REPRODUCTIVE HEALTH QUESTIONS AND ANSWERS

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Questions and Answers

Question 1

LUGAZI SCHOOL OF NURSING AND MIDWIFERY - NO.116

- List 5 physiological causes of amenorrhea.

- Outline 5 common causes of bleeding in early pregnancy.

- Outline 10 common health problems among adolescents.

ANSWER: Examination Script

1. Pregnancy: This is the most common physiological cause of amenorrhea in women of reproductive age. Hormonal changes during pregnancy (especially high levels of progesterone and estrogen) suppress ovulation and menstruation.
2. Lactation (Breastfeeding): Exclusive and frequent breastfeeding can lead to lactational amenorrhea, especially in the first six months postpartum. The hormone prolactin, which stimulates milk production, can suppress ovulation.
3. Menopause: The natural cessation of menstruation that marks the end of a woman's reproductive years, typically occurring between ages 45-55. Ovarian function declines, leading to decreased estrogen and progesterone production.
4. Pre-puberty: Girls before they reach puberty (menarche, the first menstrual period) do not menstruate because their reproductive system is not yet mature and hormonal cycles have not begun.
5. Use of Certain Contraceptives: Some hormonal contraceptives, such as progestin-only injectables (e.g., Depo-Provera), hormonal IUDs (e.g., Mirena), or continuous-use oral contraceptive pills, can cause amenorrhea as a side effect by suppressing ovulation or thinning the endometrial lining. This is considered a physiological effect of the medication.
6. Stress (sometimes considered physiological if temporary): Severe acute stress can temporarily disrupt the hypothalamic-pituitary-ovarian (HPO) axis, leading to a missed period or temporary amenorrhea. While often linked to pathological causes if chronic, a brief interruption can be a physiological response.
7. Intense Physical Exercise / Low Body Fat (sometimes): Very high levels of physical training, often combined with low body fat (as seen in elite athletes), can disrupt the HPO axis and cause amenorrhea. This is an adaptive physiological response to conserve energy, but can become pathological if prolonged (functional hypothalamic amenorrhea).
1. Implantation Bleeding: Light spotting or bleeding that can occur about 10-14 days after conception when the fertilized egg attaches (implants) into the lining of the uterus. Usually very light and short-lived.

2. Spontaneous Abortion (Miscarriage): This is a common cause of first-trimester bleeding, often accompanied by cramping or abdominal pain. Types include: Threatened Abortion: Bleeding with a closed cervix, pregnancy may continue. Inevitable Abortion: Bleeding with an open cervix, miscarriage will occur. Incomplete Abortion: Some fetal or placental tissue remains in the uterus. Complete Abortion: All products of conception have been expelled.

3. Ectopic Pregnancy: A pregnancy that implants outside the uterus, most commonly in a fallopian tube. This is a life-threatening emergency. Symptoms can include vaginal bleeding (often dark, "prune juice" like, or spotting), abdominal or pelvic pain (often one-sided), and dizziness or fainting if rupture occurs.

4. Gestational Trophoblastic Disease (GTD) / Molar Pregnancy: A rare condition where abnormal trophoblastic tissue (tissue that normally develops into the placenta) grows in the uterus. Can cause vaginal bleeding (often dark brown, like "grape-like clusters"), severe nausea/vomiting, and a uterus larger than expected for dates.

5. Cervical Causes: Bleeding can originate from the cervix due to reasons unrelated to the pregnancy itself, but exacerbated by increased cervical vascularity in pregnancy. Cervical Ectropion/Erosion: Benign condition where glandular cells from inside the cervical canal are present on the outside of the cervix, making it prone to bleeding, especially after intercourse. Cervical Polyps: Benign growths on the cervix that can bleed. Cervicitis: Inflammation or infection of the cervix. Cervical Cancer (rare in pregnancy, but possible).

6. Vaginal Causes: Vaginal infections (e.g., severe yeast infection, bacterial vaginosis) or trauma to the vagina can sometimes cause bleeding.

7. Subchorionic Hematoma: A collection of blood between the uterine lining and the chorion (outer fetal membrane). Can cause bleeding and may increase risk of miscarriage depending on size and location.

1. Mental Health Issues: Depression, anxiety disorders, stress, eating disorders (anorexia, bulimia), self-harm, and suicidal ideation are significant concerns during adolescence.

2. Substance Use and Abuse: Experimentation with and use of alcohol, tobacco (smoking, smokeless), marijuana, and other illicit drugs. Can lead to addiction, accidents, and long-term health problems.

3. Unintentional Injuries / Accidents: Leading cause of death and disability in adolescents. Includes road traffic accidents (as drivers, passengers, pedestrians), drowning, falls, burns, and sports injuries.

4. Sexual and Reproductive Health Issues: Early/Unintended Pregnancy: Can have significant health, social, and economic consequences for adolescent girls. Sexually Transmitted Infections (STIs), including HIV/AIDS: Adolescents are at high risk due to factors like early sexual debut, multiple partners, and inconsistent condom use. Unsafe Abortion: Complications from unsafe abortions are a major cause of maternal mortality among adolescent girls in some regions.

5. Nutritional Problems: Undernutrition/Stunting: Especially in resource-poor settings. Micronutrient Deficiencies: E.g., iron-deficiency anemia (common in adolescent girls), iodine deficiency, vitamin D deficiency. Overweight and Obesity: Increasing globally due to unhealthy diets and physical inactivity, leading to risk of chronic diseases later in life. Disordered Eating Patterns.

6. Violence: Adolescents can be victims or perpetrators of violence, including bullying (physical, verbal, cyberbullying), physical fights, dating violence, sexual assault, and gang-related violence. Forced/early marriage is a form of violence.

7. Skin Conditions: Acne vulgaris is very common and can cause significant psychological distress. Other skin issues like eczema or fungal infections can also occur.

8. Infectious Diseases (other than STIs): Adolescents are still susceptible to common infections like influenza, respiratory infections, and vaccine-preventable diseases if not fully immunized (e.g., measles, meningitis). Tuberculosis can also affect adolescents.

9. Lack of Physical Activity: Many adolescents do not meet recommended levels of physical activity, contributing to risk of obesity and chronic diseases.

10. Dental Health Problems: Dental caries (cavities) and gum disease due to poor oral hygiene and sugary diets.

11. Sleep Deprivation: Due to academic pressures, social activities, and screen time, many adolescents do not get enough sleep, affecting mood, concentration, and physical health.

12. Issues Related to Growth and Development: Concerns about puberty, body image, scoliosis (curvature of the spine).

Question 2

DEFENCE SCHOOL OF NURSING AND MIDWIFERY - NO.117

- Define safe motherhood.

- Outline 5 major causes of maternal mortality and morbidity.

- Explain the 3 delays that predispose to maternal mortality and morbidity.

ANSWER: Examination Script

Safe Motherhood means that all women have access to the information and services they need to go safely through pregnancy and childbirth. It encompasses a series of initiatives, programs, and strategies aimed at reducing maternal deaths (mortality) and illnesses (morbidity) associated with pregnancy and childbirth. The goal is to ensure that women receive high-quality care before, during, and after childbirth, including family planning, antenatal care, skilled attendance at birth, emergency obstetric care, and postnatal care. (The Global Safe Motherhood Initiative was launched in 1987 to improve maternal health and reduce maternal deaths.)

1. Hemorrhage (Severe Bleeding): This is the leading cause of maternal mortality globally. Antepartum Hemorrhage (APH): Bleeding before labor, e.g., from placenta previa (placenta covers cervix) or placental abruption (placenta detaches prematurely). Postpartum Hemorrhage (PPH): Excessive bleeding after childbirth, commonly due to uterine atony (uterus fails to contract), retained placenta or placental fragments, or genital tract lacerations (tears). Bleeding from ectopic pregnancy or abortion complications. Complications: Anemia, shock, organ failure, death.

2. Infections (e.g., Postpartum Sepsis / Puerperal Sepsis): Infection of the genital tract occurring from the onset of labor until 42 days after delivery or miscarriage. Causes: Prolonged rupture of membranes, unhygienic delivery practices, retained products of conception, operative procedures with poor asepsis. Complications: Pelvic abscess, peritonitis, septic shock, death.

3. Hypertensive Disorders of Pregnancy (e.g., Pre-eclampsia, Eclampsia): High blood pressure developing during pregnancy, often with proteinuria and signs of organ damage. Eclampsia involves convulsions. Causes: Can be related to placental issues, genetic factors, pre-existing conditions like kidney disease or chronic hypertension. Complications: Stroke, liver or kidney failure, HELLP syndrome (Hemolysis, Elevated Liver enzymes, Low Platelets), placental abruption, fetal growth restriction, maternal and fetal death.

4. Obstructed Labour / Dystocia: Labor where there is poor or no progress despite good uterine contractions, usually due to cephalopelvic disproportion (baby's head too big for mother's pelvis), malpresentation (e.g., transverse lie, breech), or uterine abnormalities. Complications: Uterine rupture, obstetric fistula (VVF/RVF), maternal exhaustion, infection, fetal distress/death, maternal death.

5. Complications of Unsafe Abortion: Termination of pregnancy by individuals lacking the necessary skills or in an environment lacking minimal medical standards, or both. Complications: Severe bleeding, infection (sepsis), uterine perforation, damage to internal organs, infertility, death.

(Often included as a major cause) 6. Other Direct Causes: Including embolism (e.g., amniotic fluid embolism, pulmonary embolism), and complications of anesthesia.

Indirect Causes also contribute significantly: Pre-existing medical conditions worsened by pregnancy, e.g., malaria, anemia, HIV/AIDS, heart disease, TB.

1. Delay in Decision to Seek Care (Delay I): This refers to the delay by the woman, her family, or the community in recognizing danger signs during pregnancy, labor, or postpartum, and making the decision to seek appropriate medical help from a skilled provider or health facility. Factors Contributing: Lack of awareness of danger signs or seriousness of complications. Financial constraints (inability to pay for services or transport). Low status of women in decision-making within the family or community. Cultural beliefs, traditional practices, or preference for traditional healers/TBAs. Previous negative experiences with the health system. Distance to health facility (perceived or actual). Fear of procedures or costs at the health facility.

2. Delay in Reaching Appropriate Health Facility (Delay II): This is the delay in actually getting to a health facility that can provide the necessary level of care once the decision to seek care has been made. Factors Contributing: Long distance to the health facility. Lack of or high cost of transportation (e.g., no available vehicles, poor roads, difficult terrain, no money for fuel/fare). Poor road infrastructure or geographical barriers (e.g., rivers, mountains). Insecurity or adverse weather conditions. Inefficient referral systems between lower and higher-level facilities.

3. Delay in Receiving Adequate and Appropriate Care at the Health Facility (Delay III): This refers to delays in receiving timely and quality care once the woman arrives at the health facility. Factors Contributing: Shortage of skilled health personnel (doctors, midwives, anesthetists). Lack of essential equipment, drugs, supplies (e.g., blood for transfusion, IV fluids, oxytocics, surgical supplies). Poorly functioning equipment. Inadequate staff training or skills in managing obstetric emergencies. Slow or inefficient facility processes (e.g., delays in assessment, decision-making for C-section, or organizing theatre). Financial barriers at the facility (e.g., user fees, cost of drugs/supplies). Poor staff attitude or communication. Overcrowding or high patient load.

Question 3

NYAKIBALE SCHOOL OF NURSING AND MIDWIFERY - NO.122

- Describe the natural family planning methods.

- List 10 causes of ineffectiveness of a family planning methods.

ANSWER: Examination Script

1. Calendar Rhythm Method (Standard Days Method is a simplified version): Based on calculating the fertile period using the length of past menstrual cycles. Traditional Calendar Rhythm: Requires tracking menstrual cycle lengths for 6-12 months to estimate the fertile window. The first fertile day is estimated by subtracting 18 days from the shortest cycle length, and the last fertile day by subtracting 11 days from the longest cycle length. Standard Days Method (SDM) (e.g., using CycleBeads): Simpler method for women with regular cycles between 26 and 32 days long. Identifies days 8-19 of the cycle as fertile. CycleBeads (a string of colored beads) help track cycle days. Effectiveness: Can be less reliable, especially with irregular cycles, as ovulation can vary.

2. Basal Body Temperature (BBT) Method: Based on detecting the slight rise in a woman's resting body temperature (BBT) that occurs just after ovulation due to progesterone. Process: The woman takes her temperature orally, vaginally, or rectally every morning before getting out of bed or engaging in any activity, using a special BBT thermometer. Temperatures are charted daily. Identifying Fertile Window: The fertile period is considered to end after three consecutive days of elevated temperature are recorded. Abstinence or barrier methods are used from the beginning of the cycle until this temperature rise is confirmed. Limitations: Temperature can be affected by illness, stress, travel, alcohol, disturbed sleep, making interpretation difficult. Identifies ovulation only after it has occurred.

3. Cervical Mucus Method (Ovulation Method / Billings Ovulation Method): Based on observing changes in the characteristics (amount, consistency, appearance) of cervical mucus throughout the menstrual cycle. Process: The woman observes and records her cervical mucus daily. Early cycle (after menstruation): Mucus is often scanty, thick, cloudy, or absent ("dry days"). Approaching ovulation: Mucus becomes more abundant, clearer, wetter, and more slippery and stretchable (like raw egg white - "spinnbarkeit"). This is considered peak fertile mucus. After ovulation: Mucus returns to being thick, cloudy, and scanty, or disappears. Identifying Fertile Window: The fertile period starts with the first sign of any mucus and continues until 3-4 days after the peak day (last day of fertile-quality mucus).

4. Symptothermal Method: Combines several indicators of fertility, typically BBT and cervical mucus changes, and may also include tracking other signs like cervical position changes (cervix becomes softer, higher, more open, and wetter around ovulation - SHOW), ovulation pain (mittelschmerz), or cycle length. Effectiveness: Generally more effective than single-indicator methods because it uses multiple checks.

5. Lactational Amenorrhea Method (LAM): A temporary postpartum method of contraception based on the natural infertility that occurs when a woman is exclusively or fully breastfeeding her baby, her menstrual periods have not returned, and her baby is less than six months old. Criteria for Effectiveness (all three must be met): Amenorrhea: The mother has not had any menstrual bleeding since delivery. Fully or Nearly Fully Breastfeeding: Baby receives only breast milk (or very minimal other liquids infrequently) and breastfeeds frequently day and night, with no long intervals between feeds. Infant is Less Than Six Months Old. Mechanism: Frequent suckling suppresses ovulation. Highly effective (over 98%) if all criteria are met.

6. Coitus Interruptus (Withdrawal / "Pull-out" Method): The man withdraws his penis from the vagina before ejaculation. Not strictly a fertility awareness method but sometimes grouped with NFP. Effectiveness: High failure rate due to pre-ejaculatory fluid potentially containing sperm and the difficulty of timing withdrawal perfectly.

7. Abstinence: Completely avoiding sexual intercourse. 100% effective in preventing pregnancy. Periodic abstinence is required during fertile days when using other NFP methods to avoid pregnancy.

Benefits: No systemic side effects, inexpensive or free, always available, promotes understanding of fertility, acceptable to some religious/cultural groups.

Limitations: Effectiveness depends heavily on correct use and commitment, requires periods of abstinence or barrier use, does not protect against STIs/HIV, daily monitoring can be demanding, some methods are less reliable with irregular cycles or certain life circumstances.

1. Incorrect or Inconsistent Use of the Method: This is the most common reason for method failure. E.g., forgetting to take pills, incorrect condom application, not tracking NFP signs accurately, not abstaining during fertile periods.

2. Method-Specific Failure Rate (Intrinsic Failure): Even with perfect use, all methods (except complete abstinence or sterilization) have a small inherent failure rate.

3. Poor Partner Involvement or Cooperation (for NFP/Withdrawal): If one partner is not fully committed or does not follow the method rules (e.g., for withdrawal or abstinence during fertile days).

4. Lack of Knowledge or Misunderstanding of the Method: If the user does not fully understand how the method works, how to use it correctly, or what to do in case of errors.

5. Irregular Menstrual Cycles (for Calendar-based NFP): Makes it very difficult to predict the fertile window accurately using calendar methods.

6. Difficulty Interpreting Fertility Signs (for Symptom-based NFP): Cervical mucus or BBT changes can be affected by illness, stress, medications, making them hard to interpret correctly.

7. Drug Interactions (for Hormonal Methods): Some medications (e.g., certain antibiotics, anticonvulsants) can reduce the effectiveness of hormonal contraceptives like pills.

8. Vomiting or Severe Diarrhea (for Oral Contraceptives): Can prevent proper absorption of oral contraceptive pills, reducing their effectiveness.

9. Expulsion or Displacement of Device (e.g., IUD, Diaphragm): If an IUD is expelled or a diaphragm is dislodged, it will not be effective.

10. Barrier Method Failure (e.g., Condom Breakage or Slippage): Condoms can break, slip off, or be used incorrectly, leading to failure. Using oil-based lubricants with latex condoms can weaken them.

11. Not Meeting Criteria for LAM (Lactational Amenorrhea Method): E.g., return of menses, baby older than 6 months, not fully/exclusively breastfeeding.

12. Provider Error or Inadequate Counseling: If the healthcare provider gives incorrect information, does not counsel properly on method use, or if a procedure like IUD insertion or sterilization is not performed correctly.

13. High Fecundity (Fertility) of the Couple: Some couples are naturally more fertile and may conceive even with typical use of a less effective method.

Question 4

AGULE SCHOOL OF NURSING AND MIDWIFERY - NO.118

- Who is an adolescent?

- Outline 15 characteristics of youth friendly reproductive health services.

- List 6 barriers that interferes implementation of youth friendly services.

ANSWER: Examination Script

An adolescent is an individual in the period of transition between childhood and adulthood. The World Health Organization (WHO) defines adolescence as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19 years. This phase is characterized by rapid physical, cognitive, psychosocial, and emotional changes, including puberty, development of abstract thinking, identity formation, and increasing independence.

1. Accessible: Services are conveniently located, affordable (or free), have suitable opening hours (e.g., after school), and are easy for young people to reach without major obstacles.

2. Acceptable / Non-Judgmental: Healthcare providers are respectful, empathetic, welcoming, and non-judgmental towards young people, regardless of their sexual activity, orientation, or background.

3. Confidential and Private: Young people are assured that their information and the services they receive will be kept private and confidential, unless there is a risk of serious harm. Separate, private consultation rooms are used.

4. Equitable and Non-Discriminatory: Services are available and provided fairly to all young people, irrespective of gender, ethnicity, socioeconomic status, marital status, sexual orientation, or disability.

5. Comprehensive Range of Services: Offer a broad array of services relevant to youth needs, including contraception, STI/HIV testing and counseling, pregnancy testing and options counseling, antenatal/postnatal care for young mothers, mental health support, and information on healthy relationships.

6. Technically Competent Providers: Healthcare staff are well-trained in adolescent health issues, communication skills with youth, and providing medically accurate information and services.

7. Youth Participation and Involvement: Young people are involved in the planning, design, implementation, and evaluation of services to ensure they meet their needs and preferences.

8. Safe and Welcoming Environment: The clinic or service delivery point is physically clean, safe, comfortable, and creates a welcoming atmosphere for young people (e.g., appropriate decor, youth-friendly information materials).

9. Affordable or Free Services: Cost should not be a barrier. Services should be free or offered at a very low cost that adolescents can afford.

10. Clear Information and Education: Provide clear, accurate, easy-to-understand information about sexual and reproductive health in various formats (verbal, written, visual) that are appropriate for different literacy levels.

11. Respect for Autonomy and Decision-Making: Support young people in making their own informed decisions about their health, providing them with options and respecting their choices (within legal and ethical frameworks).

12. Minimal Waiting Times: Efforts are made to reduce waiting times, as long waits can deter young people from seeking services.

13. Integrated Services: Where possible, SRH services are integrated with other health services young people might need (e.g., general health check-ups, mental health, nutrition counseling) to provide holistic care and reduce stigma.

14. Linkages and Referrals: Effective referral pathways are in place for services not available at the facility (e.g., specialized care, social support services).

15. Outreach and Community Engagement: Services may extend beyond the clinic through outreach programs in schools, youth clubs, or community centers to reach more young people.

1. Negative Attitudes of Healthcare Providers: Judgmental, moralistic, or unsympathetic attitudes from staff can deter young people from seeking or returning to services. Lack of training in adolescent-specific communication.

2. Lack of Confidentiality and Privacy: Fear that personal information will not be kept private or that parents/community members will find out about their visit or the services they received. Inadequate private spaces for consultation.

3. Cost of Services and Products: Even small fees can be a significant barrier for adolescents who often have limited financial resources and may not want to ask parents for money for SRH services.

4. Inconvenient Location and Opening Hours: Clinics located far from where young people live or study, or that are only open during school/work hours, make access difficult.

5. Lack of Awareness or Information About Available Services: Adolescents may not know that youth-friendly services exist, what they offer, or where to find them. Inadequate outreach and promotion.

6. Policy and Legal Barriers: Laws or policies requiring parental consent for certain services (like contraception or STI testing for minors), or age restrictions, can prevent adolescents from accessing needed care independently.

7. Social and Cultural Norms / Stigma: Societal disapproval of adolescent sexuality, premarital sex, or use of contraception can create stigma and make young people hesitant to seek SRH services for fear of judgment or gossip.

8. Limited Range of Services Offered: If a clinic only offers a very narrow range of services, it may not meet the diverse needs of young people, requiring them to go to multiple places.

9. Insufficient Resources and Funding: Lack of funding for staff training, appropriate supplies (e.g., wide range of contraceptives), youth-friendly clinic modifications, and outreach activities.

10. Lack of Youth Involvement in Service Design: If services are not designed with input from young people themselves, they may not be appealing or meet their actual needs and preferences.

Question 5

LIRA COMPREHESIVE SCHOOL OF NURSING AND MIDWIFERY - NO.119

- Outline 5 communication barriers that can be faced during counseling for family planning services.

- Outline the 3 approaches of counseling for Family planning services.

- Explain 5 situations where confidentiality can be broken in counseling.

ANSWER: Examination Script

1. Language Differences and Use of Jargon: If the counselor and client do not share a common language fluently, or if the counselor uses technical medical terms that the client does not understand, effective communication is hindered.
2. Provider Bias or Judgmental Attitude: If the counselor imposes their own values, beliefs, or judgments about family planning methods, sexual activity, or family size, it can make the client feel uncomfortable, ashamed, or unwilling to share openly or ask questions.
3. Lack of Privacy and Confidentiality (or Perceived Lack): If counseling sessions are not conducted in a private setting, or if the client fears their information will not be kept confidential, they may be reluctant to discuss sensitive personal matters.
4. Client Factors (Fear, Embarrassment, Misinformation, Low Literacy): Clients may feel shy, embarrassed, or afraid to discuss sexual matters or family planning. They may also have pre-existing misinformation or cultural myths about contraception, or low literacy levels that make it difficult to understand information provided.
5. Inadequate Listening Skills or Time Constraints on the Part of the Counselor: If the counselor does not listen actively to the client's needs, concerns, and preferences, or if they are rushed due to high patient load, the counseling may be ineffective and client-centeredness is lost.
6. Cultural and Religious Beliefs: Deeply held cultural or religious views about family size, contraception, or gender roles can create barriers if not respectfully acknowledged and addressed during counseling.
7. Non-Verbal Communication Mismatches: Inappropriate body language, lack of eye contact (or too much, depending on culture), or facial expressions from either the counselor or client can send conflicting messages and impede trust.

1. The GATHER Approach (A step-by-step guide for counseling): This is a widely used framework. G - Greet: Welcome the client warmly and establish rapport. A - Ask: Ask the client about themselves, their needs, reproductive goals, previous experiences with family planning, and any concerns. Listen actively. T - Tell: Tell the client about different family planning methods that might suit their needs, including how they work, effectiveness, benefits, side effects, and how to use them. Use clear, simple language and visual aids if helpful. H - Help: Help the client make an informed choice by discussing the pros and cons of methods they are interested in, addressing their concerns, and ensuring they understand. E - Explain: Explain clearly how to use the chosen method correctly, what to do if problems arise, and when to return for follow-up. R - Return: Schedule a return visit or explain when and why they should come back. Ensure they know they can return anytime they have questions or concerns.

2. Client-Centered Approach (Person-Centered Counseling): This approach emphasizes the client's autonomy and their central role in the decision-making process. Focus: The counselor's role is to facilitate the client's exploration of their own needs, values, and feelings regarding family planning. Core Conditions: The counselor exhibits empathy (understanding the client's perspective), genuineness (being authentic), and unconditional positive regard (accepting the client without judgment). Process: Involves active listening, reflecting feelings, asking open-ended questions, and empowering the client to make choices that are right for them. The counselor provides information as requested but does not direct the decision.

3. The Balanced Counseling Strategy (BCS) / BCS Plus: A more structured, evidence-based approach using job aids (like counseling cards) to ensure comprehensive and accurate information is provided about a range of methods. Process: The counselor uses a set of cards that describe different contraceptive methods. They guide the client through the cards, discussing each method's characteristics (effectiveness, side effects, how it works, return to fertility, STI protection). Goal: To help clients make an informed choice by comparing methods systematically. BCS Plus may incorporate additional topics like STI prevention or dual protection.

(Another common framework) 4. The REDI Framework (Rapport-building, Exploration, Decision-making, Implementation): A structured approach to counseling. R - Rapport-building: Establishing a trusting relationship. E - Exploration: Understanding the client's needs, concerns, and context. D - Decision-making: Helping the client weigh options and make an informed choice. I - Implementation: Explaining how to use the chosen method and planning for follow-up.

1. Risk of Serious Harm to Self (Client is Suicidal): If a counselor has a credible reason to believe that a client is a serious and imminent danger to themselves (e.g., expresses clear suicidal intent with a plan), the counselor has a duty to protect the client. This may involve informing family members, crisis services, or authorities to ensure the client's safety.

2. Risk of Serious Harm to Others (Client Threatens Violence): If a client makes a credible threat of serious violence against an identifiable third party, the counselor may have a "duty to warn" or "duty to protect" that person. This could involve notifying the potential victim and/or law enforcement.

3. Suspected Child Abuse or Neglect: In many jurisdictions, healthcare providers and counselors are mandated reporters. If a counselor learns of or suspects that a child is being abused (physically, sexually, emotionally) or neglected, they are legally obligated to report this to child protective services or the police.

4. Suspected Abuse of Vulnerable Adults: Similar to child abuse, if a counselor learns of or suspects abuse or neglect of a vulnerable adult (e.g., an elderly person or an adult with disabilities who cannot protect themselves), they may be legally required to report it to adult protective services or appropriate authorities.

5. When Required by Court Order or Law: If a court issues a subpoena or court order requiring the counselor to release client records or testify, the counselor may be legally obligated to comply, though they should seek legal advice and try to protect client confidentiality as much as legally possible.

6. Client Gives Written Consent for Disclosure: If the client gives informed, written consent for their information to be shared with a specific third party (e.g., another healthcare provider, a family member, an employer), then confidentiality can be "broken" within the limits of that consent.

7. During Professional Supervision or Consultation (with caveats): Counselors may discuss cases with supervisors or colleagues for professional guidance. However, client identity should be protected (e.g., by using anonymous details), and these consultations are also bound by confidentiality. This is more about improving care than a true "breach" from the client's perspective if done correctly.

Question 6

KABALE SCHOOL OF COMPREHENSIVE NURSING - NO.120

- List 10 common sexually transmitted infections.

- Outline 7 (seven) factors that make adolescents at high risk of sexually transmitted infections.

- Explain 8 major points you would educate a client after treatment of sexually transmitted infections.

ANSWER: Examination Script

1. Chlamydia
2. Gonorrhea
3. Syphilis
4. Human Papillomavirus (HPV) Infection (causing genital warts and some cancers)
5. Genital Herpes (HSV-1 or HSV-2)
6. Human Immunodeficiency Virus (HIV) Infection
7. Trichomoniasis ("Trich")
8. Hepatitis B (HBV)
9. Hepatitis C (HCV) (can be sexually transmitted, though less commonly than HBV)
10. Mycoplasma genitalium
11. Pubic Lice ("Crabs")
12. Scabies (can be sexually transmitted through close skin contact)

1. Early Sexual Debut: Starting sexual activity at a younger age often means less knowledge about STIs and contraception, and potentially more partners over time. The cervix in adolescent girls is also biologically more susceptible to some STIs like chlamydia.

2. Multiple Sexual Partners / Serial Monogamy: Having more than one sexual partner (concurrently or sequentially over a short period) significantly increases the probability of encountering an infected partner.

3. Inconsistent or Incorrect Condom Use: Adolescents may not use condoms every time they have sex, or may not use them correctly, due to lack of knowledge, embarrassment, access issues, partner refusal, or perceived low risk.

4. Biological Susceptibility (especially for adolescent girls): The adolescent female cervix has a larger area of ectropion (exposed columnar epithelial cells) which is more vulnerable to infections like chlamydia and gonorrhea. They also have less developed immunity.

5. Lack of Comprehensive Sexuality Education and Knowledge: Insufficient or inaccurate information about STI transmission, symptoms (many STIs are asymptomatic), prevention methods, and where to access services.

6. Substance Use (Alcohol and Drugs): Use of alcohol or drugs can impair judgment, leading to risky sexual behaviors such as unprotected sex or sex with multiple partners.

7. Barriers to Accessing Sexual and Reproductive Health Services: Including lack of youth-friendly services, concerns about confidentiality, cost, inconvenient hours/location, provider bias, or legal restrictions (e.g., needing parental consent). This can delay testing and treatment.

8. Peer Pressure and Social Norms: Influence from peers to engage in sexual activity or risky behaviors. Social norms that discourage open discussion about sex or condom use.

9. Power Imbalances in Relationships / Coercion: Adolescents, particularly girls, may be in relationships where they have less power to negotiate safer sex practices or refuse unwanted sex.

10. Perceived Invulnerability ("It won't happen to me"): A common adolescent trait of underestimating personal risk.

1. Importance of Completing Full Course of Medication (if applicable): Emphasize taking all prescribed antibiotics or antiviral medications exactly as directed, even if symptoms improve before finishing, to ensure the infection is fully eradicated and to prevent drug resistance.

2. Abstinence from Sexual Activity During and Shortly After Treatment: Advise abstaining from sexual contact until they (and their partner(s)) have completed treatment and symptoms have resolved (usually for about 7 days after single-dose treatment or completion of multi-dose regimen) to prevent re-infection or transmission.

3. Partner Notification and Treatment: Stress the critical importance of informing all recent sexual partners (e.g., within the last 60 days or more, depending on the STI) so they can also be tested and treated, even if they have no symptoms. This helps prevent re-infection of the client and further spread of the STI in the community. Discuss options for partner notification (e.g., client informs them, provider assists, anonymous notification services if available).

4. Consistent and Correct Condom Use for Future Prevention: Educate on how to use male or female condoms correctly and consistently for every sexual encounter to reduce the risk of acquiring new STIs or transmitting existing ones (like viral STIs that are managed but not cured, e.g., herpes, HIV).

5. Importance of Follow-up Testing (Test-of-Cure or Re-screening): Explain if a follow-up test is needed to confirm the infection is cured (e.g., for gonorrhea, chlamydia in some cases, especially if pregnant or compliance is a concern) or to re-screen for re-infection (recommended for chlamydia and gonorrhea 3 months after treatment due to high re-infection rates).

6. Recognizing Symptoms of Recurrence or New Infection: Educate the client on common STI symptoms (though many are asymptomatic) and advise them to seek medical attention promptly if they experience any new or recurrent symptoms.

7. Reducing Future Risk / Safer Sex Practices: Discuss strategies to reduce future risk, such as limiting the number of sexual partners, knowing a partner's sexual history, avoiding alcohol/drug use that impairs judgment, and regular STI screening if sexually active with new or multiple partners. Discuss mutual monogamy with an uninfected, tested partner.

8. Information about the Specific STI and its Potential Long-Term Consequences (if untreated or recurrent): Provide clear, simple information about the STI they were treated for, including how it's transmitted and potential long-term health problems if it recurs or if partners are not treated (e.g., PID, infertility, chronic pain for chlamydia/gonorrhea; neurological or cardiovascular damage for syphilis; cancer risk for HPV). This reinforces the importance of prevention and partner treatment.

9. Availability of Other SRH Services: Inform about other available services like HIV testing/counseling, contraception, and vaccinations (e.g., HPV, Hepatitis B) if appropriate.

10. Address Questions and Concerns: Provide an opportunity for the client to ask any questions and address any anxieties or misconceptions they may have in a confidential and non-judgmental manner.

Question 7

MILDMAY UGANDA SCHOOL OF NURSING AND MIDWIFERY - NO.121

- With a well labeled diagram

- Describe the male reproductive system

- List 8 (eight) conditions that can occur in the male reproductive organs interfering its normal reproductive functions

- Outline 4 warning signs of andropause

ANSWER: Examination Script

External Genital Organs: Penis: The external male copulatory organ. Composed of erectile tissue (corpora cavernosa and corpus spongiosum) that fills with blood to cause an erection. The urethra passes through the corpus spongiosum and opens at the tip of the glans penis. Functions: Sexual intercourse and urination. Scrotum: A sac of skin and muscle that hangs outside the abdominal cavity, behind the penis. It houses the testes and epididymides. Its function is to maintain the testes at a temperature slightly lower than body temperature, which is optimal for sperm production.

Internal Reproductive Organs: Testes (Testicles): Two oval-shaped glands located in the scrotum. Functions: Spermatogenesis: Production of sperm in the seminiferous tubules. Hormone Production: Production of male sex hormones, primarily testosterone, by Leydig cells (interstitial cells). Epididymis: A long, coiled tube located on the posterior surface of each testis. Functions: Site of sperm maturation (sperm become motile and fertile here) and temporary storage of sperm. Vas Deferens (Ductus Deferens): A muscular tube that transports mature sperm from the epididymis up into the pelvic cavity, over the bladder, towards the ejaculatory duct. It is part of the spermatic cord. Ejaculatory Ducts: Formed by the union of the duct from the seminal vesicle and the vas deferens. These short ducts pass through the prostate gland and empty sperm and seminal fluid into the prostatic urethra during ejaculation. Urethra: A tube that extends from the urinary bladder, through the prostate gland and penis, to the external urethral meatus (opening at the tip of the penis). Functions: Carries urine from the bladder out of the body, and also carries semen out of the body during ejaculation. (Shared pathway for urinary and reproductive systems).

Accessory Glands: These glands produce fluids that mix with sperm to form semen. Seminal fluid nourishes sperm, helps transport them, and neutralizes the acidity of the male urethra and female vagina. Seminal Vesicles (2): Glands located posterior to the bladder. They produce a thick, alkaline, fructose-rich fluid that makes up about 60-70% of semen volume, providing energy for sperm. Prostate Gland (1): A single gland located below the bladder, surrounding the urethra. Produces a thin, milky, slightly acidic fluid that contributes to semen volume (about 20-30%) and contains enzymes that activate sperm and enhance their motility. Bulbourethral Glands (Cowper's Glands) (2): Small glands located inferior to the prostate, at the base of the penis. During sexual arousal, they secrete a clear, alkaline mucus (pre-ejaculate) that lubricates the urethra and neutralizes any acidic urine residue before ejaculation.

Semen: A mixture of sperm and seminal fluid from the accessory glands. Ejaculated during orgasm.

1. Erectile Dysfunction (ED): The inability to achieve or maintain an erection firm enough for satisfactory sexual intercourse. Interferes with sperm delivery.

2. Varicocele: Enlargement of veins within the scrotum (pampiniform plexus). Can impair sperm production and quality by increasing testicular temperature. A common cause of male infertility.

3. Infections (e.g., Orchitis, Epididymitis, Prostatitis, STIs): Inflammation or infection of the testes (orchitis), epididymis (epididymitis), or prostate gland (prostatitis) can damage sperm production, maturation, or transport pathways. STIs like gonorrhea or chlamydia can cause urethritis and blockages.

4. Testicular Torsion: Twisting of the spermatic cord, which cuts off blood supply to the testis. A surgical emergency that can lead to loss of the testis and infertility if not treated promptly.

5. Undescended Testis (Cryptorchidism): Failure of one or both testes to descend into the scrotum during fetal development. If not corrected, can lead to impaired sperm production due to higher temperature in the abdomen, and increased risk of testicular cancer.

6. Hypogonadism (Low Testosterone): Reduced production of testosterone by the testes. Can lead to decreased libido, erectile dysfunction, and impaired sperm production.

7. Obstruction of Sperm Ducts: Blockages in the epididymis, vas deferens, or ejaculatory ducts (e.g., due to infection, surgery, congenital absence of vas deferens) can prevent sperm from being ejaculated (obstructive azoospermia).

8. Retrograde Ejaculation: Semen enters the bladder during orgasm instead of emerging through the penis. Can be caused by prostate surgery, certain medications, or nerve damage (e.g., from diabetes).

9. Testicular Cancer: Malignant tumor of the testis. Treatment (surgery, chemotherapy, radiotherapy) can affect fertility.

10. Benign Prostatic Hyperplasia (BPH) / Prostatitis: While primarily affecting urinary function, severe BPH or chronic prostatitis can sometimes affect ejaculation or cause discomfort that interferes with sexual function.

11. Genetic Conditions: E.g., Klinefelter syndrome (XXY), Y-chromosome microdeletions can cause impaired sperm production.

1. Decreased Libido (Low Sex Drive) and Sexual Dysfunction: Reduced interest in sex, difficulty achieving or maintaining erections (erectile dysfunction), or decreased sexual satisfaction.

2. Fatigue, Low Energy Levels, and Decreased Stamina: Persistent tiredness, lack of motivation, feeling easily exhausted, and a general decline in physical endurance.

3. Mood Changes and Cognitive Issues: Increased irritability, sadness, or symptoms of depression. Difficulty concentrating, memory problems ("brain fog"). Decreased motivation or drive.

4. Physical Changes: Decreased muscle mass and strength. Increased body fat, especially abdominal fat. Reduced bone density (osteoporosis risk). Hair loss (body or facial hair). Sometimes, breast discomfort or enlargement (gynecomastia). Hot flashes or sweats (less common than in female menopause but can occur).

5. Sleep Disturbances: Difficulty falling asleep (insomnia) or staying asleep, or changes in sleep patterns.