phases are:

1. Delay in deciding to seek care
- Failure to perceive severity of illness
- Cost consideration
- Previous negative experience with the health system
- Transportation difficulties

2. Delay in reaching care
- Lengthy distance to a facility
- Condition of roads
- Lack of available transportation

3. Delay in receiving care

- Uncaring attitudes of providers
- Shortage of supplies and basic equipment
- Non-availability of health personnel
- Poor skills of health providers Nursing role

in safe motherhood:- Health Education

The public health nurse should provide health education during reproductive cycle, including preconception period, family planning, antenatal care, delivery, and postnatal services.

Record and documentation

Nurses are expected to improve the reporting and documentation in the following areas: Prenatal, perinatal complications, referral, delivery care, contraception and follow up health institutions workload should also document.

Immunization

Nurses should ensure the effectiveness of immunization at all level through

• Maintenance of cold chain

• Appropriate administration of vaccines (the right type, dose, route, schedule etc.)

Nutritional Education

Educations on nutrition and vitamin supplementations are among the very important preventive and promotive activities in safe-motherhood. **Home Visiting**

Home visits are important to understand the real background of their living condition and the environment of families.

The essential interventions for safe motherhood, to which UNHCR agrees, can be summed up as follows2:

Before and During Pregnancy

- information and services for family planning
- STD/HIV prevention and management
- tetanus toxoid immunization
- Antenatal registration and care
- Advice regarding nutrition and diet
- iron /folate supplementation
- Prevention, early detection and management of complications (e.g. hemorrhage, preeclampsia/eclampsia, anaemia, abortion).

During Delivery

- clean and safe (a traumatic) delivery
- prevention, early detection and management of complications (e.g. hemorrhage, prolonged/obstructed labour, eclampsia).

After Delivery:

- management of complications(e.g haemorrhage ,sepsis,eclampsia)
- postpartum care
- information and services for family planning

How to Educate Others on the Importance of Safe Motherhood and Newborn Health

1- Understand the importance of safe motherhood and newborn health.

In order to spread the message, it is important to know the facts.

The basics are

- o Girls who are educated, healthy and who have a nutritious diet throughout their childhood and teenage years are more likely to have healthy babies and go through pregnancy and childbirth safely if childbearing begins after they are 18 years old.

- o A healthy mother, a safe birth, essential newborn care and attention, a loving family and a clean home environment contribute greatly to newborn health and survival.

- o Smoking, alcohol, drugs, poisons and pollutants are particularly harmful to pregnant women, the developing fetus, babies and young children.

2- Explain the value of: Violence against women is a serious public health problem in most communities.

- When a woman is pregnant, violence is very dangerous to both the woman and her pregnancy. It increases the risk of miscarriage, premature labor and having a low-birth weight baby.

3- In the workplace, pregnant women and mothers should be protected from discrimination and exposure to health risks and granted time to breastfeed or express breast milk.

They should be entitled to maternity leave, employment protection, medical benefits and, where applicable, cash support.

4- Explain that everyone has a responsibility for safe motherhood and newborn health.

Every woman has the right to quality health care, especially a pregnant woman or a new mother.

Violence against women

Out Line:

- Introduction
- Definition
- Incidence of violence
- Types of Violence - physical
  - psychological
  - sexual
- Ecological framework for understand domestic violence
- Signs and symptoms
- Cycle of violence
- What are the causes of domestic abuse
- Characteristics of victims and abusers
- Form of violence against women
- Consequences of domestic violence

- Health consequences
- Social and economic consequences
- Consequences on family
- Consequences on children

- Strategies to manage violence A) Primary level of prevention

b) Secondary level of prevention
c) Tertiary level of prevention

- Nursing care violence - abuse of women

Violence against women

Introduction:

Violence against females is a major health problem and human rights issue through out the world .One in fifth women has been either physical, sexually or emotionally abuse at sometime in her life, many including pregnant women and young girls.

Violence against women is a manifestation of historically unequal power relations between men and women" and that "violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men.

The World Health Organization (WHO), in its research on VAW, categorized it as occurring through five stages of the life cycle: "1) pre- birth, 2) infancy, 3) girlhood, 4) adolescence and adulthood and 5) elderly"

Definition:-

The word ***violence*** comes from Latin "violre" meaning to violate, injure or rape.

- **Violence:** Is the use of physical force to cause injury, damage or death.

The United Nations General Assembly (UNGA), in its resolution on the Declaration on the Elimination of

Violence Against Women, defines **"violence against women"** as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."

Incidence of violence:

The Egyptian demographic health survey conducted in Egypt 2008 , found that 38% of ever married women had been beaten at least once since marriage. 46% of men had sexual intercourse with their wives even when arguing or refused.

In Middle East area reported that of even married women aged is 15-49 years 35% of women in Egypt and 29% in Canada reported being beater by their husband. In Unit States, one woman is physically abused every eight seconds and one is raped every six minutes. Approximately 25% of women.

WHO multi-country study found that between 15-71% of women reported experiencing physical and/or sexual violence by an intimate
partner at some point in their lives.

Types of Violence and Abuse		
Physical Violence Physical violence occurs when someone uses a part of their body or an object to control a	**Sexual Violence** Sexual violence occurs when a person is forced to unwillingly take part in sexual activity.	**Emotional Violence** Emotional violence occurs when someone says or does something to make a person feel stupid or worthless.
Psychological Violence Psychological violence occurs when someone uses threats and causes fear in an individual to gain control.	**Spiritual Violence** Spiritual (or religious) violence occurs when someone uses an individual's spiritual beliefs to manipulate, dominate or control that person.	**Cultural Violence** Cultural violence occurs when an individual is harmed as a result of practices that are part of her or his culture, religion or tradition.

Verbal Abuse	Financial Abuse	
Verbal abuse occurs when someone uses language, spoken or to cause harm an individual.	Financial abuse when someone an individual's financial resources without the person's consent or misuses those resources.	**Neglect** Neglect occurs when someone has responsibility to provide care or assistance for an individual but

Risk Factors of Violence against Women

I- Social Factors

1. Lack of family and support
   - **a.** Single parenthood
   - **b.** Divorced, separated or unmarried
2. Early, frequent, unintended pregnancies
3. Lack of, education.
4. Involuntary job loss
5. Poverty
   - **a.** Homeless or housing insecurity
   - **b.** limited food choices
   - **c.** Lack of reliable, culturally and sensitive medical care

II- Environmental Factors

1. Unhealthy, substandard living conditions
    a. Toxins
    b. Crowded
    c. Noisy
2. Lack of transportation
3. Lack of green space

III- Medical Factors

1. Little or no health care (including mental, oral health, vision)

a. Limited or no access
b. No preventive health care ■ No preconception care

2. Inadequate treatment for chronic conditions

VI- Other Factors

1. Substance abuse including tobacco and alcohol
2. Deprassion
3. history of childhood abuse
4. history of antisocial behavior 2. Current unemployment

Sings and symptoms A-physical sings abuse can include:- Bone fracture.

- Injuries on different part of the body
- Unexplained cuts, head in injuries or bruises.
- Problems with walking
- Difficulties with daily activities
- Reduced physical functioning

B-**The emotional sings of abuse** are not easy to see the victim may have this: -

- Anxiety, Depression,Low self-esteem, Stress, Suicidal gestures, Sleep disturbance

C- Sexually abused Violence increases risk for other gynecological problems, A history of sexual violence has been associated with:

a. Vaginal bleeding, vaginal discharge and painful menstruation
b. Sexual dysfunction
c. Pelvic inflammatory disease

Sexual offence are classified into:

Natural sexual offences: rape and incest.
Unnatural sexual offences: sodomy, and
bestiality Sexual perversion \deviation.

Increases women's risk of HIV/AIDS directly and indirectly
Violence can prevent women from accessing HIV/AIDS information,
treatment and care.
Fear of violence is a barrier to HIV testing and appearing.
Violence affects women's ability to mitigate the impact of
HIV/AIDS on themselves and their children.

Characteristics of Victims and Abusers 1- characteristics of battered women (victims):

- Many were raised to be submissive, passive, and dependent and to seek approval from male figures.
- Some battered women were exposed to domestic violence between their parents, others first experience it from their husbands,
- battered women are likely to accept the traditional female role in their marriage, and belive their husbands will love and protect them.
- Many women suffer from low self-esteem and may have histories of domestic violence in their families of origin.

- Majority of battered women remain in an abusive relationship, several factors contribute to their stay in the relationship. Among these fators, ignorance, love, fear, pride, loyalty, financial dependence, low self-esteem, and children.

2- characteristics of abuser:

Elbow (1977) has identified four types of men who become abusive husband and has categorized them as the **Controller, the Defender, the Approval Seeker, and the Incorporator.**

1- **Controller** :

The controller strives for autonomy through the control of others. He is not emotionally reciprocal in his relationships; he usally gets his way and is never to blame when things go wrong.

2- Defender (Protector) :

Having a spouse to harm, love and forgive is a fundamental need of the defender. His fear is that he will be harmed, and he strikes out before he is struck. He needs a wife who is totally dependent on-him, clings to him, and is defenseless so that he can protect her.

3- Approval seeker: Continued reaffirmation of self-esteem is required by the Approval seeker. He has a low self-image and expects rejection. He may even participate rejection by his mate through his behavior, violence occurs when he feels the most criticized.

4- Incorporator:

The need of the incorporator is to draw another individual's strength into his own psyche to fill his emotional gaps. His desperation can be observed in several ways. Any attempt by

the wife to withdraw from the situation increases his desperation and may lead to violence .

Consequences of Domestic Violence:

1- Health consequences

2- Social and economic consequences

3) Consequences on family

4) Consequences on children

1- Health outcomes of violence against women

a) Fatal Out Comes

b) Non Fatal
Outcomes
a) Fatal
Outcomes

- Homicide.
- Suicide.
- Rape.
- sexual transimetted disease and AIDs.

Homicide

- Is any non-war-related action taken to cause the death of anther person.
- Many homicide casualties are victims of domestic abuse. The cycle of violence escalates and the partner is killed, most often in a violent episode, or by arrangement with the homicide committed by a third part.

Suicide

- Suicide is taking action that cause one's death .One study found that one fourth of all suicide attempts were precede by abuse. Completed suicides are carried out in a variety of ways, some more violent than others. Women usually choose less violent methods, such as overdosing on medication.

Rape

Legal definitions of rape vary, but the key elements include some form of sexual contact and a lack of consent. Consent is

considered lacking under conditions of force, deception, or coercion, or when the victim is a minor is drugged, unconscious, mentally retarded, or physically restrained
Rape is defined as any time a man puts his penis, finger or any object, in to a women vagina, anus or mouth without her consent.

Prevention of rape requires a broad-based community focus for educating both the community as whole and key groups such as police, health providers, educators, and social workers.

Strategies for Eliminating violence against women

Eliminating violence against women requires strategies coordinated among many sectors of society and at community and national levels. Efforts must go for beyond the health sector alone. An agenda for change must include: empowering women and girls, raising the cost of abuser, providing for the needs of victims, coordinating institutional and individual responses

1- Empowering women and girls

Empowering is generally viewed as a long-term process, occurring at the international, national community and individual level. Its goals are to:

- Eliminated laws that discriminate against women and children
- Strengthen women in leadership and decision making
- Increase access to education for women and girls
- Increase women's access to and control over economic resources
- Increase women's access to health information

- Improve women's self-esteem and sense of personal power

non- Governmental organization (NGOs) are working to instill a greater sense of entitlement among women via human rights education, legal literacy programs, gender training and other small group efforts.

2- Raising the cost of abuser"

Many communities have explored other means to raise costs to individual abusers of their violent behavior, such as public shaming, picketing an abuser's home or workplace, and requiring community service for offenders. Such practices presume that community disapproval can help deter domestic violence.

3- Providing for the needs of victims

The needs of victims are complex. A women in crisis needs physical safety, emotional support, and assistance in resolving such as child support and employment.

4- Coordinating institutional and individual responses

In most countries women have to overcome many institutional barriers to get the help they need. There is little coordination among the many institutions with which abuse victim interact such as health care child welfare and law enforcement agencies.

5- Involving Youth:

Social behavior is learned at an early age. Around the world a number of programs are working with young people to encourage nonviolent forms of conflict resolution, to challenge traditional gender norms, and to create new models of health relationships

6- Reaching out to men:

Working with men to change their behavior is an important part of any solution to the problem of violence against women. To date, most programmatic work with men has focused on establishing treatment programs for men who batter. to accept personal responsibility for their violent behavior and to learn nonviolent way to manage their anger and interpersonal conflict.

7- Changing Community Norms:

Ending violence against women means changing the community norms and cultural attitudes and beliefs that give rise to men's abusive behavior toward women and that permit it to persist. A variety of norms and beliefs are particularly powerful in perpetuating violence against women. These include a belief that men are herently superior to women, that men have a right to "correct" female behavior, and that family matters are private and it is inappropriate for others to intervene.

The Promotion And Protection Of Women's Reproductive Health Through Women's Rights

- The right to be free from all forms of discrimination.
- The right to have family and private life.
- The right to survival, liberty and security.
- The right to individual freedom and autonomy.
- The right to health and health care
- The right to information and education
- The right to political participation.
-

- Role of the Nurse through level of prevention

A- Primary prevention

B- Secondary prevention

C- Tertiary prevention.

A) - The goal of primary intervention in an abusive situation is to decrease the incidence of violence and abuse of women.
-The major focus is identifying abused women and increasing an awareness of problem of violence and abuse at the group and community level.
Primary prevention of abuse includes strengthening women and families such as

- Education of women in schools about healthy family, non violence methods of conflict resolution, what's violence, its causes, consequences and prevention.
- Premarital counseling about family life, roles, and method of conflict resolution.
- Use the mass media programs to increase the community awareness about the problem and its prevention.
- Use community resources as (telephone number-

shelter).

- Provide gender equity and equality in the important aspects of social life.

B) Secondary intervention includes assessing the abused women and implementing an appropriate plan of care.

- Routine screening for early case finding
- Assessment of the victim includes:

- History taking
- Complete physical examination
- Psychological assessment through communication skills **C) Tertiary** Helping the abused women in the making long-term plans, providing continues support for her decisions, and making effective referrals are all a part of tertiary intervention.

- Helping the abused women in the making long-term plans, providing continues support for her decisions, and making effective referrals are all a part of tertiary intervention.
- Facilitate the women establishment of support network of maternity, pediatric, community health nurses and appropriate referral system
- Provide social support group
- Involve the whole family in teaching program including conflict resolution methods
- Provide psychological care to all family members

Maternal &child health

Out lines

- Introduction:
- Definitions
- Health status Indicators:
- Factors affecting women's health
- Factors Influencing Maternal and Child Health Lifestyles:
- Examples of Healthy Lifestyles Choices of Maternal and Child Health:
- Woman's health concerns:
    - Reproductive Health
    - Menopause
    - Breast Cancer
    - Osteoporosis
    - Female Genital Mutilation (FGM)
- Role of nurse in women's health
- Child Health:
- Concept and importance:
- Child Health problems:
- Health dangers for children
- WHO guidelines on maternal and child health
- References

Introduction:

Health of mothers and children is very important for acceptance and practice of family norms to stabilize population. Maternal and Child Health care services are essential and specialized services because mothers and children have special health needs which are not catered to by general health care services.

Definitions

- **Health:** The basic definition of health adapted by the World Health organization (WHO): "a state of complete

physical, mental, and social well-being, and not merely the absence of disease or infirmity"

- **Women's health:** From a physiological perspective, women's health now refers to the prevention, diagnosis, and management of conditions or diseases that may be unique to women (e.g. menstruation, pregnancy, menopause, diseases of the reproductive tract), be more prevalent in women than in men (e.g. bone, joint, and rheumatic diseases; diabetes mellitus; eating disorders; breast cancer; and specific thyroid, neuralgic, gastrointestinal, and psychiatric diseases), or manifest differently in women than men (e.g. heart disease, substance abuse, acquired immunodeficiency syndrome [AIDS], violence)

Factors affecting women's health

Women's health affects and is affected by the broader context of people's live including:

1. Family environment and living conditions
2. Gender and social relationships
3. Education
4. Employment
5. Economic circumstances
6. Traditional and legal structures
7. Resource deficit
8. Human resources and development

9. Referral system

There are different factors which influence the maternal and child health are:

1) <u>Maternal Age</u>:

- Maternal age advances, the rates of pregnancy loss and birth of infants with chromosomal anomalies result is increased.
- Most women and men are aware that advanced maternal age (older than 35 years) may affect a pregnancy adversely.
- Conversely, the general public health care providers are less aware that advanced paternal age (older than 45 years at conception) un favourably affects fetal growth and development.
- People of advanced reproductive age require information about the possible outcomes for a child conceived with their genetic gametes.
- The nurse should offer education and counseling using incidence tables for chromosomes anomalies associated with advanced maternal age and review characteristics of disorders that may occur through paternal transmission of spontaneous new mutation as a result of advanced paternal age.

2) <u>Sexuality Factor</u>:

- Both the client and her partner may express concerns about sexuality and intercourse during pregnancy**.**
- Regardless of suggestions studies have found that the frequency of coitus decreases as pregnancy progresses. Intercourse or orgasm is contraindicated in cases of known placenta previa, or ruptured membranes.
- Nipple stimulation, vaginal penetration, or orgasm may cause uterine contractions secondary to the release of prostaglandins and oxytocin.
- Development of sexuality is an important part of each person's psychosocial identity, integrated sense of self, reproductive capacity and ability to fulfill role functions in society.

3) Nutrition factors:

- During pregnancy changes must occur to ensure that gestation progresses and both mother and fetus remain healthy.
- These changes involve synthesis of new tissues and hormonal variations to regulate essential processes.
- Nutrition has critical role in pregnancy outcomes maternal nutritional status at conception and throughout gestation greatly influences not only the mother's health but also that of the fetus.
- Adequate foliate status, which helps prevent neural tube defects, and control of blood glucose level, which

improves the abilities to conceive and to give birth to a healthy newborn.

- Women require proper nutrition and normal endocrine function for normal fetal development.
- Women specially require additional vitamins and minerals to support fetal growth and development. Especially important is additional folic acid to reduce the risk for neural tube defects.

4. <u>Environmental Factor</u>:

- Environmental factor also influence on maternal and child health. So we have to know about the environment in which the woman and partner reside and work.
- Men exposed to toxic substances such as heat, radiation, viruses, bacteria, alcohol, and prescription and recreational drugs are more likely to have decreased morphologically and genetically normal sperm in a single ejaculate. This results in reproductive failure preconception and post fertilization.
- Women exposed to similar toxic agents experience diminished ovarian reserve, poor endometrial lining development, and abnormal fetal development.

5. <u>Psychological Factor</u>:

- An absence of stress is important in ensuring a successful outcome for the mother and baby.
- Harmony with other people must be fostered, and visits from extended family members may be required to demonstrate pleasant and no controversial relationships.
- If discord exists in a relationship, it is usually dealt with in culturally prescribed ways.
- Certain environmental factors such as emotional stress, anxiety, fears, frustrations, broken homes, poverty and many others can lead to mental illness. The psychosocial environment at home or school is an essential factor for health.
- Children exposed to happy and healthy homes make them physically and mentally healthy.
- Other factors affecting the health status of children include community and social support measures….etc.
- Support must be individualized and tailored to the woman's changing needs during labor.
- Emotional support includes physical presence and words of affirmation reassurance, encouragement and praise.
- Comfort measures are any hands on activity aim at decreasing the physical discomfort (pain, hunger and thirst) of labor.

- Information and advice ensure that the woman is aware of what is happening and of techniques that may help her to cope.

6. <u>Ethnic and Socio Cultural Factor</u>:

- Culture and family must be viewed simultaneously for, regardless of the family type, it remains the basic unit of society and influences human development over the life span.
- The older adults in these families often have significant roles in health and child care, household maintenance, and decision making. Multiple care takers are available to help with childrearing and discipline.
- Socialization is an early family function. Socialization includes all the learning experiences of early life.
- Home remedies and folk care practices for prevention of illness, maintenance of health, and curative purposes remain primary sources for most families, regardless of ethnic and cultural backgrounds.
- Communication patterns are influenced by a family's culture. Religious beliefs and practices are part of cultural and familial heritage and influence health care behaviors.
- The value of the children varies greatly, depending on the meaning each society attaches to children. Health

values and beliefs are also important in understanding reactions and behavior.

- If a culture views pregnancy as a sickness, certain behaviors can be expected, whereas if pregnancy is viewed as a natural occurrence, other behaviors may be expected. Prenatal care may not be a priority for women who view pregnancy as a natural phenomenon.

7. Lifestyle Factors:

The health of an individual has direct relationship to the lifestyle. It is nothing but just a way of living. A person who has healthy practices of day to day living will remain healthy. Those people who follow the healthy life styles are much healthier than those who follow injurious life styles.

The way of life of people in a community and their individual life style also has a significant impact on health.

Life style refers to a person's general way of living, including living conditions and individual patterns of behavior that are influenced by socio-cultural factors and personal characteristics.

Life styles choices may have positive or negative effects on health. Practices that have potentially negative effects on health are often referred to as risk factors. E.g. over eating,

getting insufficient exercise, being over viewing are closely related to the incidence of heart disease, diabetes and hypertension.

Excessive use of tobacco is clearly implicated in lung cancer, emphysema and cardiovascular diseases.

Factors Influencing Maternal and Child Health Lifestyles:

- Proper nutrition and exercise.
- Healthy sleep patterns.
- Adequate rest.
- Healthy coping with stress.
- Ability to use family and community support and resources.
- Health promotion progress in community
- Educating school children about the food guide.
- Encouraging the provision of healthy snacks.
- Well – balanced meals in the home.
- Fitness program for all ages.
- Promotion of community play grounds in the community.
- Establishing networks of support in the community.
- Life enhancing activities
- Meaningful work
- Creative outlet
- Interpersonal Relationship

- Recreational activities
- Opportunity for spiritual and intellectual growth
- Mental Health Promotion interventions
- Arts and crafts classes
- Encourage creative expression
- Community event sports events.
- Volunteer programs encourage community participants.
- Personal hygiene: Washing hands with soap and water before eating.
- Avoidance of excess salt, fats, sweets and cholesterol containing items.
- Consumptions of fiber- rich foods.
- Avoiding of having tobacco, alcohol, drugs of addiction.
- Indulgence in safe sex practices
- Practicing relaxation techniques. E.g. yoga, Mediation
- Health education is an important aspect to change life style and practicing the healthy ways of living.
- The school children must be taught good health habits and include health topic in curriculum.
- Health education is a basic element of all health activity.
- Changing views of people
- Changing behavior of people
- Changing habits of people

8- Gender:

In some society there may be the discrimination between the male and female baby. If the mother having a male baby the family will provide more care and attention towards the mother and baby. And if the mother having a female babies the family members will provide her less care and attention towards the mother and baby. So gender also influences the maternal and child health.

Common screening tests

Formally stated by the World Health Organization, screening is "the presumptive identification of unrecognized disease or defect by the application of tests, examination or other procedures which can be applied rapidly. Screening tests sort out apparently well persons who have a disease from those who probably do not"

Large numbers of women do not receive the health screenings intended to prevent and identify disease. Nurses play a key role in encouraging women to identify primary care providers and obtain a physical examination and the recommended screening tests appropriate to that individual. Women who can establish a working relationship with their health care provider and participate in the recommended screening tests may help them live healthier, happier, and longer lives.

Heath screening:

- Blood pressure
- Height and weight
- Nutritional screening (obesity)
- Lipid disorders (women 45 and older)
- Papanicolaou (Pap) test (all women sexually active with a cervix)
- Colorectal cancer (adults 50 and older)
- Mammogram (women 40 and older)
- Osteoporosis (postmenopausal women 60 and older)
- Problem drinking
- Depression screening
- Tobacco use/tobacco-causing diseases
- Rubella serology or vaccination(women of childbearing age)
- Chlamydia (sexually active women age 25 and younger; women older than 25 with new/multiple sexual partners)
- Coronary heart disease screening (EEG; exercise treadmill)
- Syphilis screening (for at-risk population only)
- Diabetes mellitus (adults with hypertension or hyperlipidemia)

Reproductive Health

Women's reproductive health covers diseases and conditions that affect the female reproductive system. Includes symptoms, diagnosis, treatment, and prevention of women's reproductive health issues. Covers woman's health diseases

that affect the uterus, cervix, vagina, fallopian tubes, and breasts. Women often use health care services for reproductive health concerns. The various elements of reproductive health include the following: Empowerment of women, women's nutrition, care of adolescents, safe sexual behavior, elimination of unsafe abortion, safe motherhood, prevention and management of infertility, male involvement, post natal care, and prevention of unwanted pregnancy.
Reproductive health problems remain the leading cause of ill health and death for women of childbearing age worldwide. Impoverished women, especially those living in developing countries, suffer disproportionately from unintended pregnancies, maternal death and disability, sexually transmitted infections including HIV, gender-based violence and other problems related to their reproductive system and sexual behavior.

Nurses are in a unique position to advocate for policies that increase women's access to services for reproductive health. In addition, many nurses discuss contraception with women of childbearing age. Contraceptive counseling requires accurate knowledge of current contraceptive choices and a nonjudgmental approach. The goal of contraceptive counseling is to ensure that women have appropriate instruction to make informed choices about reproduction. The choice of contraceptive method depends on many factors

including the woman's health, frequency of sexual activity, number of partners, and plans to have future children.

Menopause

During **menopause** the levels of the hormones estrogen and progesterone change in a woman's body. This change leads to the cessation of menstruation. Decline in these hormone levels can affect the vaginal and urinary tract, cardiovascular system, bone density, libido, sleep patterns, memory, and emotions.

Women's attitudes toward menopause vary greatly and are influenced by culture, age, support, and the recounted experiences of other women.

Hormone replacement therapy (HRT) did not prevent heart disease and that to prevent heart disease women should avoid smoking, reduce fat and cholesterol intake, limit salt and alcohol intake, maintain a healthy weight, and be physically active. Scientists also concluded that HRT should be used to prevent osteoporosis only among women who are unable to take non-estrogen medications. Use of HRT for severe menopausal symptoms should be at low doses only and for a short duration. *Complementary* and *Alternative Therapies* The change in the recommendations regarding HRT led many women to seek alternative approaches for the management of menopausal symptoms. Women experiencing menopause frequently report symptoms including hot flashes,

vaginal dryness, and irregular menses. Examples of alternative therapies are those actions that are taken by women instead of HRT. Complementary therapies are those taken to augment (or as a complement to) HRT.

Examples of Alternative/ Complementary Therapies for Menopausal Symptoms: Herbal remedies, Acupuncture, Acupressure. Massage therapy and Healing touch.

Breast Cancer

Breast cancer is the second leading cause of cancer deaths among all women. Carcinoma of the breast is the most prevalent cancer among Egyptian women and constitutes 29% of National Cancer Institute cases. Breast cancer in Egyptian patients has a younger age distribution with the majority of cases occurring at 30–60 years of age. The median age is 46 years. Most patients are premenopausal (60.5%) with a female to male ratio of 44:1. Secondary prevention that includes screening activities, such as mammography, clinical breast examination, and self-breast examination, make a difference in death rates. Early detection can promote a cure whereas late detection typically ensures a poor prognosis. The differences in the outcomes between women of color and white women point to issues associated with early detection, access to health care, and follow-up by a regular care provider.

Osteoporosis

Osteoporosis is a disease characterized by low bone mass and structural deterioration of bone tissue, leading to bone fragility and an increased risk of fractures of the hip, spine, and wrist. Women are more susceptible than men because they tend to have lower peak bone mass, to suffer bone mass loss at an accelerated rate as estrogen levels decline, and to have a longer lifespan. Some loss of bone occurs naturally after age 30, but the severity of this process is increased with reduced levels of calcium, estrogen, and physical activity. Physical activity may play a substantial role in the development of bone mass during childhood and adolescence and in the maintenance of skeletal mass into adulthood. Prevention also includes diets rich in calcium and vitamin D. Exercise also improves bone density, especially weight-bearing activities such as walking, running, stair climbing, and weight lifting. Limiting alcohol consumption and avoiding smoking are also important.

Female Genital Mutilation (FGM)

It refers to all procedures that involve partial or total removal of the external female genitalia. or injury to the female genital organs whether for cultural or any other non-therapeutic reasons Common in many African countries and certain Asian and Middle Eastern countries, female genital mutilation (FGM) is a centuries-old practice. According to the World Health Organization (WHO), today

there are between 100 and 140 million women who have undergone FGM. FGM can take several forms ranging from the excision of the clitoris with partial or total removal of the labia minora to the severe form where the labia majora is fused following the removal of the clitoris and labia minora. These procedures are associated with morbidity related to substantial complications such as hemorrhage, infection, tetanus, septicemia, and HIV infection. Some of the long-term effects of FGM include impaired urinary and menstrual functioning, chronic genital pain, cysts, neuromas, ulcers, urinary incontinence, and infertility.

FGM is related to tradition, power inequities, and the compliance of women to community norms. Some consider this practice an important part of a woman's access to marriage and childbearing. In Egypt FGC is mostly practiced between 9 and 13 years of age. When early sexual maturity starts. It was found that the great majority of girls in the adolescent age have been subjected to FGC. The process was found to be more and more practiced by physicians rather than by traditional "days" or "health barbers". Nonetheless, under" the Egyptian Penal Code, the practice of FGC is incriminated. Since the early 1980s, the WHO has proposed laws prohibiting FMG in all countries.

Public policies for improve maternal health in Egypt

- The maternal health program, safe motherhood was one of the main vertical programs implemented by MOHP.
- About 300 maternity centers were upgraded with more than 170 of theses centers in the underserved urban and rural areas.
- Egypt also launched its Health Sector Reform (HSR) program in response to improve general health and reproductive health outcomes of the population through more equitable access to basic health care service.

Role of nurse in women's health

The nurse works with women in all age groups using the three levels of prevention—primary, secondary, and tertiary—as a guide. Interventions are conducted individually, in families, in small groups, and in aggregates.

Primary Prevention

Primary prevention activities focus on education to promote a healthy lifestyle. Much of nurse’s time is spent in the educator role. During home visits to pregnant women, the nurse teaches nutrition, provides anticipatory guidance, emphasized the importance of staying drug and alcohol free, and teaches about bodily changes during pregnancy. With small groups of women in the work setting, the nurse can teach safety, illness prevention, use of safety devices, and balancing work and home responsibilities. Among aggregates, the nurse focuses on women needs in services and programs that will keep that

aggregate healthy.

Secondary Prevention

Secondary prevention focuses on screening and early diagnosis of disease or injury. A significant amount of the nurse's time is spent in assessing the need for, planning, implementing, or evaluating programs that focus on the early detection of diseases. This is followed with teaching to prevent further damage from the disease in progress or to prevent the spread of the disease if it is communicable. Examples of secondary prevention programs include establishing mammography clinics, teaching breast self-examination, administering tuberculosis skin tests to groups of women in their work setting or to residents of a long-term care center, conducting blood pressure screening booths at shopping malls or among groups of women when they come to a senior center for flu shots. Wherever women gather in groups is a good place to provide both primary and secondary health care services.

Tertiary Prevention

The tertiary level of prevention focuses on rehabilitation and preventing further damage to an already compromised system. Many of nurse works the women with have chronic diseases, long-standing injuries with resulting disability, or conditions resulting from another disease. Examples include DM that is

out of control because the client is 100 pounds overweight and broken bones resulting from falls in a woman with advanced osteoporosis. Ideally, negative health conditions can be prevented. If not, the next best thing is for them to be diagnosed early, without damage to the woman's health. But if negative health conditions have not been treated or brought under control, then the woman is at a tertiary level of prevention when someone intervenes. At this level of prevention, the nurse focuses on quality of life and may even take a life-saving stance in the approach used.

Child Health:

Concept and importance:

Child health refers to a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in matters relating to growth and development of fetus during antenatal period and from birth of the baby till five-year of age.

Child Health problems:

- Problems of neonates
- Low birth weight
- Small for date (SFD)
- Pre-term babies
- Infectious diseases
- Accidents and poisoning
- Malnutrition

Health dangers for children

Nearly 6.9 million children under the age of five died in 2011 – nearly 800 every hour – but most could survive threats and thrive with access to simple, affordable interventions.

The risk of death is highest in the first month of life. Preterm birth, birth asphyxia and infections cause most newborn deaths. Health risks to newborns are minimized by:

- quality care during pregnancy;
- safe delivery by a skilled birth attendant; and
- strong neonatal care: immediate attention to breathing and warmth, hygienic cord and skin care, and early initiation of exclusive breastfeeding.

From one month to five years of age, the main causes of death are pneumonia, diarrhoea, malaria and measles. Malnutrition is estimated to contribute to more than one third of all child deaths.

- Pneumonia is the prime cause of death in children under five years of age. Addressing the major risk factors – including malnutrition and indoor air pollution – is essential to preventing pneumonia, as are vaccination and breastfeeding. Antibiotics and oxygen are vital tools for effectively managing the illness.

- Diarrhoeal diseases are a leading cause of sickness and death among children in developing countries. Breastfeeding helps prevent diarrhoea among young children. Treatment for sick children with Oral Rehydration Salts (ORS) combined with zinc supplements is safe, cost-effective, and saves lives.
- One child dies every minute from malaria. Insecticide-treated nets prevent transmission and increase child survival.
- Over 90% of children with HIV are infected through mother-to-child transmission; this can be prevented with antiretrovirals, as well as safer delivery and feeding practices.
- Worldwide, about 20% of deaths among children under-five could be avoided if feeding guidelines are followed. WHO recommends exclusive breastfeeding for six months, introducing age-appropriate and safe complementary foods at six months, and continuing breastfeeding for up to two years or beyond.

About two-thirds of child deaths are preventable through practical, low-cost interventions. WHO is improving child health by helping countries to deliver integrated, effective care in a continuum - starting with a healthy pregnancy for the mother, through birth and care up to five years of age. Investing in strong health systems is key to prevention and delivery of quality care

WHO guidelines on maternal and child health

- Vitamin D, Calcium , iron and folic acid, and Vitamin A supplementation in pregnant women
- Calcium supplementation during pregnancy (at doses of 1.5–2.0 g elemental calcium/day) or Low-dose acetylsalicylic acid (aspirin, 75 mg) is recommended for the prevention of pre-eclampsia in all women, especially those at high risk of developing pre-eclampsia.
- Vitamin A supplementation during pregnancy for reducing the risk of mother-to-child transmission of HIV
- WHO recommendations on postnatal care of the mother and newborn
- Delayed umbilical cord clamping for improved maternal and infant health and nutrition outcomes
- Guidelines on basic newborn resuscitation
- Acceptable medical reasons for use of breast-milk substitutes
- Antiretroviral therapy for HIV infection in infants and childrenDiagnosis of HIV infection in infants and children
- Guideline on HIV disclosure counselling for children up to 12 years of age
- Guidelines for an integrated approach to nutritional care of HIV-infected children (6 month-14 years)

- Guidelines for identification and management of substance use and substance use disorders in pregnancy
- Guidelines on optimal feeding of low birth-weight infants in low- and middle-income countries
- Home visits for the newborn child
- Infant and young child feeding
- Neonatal vitamin A supplementation

Premarital counseling

Outlines:

- Introduction
- Definitions.
- Benefits of premarital counseling.
- PMC-FP Related Outcomes.
- Types of premarital counseling.
- Premarital screening program.
- Objectives of premarital screening program:
- Testes performed during premarital screening:
- Premarital testing and counseling visits:
- Steps of premarital counseling:
- Premarital screening counseling clinics in Egypt:
- Premarital screening service during covid-19
- Methods of premarital health education.

Introduction:

Premarital counseling is a way to help couples prepare for marriage. It identifies and modifies behavioral, medical and other health risk factors through prevention and management. Husband and wife are the foundation of family and their sound health is

very important for strong and healthy family and the future progeny. Many couples

choose to have children after they get married, but that is not always the case. It is a good starting point to build on in advance to ensure couples have the same family and reproductive health goals.

Definitions:

A) **Premarital counseling:** is a type of advice that help couples prepare for marriage. premarital counseling can help ensure that both spouses would have a strong, healthy relationship-giving them a better chance for a stableand satisfying marriage.

Benefits of PMC:

- Aimed at equipping couples to enrich their marriage**.**
- Spells out marital roles and responsibilities**.**
- Allows a partner to gain insight into marriage.
- Inform couples how to respond when issues arise**.**
- Gives couples opportunity to identify and acquire problem-solving **skills/strategies.**
- Emphasizes importance of intimate relationship conducive to joy and **happiness.**

- Expands one's horizons and extend their views concerning marriage
- Realistic acceptance to change in order to keep unity and peace in a relationship.
- Used therapeutically to solve medical problems in the relationship.

- PMC Related Outcomes:-

3. Improved couple communication and partner support.

Increased partner support and couple interposal communication about positive attitude towa planned parenthood and improved decision-making about family well-being.

4. Improved health seeking behaviors.

d s

Facilitate and support inter-spousal communication and counseling on healthy timing spacing of pregnancy, some infectious sexually transmitted infections - STIs, Hepatitis B, C and HIV and any genetic disorder.

5. Increased male outreach and participation.

Increased uptake of couples counseling services, and accompaniment of husband for general or specific visits to the health clinic.

6. Improved knowledge about fertility and planning family.

Increased knowledge about fertility, pre-conception care, pregnancy, and use of family planning

7. Improved contraceptive use.

Increased adoption and continuation of contraception, in addition to increased birth spacing for better health outcomes.

Types of premarital counseling:

7. Medical counseling
7. Genetic counseling
7. Nutritional counseling
7. Sex education

1. Medical counseling:

4- The aim is diagnosis of diseases

B) Transmitted to the other partner: STD, TB

C) Represent a risk factor during pregnancy:

- ❖ Cardiac disease
- ❖ Chronic renal disease
- ❖ Renal transplantation

D) Affect reproductive function:

^ Female

Fibroid, genital hypoplasia, anovulation, menstrual disorders, hirsutism ^ Male

Undesended testes, varicocele, azospermia, physical disability

2. **Genetic counseling**

Aim identify individuals at risk of having a child with genetic disorder

Includes:

- ■ Sickle cell anemia (SS) and analogous interactions e.g. Hb S/C, Hb S/3-Thalassemia, Hb S/D Punjab, Hb S/O Arab, and Hb S/Lepore.
- ■ Thalassemia major (co-inheritance of 3- and/or 50- Thalassemiamutations).
- ■ Hb E Thalassemia (co-inheritance of 0- Thalassemia mutations with Hb E)
- ■ Hb Bart's Hydrops Fetalis syndrome.

3. **Nutritional counseling**
   - ■ Body mass index (BMI) preferred indicator of nutritional status
   - ■ Eating habits fasting, eating disorders, megavitamin
   - ■ Preconcetional intake of folic acid
4. **Sex education:**
   Includes:

1. Sensitive sexual sites
2. Healthy marital relations
3. Communication skills to reduce the chance of marital difficulties and toincrease marital satisfaction
4. Safe sex and protection against STD

- ❖ **Who are providing premarital care services in Egypt □**

- The community health nurses play a fundamental role in providing premarital care services that include assess hereditary risk, provide information, discuss available testing options and provide appropriate helpful counseling. Nursing is an integral part of the health care system and play a valuable role in changing females believes, behaviors which the providing health education about premarital counseling, discussing the benefits of premarital counseling.

- ❖ **Testes performed during premarital screening:**

- CBC : Complete Blood Count

4- **Steps of premarital counseling:**

1. Creating safe spaces and introductions:
   - Take care to show courtesy and respect by:
     - Standing, smiling and shaking hands
     - Introduce yourself
2. Record Personal Information
   - At the first visit, all personal data should be documented including name, national ID number, age, education, occupation, contact number, and consanguinity.
3. Background information and knowledge:
   - Always ask the client what they know about the premarital screening program before providing any information. This will

provide a starting point in your counseling by picking off where the client had ended, and will allow you to detect any misconceptions and thus correcting them.

C) Listening skills

- It is an active process and includes listening to what is verbally communicated as well as observing the nonverbal communications of client

CI) Non-judgmental attitude

D) The counselor should accept the client regardless of their social status, gender, race group, religion and looks.

D) Clarifying and questioning

E) Questions help to obtain more information and clarify certain points always remember to:

1- Avoid leading questions
2- Use open-ended questions

4- Premarital screening counseling clinics in Egypt:

4- Premarital screening service during covid-19:

- The primary health care confirmed that the premarital screening service remain available, alongside all the precautionary measures to prevent coronavirus are instructed by the trained medical staff.

4- Methods of premarital health education:

<u>Individual methods(one-on-one)premarital counseling</u>:

d) This is the most traditional and commonly-used method of counseling.
e) It is focus on one couple or one individual only.
f) Premarital counselor conduct face to face sessions and help couples tackletheir issues and develop the appropriate tools to resolve any future problems in their marriage
g) **Advantages:**

3- Provide complete privacy for the client, to ensure confidentiality and promote an environment which encourages the client to communicate
4- Two way communication
5- Easy to make follow up

6- no interruptions or distractions, such as phone calls

- **Disadvantages:**

    - Time consuming.
    - Difficult to cover wide range of people

Group sessions and open discussion:

- Group sessions do not focus on one couple, they can be a valuable experience
- Group sessions can be used for engaging purposes and to elicit helpfuldiscussions that will teach them different perspective and ideas.
- May use videos, posters, printed materials
- Advantages:
    - Group discussion is considered a very effective method of healthteaching.
    - It is a tow-way teaching method.
    - People learn by exchanging their views and experiences.
    - Enhance active participation and interaction.
- Disadvantages
    - Privacy at risk her due to participation of other people.
    - It require coordinate.
    - Can be blocked due to side talking or interruption

Symposium:

- A Symposium is a series of speeches on the selected subject(premaritalscreening program) by experts.
- In symposium, there is no discussion among the members but in the end,the audience may raise question.
- Advantages:
    - Interesting and can draw attention.

• Provide varied knowledge, Ideas and experience.

• A ccomodate large number of participants.

- Disadvantages:

  • No discussion among members.

  • Preparation and teaching takes a lot of hard work.

  • Sometimes it is difficult to get the appropriate experts.

Online premarital counseling:

- In todays technological age an increasing number of Therapists are beginning to see the benefits of offering premarital counseling online.
- This is accomplished through the use of video conferencing programs such as Skype and Face Time.
- Online premarital care programs can take various forms: online courses to deliver premarital counseling, and mobile health (mHealth) apps to provide mental consultations.
- In the midst of the COVID-19 pandemic, it is advisable that couples should stay at home and receive necessary premarital counseling via online programs.
- **Advantages:**
  • Its more flexibility.
  • Save time, cost
- **Disadvantages:**
  • Online not available for all people

Puberty

outlines:

- Introduction
- Definition
  - Definition
  - Types
  - When puberty stats:
- Tanner stages summary

Puberty and Disorders

Introduction

Puberty is the time in life when a boy or girl becomes sexually mature. It is a physiological phase lasting 2 to 5 years, during which the genital organs mature. It is a process that usually happens between ages 10 and 14 for girls and ages 12 and 16 for boys. It causes physical changes, and affects boys and girls differently. The manifestations of puberty in the female include menarche, appearance of secondary sex characters, physical development n psychological changes.

When puberty stats:

Puberty starts when a part of your child's brain called the hypothalamus begins producing a hormone called gonadotropin-releasing hormone (GnRH). The hypothalamus sends GnRH to another part of the brain called the pituitary gland. GnRH stimulates the pituitary gland to release two more hormones — luteinizing hormone (LH) and follicle-stimulating hormone (FSH). These hormones travel to the sex organs (ovaries and testes), triggering them to begin releasing sex hormones (estrogen and testosterone). These messenger hormones cause the telltale signs of puberty to begin.

The symptoms and types of puberty:

Normal Puberty

In Girls

The signs of puberty include:

- Growth of pubic and other body hair
- Growth spurt
- Breast development
- Onset of menstruation (after puberty is well advanced)
- Acne

In Boys

The signs of puberty include:

- Growth of pubic hair, other body hair, and facial hair
- Enlargement of testicles and penis
- Muscle growth
- Growth spurt
- Acne
- Deepening of the voice

Both boys and girls may get acne. They also usually have a growth spurt (a rapid increase in height) that lasts for about 2 or 3 years. This brings them closer to their adult height, which they reach after puberty.

Body odor in puberty

Larger sweat glands also develop during puberty. To prevent body odor, talk with your child about deodorant options and make sure they shower regularly, especially after intense physical activity.

Mood changes in puberty

Is your teen is moody or otherwise behaving differently? Hormones or your child's feelings about physical changes, friends, or school may be the culprit. If you're concerned, there are a number of mental health resources you can find online as well as local support groups, school psychologists, and community programs that may help.

Precocious Puberty

The symptoms of precocious puberty are similar to the signs of normal puberty but they manifest earlier—before the age of 8 in girls and before

age 9 in boys.

Delayed Puberty

Delayed puberty is characterized by the lack of onset of puberty within the normal range of ages.

Tanner stages summary

Tanner stages in females	Age at the start	Noticeable changes
Stage 1	After the 8th birthday	None
Stage 2	From age 9–11	Breast "buds" start to form; pubic hair starts to form
Stage 3	After age 12	Acne first appears; armpit hair forms; height increases at its fastest rate
Stage 4	Around age 13	First period arrives
Stage 5	Around age 15	Reproductive organs and genitals are fully developed

Tanner stages in males	Age at the start	Noticeable changes
Stage 1	After the 9th or 10th birthday	None
Stage 2	Around age 11	Pubic hair starts to form
Stage 3	Around age 13	Voice begins to change or "crack"; muscles get larger
Stage 4	Around age 14	Acne may appear; armpit hair forms
Stage 5	Around age 15	Facial hair comes in

Definition of puberty

- It is the accusation of the ability of capacity of procreation and is associated with certain characteristic changes that are sex-specific.

- It is a gradual process which starts before menarche and continues for the few years after it.

- It is the physiological stage that leads to reproductive capability manifested by spermatogenesis in the male and ovulation in the female.

Conditions that influence the age onset of puberty

- Socioeconomic conditions
- Environmental factors as increased temperature lead to early onset of puberty.
- Nutritional status
- Health status
- Chronic disease
- Genetic factors
- Strenuous physical activity

Management of puberty

This is a duty of the parent and school and ideally comprises the following:

1-Psychological preparation of the girl will ensure that she is not taken by surprise by the beginning of the menstruation and other changes. This is mainly the role of the mother. Frequently monthly mucoid discharge and lower abdominal cramps precede the menarche. This introduction of the girl needs the emphasis of the normality, and provision help and advice on how she will contain the menstrual flow. The girl should be encouraged not to abstain from daily functions (other than those religiously determined), e.g. socializing, sport activity and bathing.

2-The attending symptoms of may need reassurance from the consulted physician.

3-Menstrual irregularities are common in post-menarchal years and usually need nothing but reassurance.