



Federal Democratic Republic of Ethiopia
Ministry of Health

Adolescent and Youth Reproductive Health

Blended Learning Module for
the Health Extension Programme



HEAT

Health Education and Training
HEAT in Africa



Federal Democratic Republic of Ethiopia Ministry of Health

The Ethiopian Federal Ministry of Health (FMOH) and the Regional Health Bureaus (RHBs) have developed this innovative Blended Learning Programme in partnership with the HEAT Team from The Open University UK and a range of medical experts and health science specialists within Ethiopia. Together, we are producing 13 Modules to upgrade the theoretical knowledge of the country's 33,000 rural Health Extension Workers to that of Health Extension Practitioners and to train new entrants to the service. Every student learning from these Modules is supported by a Tutor and a series of Practical Training Mentors who deliver the parallel Practical Skills Training Programme. This blended approach to work-place learning ensures that students achieve all the required theoretical and practical competencies while they continue to provide health services for their communities.

These Blended Learning Modules cover the full range of health promotion, disease prevention, basic management and essential treatment protocols to improve and protect the health of rural communities in Ethiopia. A strong focus is on enabling Ethiopia to meet the Millennium Development Goals to reduce maternal mortality by three-quarters and under-5 child mortality by two-thirds by the year 2015. The Modules cover antenatal care, labour and delivery, postnatal care, the integrated management of newborn and childhood illness, communicable diseases (including HIV/AIDS, malaria, TB, leprosy and other common infectious diseases), family planning, adolescent and youth reproductive health, nutrition and food safety, hygiene and environmental health, non-communicable diseases, health education and community mobilisation, and health planning and professional ethics.

In time, all the Modules will be accessible from the Ethiopian Federal Ministry of Health website at www.moh.gov.et; online versions will also be available to download from the HEAT (Health Education and Training) website at www.open.ac.uk/africa/heat as open educational resources, free to other countries across Africa and anywhere in the world to download and adapt for their own training programmes.

Dr Kesetebirhan Admasu
State Minister of Health

Acknowledgements

Adolescent and Youth Reproductive Health is one of the 13 Blended Learning Modules for the Ethiopian Health Extension Programme. Together with the practical skills training sessions that accompany each of the supported self-study texts, this programme will upgrade the Health Extension Workers who complete the curriculum to Health Extension Practitioners at Level-IV of the Ethiopian Occupational Standards. The upgrading programme is sponsored by the Ethiopian Federal Ministry of Health (FMOH) and the Regional Health Bureaus (RHBs). The FMOH gratefully acknowledges the receipt of funding for this programme from the Ethiopian Office of UNICEF (the United Nations Children’s Emergency Fund), The Open University UK, the Alan and Nesta Ferguson Foundation Trust UK, and AMREF (the African Medical and Research Foundation). We are also thankful for the support of the Ethiopian Offices of Jhpiego and the World Health Organisation (WHO) for freely enabling their experts to participate in the development of this module.

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Ato Mohammed Hussein Abeseko, UNICEF Ethiopia and the Federal Ministry of Health

Ato Tedla Mulatu, AMREF Ethiopia

The cover design for *Adolescent and Youth Reproductive Health* is by Chris Hough, Learning and Teaching Solutions, The Open University UK. The cover photographs are reproduced with the permission of Dr Zewditu Kebede.

We particularly wish to acknowledge our use in this Module of adapted extracts and illustrations from *National Comprehensive Reproductive Health Services for Adolescents and Youth: A Training Manual for Health Workers in Ethiopia* (2008), which was based on the Comprehensive Reproductive Health and Family Planning Training Curriculum, Module 16: *Reproductive Health Services for Adolescents* by Judith Senderowitz, Cathy Solter, and Gwyn Hainsworth, Pathfinder International, revised 2004.

The opinions expressed in this Module are those of the authors and do not necessarily reflect the views of any of the donor organisations whose generous support made the production of *Adolescent and Youth Reproductive Health* possible.

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Introduction to the *Adolescent and Youth Reproductive Health* Module

Ethiopia is a country with an overwhelmingly young population. About 63% of the total population of Ethiopia is below the age of 25 years. Young people of ages 10–24 are the largest group to be entering adulthood in Ethiopian history. This cohort of young people makes up 25% of the total population (2007 Census). The health of young people is directly affected by the socio-cultural and economic context in which they live. This young section of the population in Ethiopia is faced with multiple and interrelated social, economic and health problems.

Gender inequality, sexual coercion, early marriage, high levels of teenage pregnancy, unsafe abortion and sexually transmitted infections (STIs), including HIV, and AIDS, are among the sexual and reproductive health problem faced by many young Ethiopians. These are further complicated by limited access to reproductive health information and good quality adolescent and youth-friendly reproductive health services in the country.

Being aware of the various interrelated and complex reproductive health problems that young Ethiopians face, the Government of Ethiopia has shown its commitment to improving the reproductive health status of young Ethiopians through issuing the National Adolescent and Youth Reproductive Health Strategy (Federal Ministry of Health, (FMOH) 2007). The National Adolescent and Youth Reproductive Health Strategy reaffirms the government's commitment by setting forth its priorities and agenda for a decade.

In line with the strategy, the Federal Ministry of Health has also developed service delivery guidelines and standards and training manuals on youth-friendly reproductive health services. Health workers have an important role in improving the reproductive health of young people in Ethiopia. As a community health practitioner, you can contribute to the improvement of the reproductive health of young people through various means. Young people have needs that are quite different from those of older people. Understanding their special needs is key to helping them. Providing them with the appropriate information and services, mobilising the community in support of adolescent and youth reproductive health programmes, and working with and for young people are the major interventions that you can focus on in your community.

In this Module, you will learn about adolescent and youth reproductive health in detail. Beginning with the introduction to adolescent and youth reproductive health, you will learn that the major sexual and reproductive health problems that face young people include unwanted pregnancy and unsafe abortion, sexually transmitted infections including HIV, harmful traditional practices, gender-based violence and substance use. You will learn that young people have specific vulnerabilities and are inclined to indulge in risk-taking behaviour. To counteract these vulnerabilities, young people need life skills, and you will learn how to help them acquire these skills through education and counselling. You will also counsel young people on a range of issues related to their sexual and reproductive health, including contraceptive options. To be able to do this you will learn how to promote and provide adolescent and youth friendly services. Finally, you will learn how you can manage adolescent and youth reproductive health programmes in your community.

As this Module was going to press the World Health Organization (2011) collected together the core sexual and reproductive health (SRH) competencies that are desirable for use in primary health care. This can be accessed at:
http://www.who.int/reproductivehealth/publications/health_systems/9789241501002/en/index.html

Study Session I Introduction to Adolescent and Youth Reproductive Health (AYRH)

Introduction

More than a quarter of the world's population is between the ages of 10 and 24, with 86% living in less developed countries. These young people are tomorrow's parents. The reproductive and sexual health decisions they make today will affect the health and wellbeing of their communities and of their countries for decades to come.

In particular, two issues have a profound impact on young people's sexual health and reproductive lives: family planning and HIV/AIDS. Teenage girls are more likely to die from pregnancy-related health complications than older women in their 20s. Statistics indicate that one-half of all new HIV infections worldwide occur among young people aged 15 to 24.

In this study session you will learn about changes during adolescence and why it is important to deal with adolescents' reproductive health problems. You will learn about factors affecting adolescents' risk-taking behaviours and its consequences. You will also learn the importance of raising awareness about adolescent reproductive health rights.

Learning Outcomes for Study Session I

When you have studied this session, you should be able to:

- 1.1 Define and use correctly all of the key words printed in **bold**. (SAQs 1.1 and 1.5)
- 1.2 Show that you understand that different groups of adolescents have different needs. (SAQs 1.1 and 1.5)
- 1.3 Briefly describe the biological and psychosocial changes during adolescence. (SAQ 1.2)
- 1.4 Explain why adolescents are especially vulnerable to reproductive health risks. (SAQ 1.3)
- 1.5 Show that you are aware of adolescent reproductive health rights and the need to provide appropriate information and services. (SAQ 1.4)

1.1 Why it is important to provide services for adolescents and young people

The World Health Organization (WHO) defines an **adolescent** as an individual in the 10–19 years age group and usually uses the term **young person** to denote those between 10 and 24 years. In this Module we will use these definitions and also the terms **early adolescence** (10–14), **late adolescence** (15–19) and **post-adolescence** (20–24), because they are helpful in understanding the problems and designing appropriate interventions for young people of different ages. You will explore the relevance of this classification in greater detail in Study Sessions 10 and 12 which discuss how you can promote and provide adolescent and youth-friendly reproductive services.

Adolescence is a period of transition from childhood to adulthood during which adolescents develop biologically and psychologically and move towards independence. Although we may think of adolescents as a healthy group, many die prematurely and unnecessarily through accidents, suicide, violence and pregnancy-related complications. Some of the serious conditions of adulthood (for example, sexually transmitted infections (STIs), like HIV; and tobacco use) have their roots in adolescent behaviour.

Studies show that young people are not affected equally by reproductive health problems. Orphans, young girls in rural areas, young people who are physically or mentally impaired, abused or have been abused as children and those migrating to urban areas or being trafficked are more likely to have problems.

Despite their numbers, adolescents have not traditionally been considered a health priority in many countries, including Ethiopia. While the country has been implementing major interventions to reduce child mortality and morbidity, interventions addressing the health needs of young people have been limited. Young people often have less access to information, services and resources than those who are older. Health services are rarely designed specifically to meet their needs and health workers only occasionally receive specialist training in issues pertinent to adolescent sexual health. It is perhaps not surprising therefore that there are particularly low levels of health-seeking behaviour among young people. Similarly, young people in a variety of contexts have reported that access to contraception and condoms is difficult.

The negative health consequences of adolescents can pass from one generation to the next. For example, babies born to adolescent mothers have a high risk of being underweight or stillborn. They are also likely to suffer from the same social and economic disadvantages encountered by their mothers. That is why addressing the needs of adolescents is an intergenerational investment with huge benefits to subsequent generations (see Figure 1.1).

If the nation is to address its rapid population growth, it is crucial to acknowledge the importance of the reproductive health concerns of adolescents and young people, particularly in their decisions related to avoidance of unwanted pregnancy.

1.2 Strategies for promoting the reproductive health of young people

The Government of Ethiopia has adopted policies and strategies to address some of the social, economic, educational and health problems faced by young people. Currently, national programmes are guided by a 10-year plan which is based on the ‘National Adolescent and Youth Reproductive Health Strategy 2006–2015’. Other key documents indicating government commitment include the Young People Policy issued in 2000, the Policy on HIV/AIDS launched in 1998, the Revised Family Laws amended in 2000 to protect young women’s rights, (for example against forced marriages), and the Revised Penal Code, which penalises sexual violence and many harmful traditional practices.



Figure 1.1 Young people are the future of societies and their needs should be addressed in order to have healthy and productive citizens.

When developing and implementing interventions you need to take into account that while many adolescents and young people share common characteristics, their needs vary by age, sex, educational status, marital status, migration status and residence. When developing and implementing interventions you need to appreciate that you will have to work in different ways with different age groups.

An activity that is suitable for those in early adolescence (10–14 years old) may not be suitable for those in post-adolescence (20–24 years old). For instance, those in their early adolescence are more likely to be in primary schools, not yet married and hence less likely to have started sexual relationships, all of which determine the type of information and services that would be appropriate for them.

You need to give special attention to these vulnerable young adolescents (aged 10–14) and those at risk of irreversible harm to their reproductive health and rights (e.g. through forced sex, early marriage, poverty-driven exchanges of sex for gifts or money, and violence). As has already been mentioned, some groups are more vulnerable than others and it is to vulnerable individuals that you need to offer most help. In this Module you will gain an understanding of who these vulnerable individuals are and insight into their difficulties, and you will learn how you can help them.

You may have already recognised that men and women are not treated equally in your community. In general, girls and women are treated as inferior and they are given fewer privileges and less access to resources. The roles they have within your community are different to the roles given to men. **Gender** refers to the socially and culturally defined roles for males and females. These roles are learned over time, can change from time to time, and vary widely within and between cultures. In Study Session 6 there will be a discussion of the way that women are treated unfairly because of the way they are viewed within many communities. This gender inequality means that girls and women need your help to safeguard their sexual and reproductive health to a greater extent than do young boys and men.

In this Module you will also learn how you can help provide a group of services for young people, such as counselling, family planning, voluntary counselling and testing for sexually transmitted infections (STIs) including HIV, maternal and child health, and post-abortion care. You will learn how to involve other members of your community and how to find ways of working with them and you will recognise when you need to refer individuals for help at the next level of health facility.

1.3 Protecting adolescent sexual and reproductive health

Adolescent sexual and reproductive health refers to the physical and emotional wellbeing of adolescents and includes their ability to remain free from unwanted pregnancy, unsafe abortion, STIs (including HIV/AIDS), and all forms of sexual violence and coercion.

One of the important concerns of young people is their sexual relationships. In particular, young people need to know how they can maintain healthy personal relationships. It is important to keep in mind that sex is never 100% 'safe', but you can advise young people on how to make sex as safe as they possibly can. That is why you should always talk about 'safer' sex and not 'safe sex'.

As a Health Extension Practitioner, you need to educate young people in what constitutes safer sex and the consequences of unsafe sexual practices. **Safer sex** is anything that can be done to lower the risk of STIs/HIV and pregnancy without reducing pleasure. The term reflects the idea that choices can be made and behaviours adopted to reduce or minimise risk.

Sexual activities may be defined as high risk, medium risk, low risk, or no risk based on the level of risk involved in contracting HIV or other STIs.

No risk

There are many ways to share sexual feelings that are not risky. Some of them include hugging, holding hands, massaging, rubbing against each other with clothes on, sharing fantasies, and self-masturbation.

Low risk

There are activities that are probably safe, such as using a condom for every act of sexual intercourse, masturbating your partner or masturbating together as long as males do not ejaculate near any opening or broken skin on their partners.

Medium risk

There are activities that carry some risk, such as introducing an injured finger into the vagina. Note that having sexual intercourse with improper use of a condom also carries a risk of HIV/STI transmission.

High risk

There are activities that are very risky because they lead to exposure to the body fluids in which HIV lives. This refers to having unprotected sexual intercourse.

Dual protection is the consistent use of a male or female condom in combination with a second contraceptive method, such as oral contraceptive pills. Often young people come to a healthcare facility for contraception and are given a method that protects them only from pregnancy. As a healthcare provider, you should ensure that all young people are using a method or combination of methods that protect them from both pregnancy and STIs/HIV to minimise their risk to the lowest level possible. Box 1.1 shows important components of adolescent and youth reproductive health programmes that should be available to all young people.

Box 1.1 Services that should be provided for young people

- Information and counselling on sexual and reproductive health issues
- Promotion of healthy sexual behaviours
- Family planning information, counselling and methods of contraception (including emergency contraceptive methods)
- Condom promotion and provision
- Testing and counselling services for pregnancy, HIV and other STIs
- Management of STIs

- Antenatal care (ANC), delivery services, postnatal care (PNC) and pregnant mother-to-child transmission (PMTCT)
- Abortion and post-abortion care
- Appropriate referral linkage between health facilities at different levels.

1.4 Biological and psychosocial changes during adolescence

For young people, adolescence is all about change: in the way they think, in their bodies and in how they relate to others. As a Health Extension Practitioner it is important for you to know these changes in order to understand the special needs of young people and provide appropriate services.

1.4.1 Changes in thinking and reasoning (cognition)

Children tend to be **concrete thinkers**, mostly relying on literal, straightforward interpretation of ideas. In adolescence they become **abstract thinkers**, as they begin to be able to think abstractly and to conceptualise abstract ideas such as love, justice, fairness, truth and spirituality.

They start to analyse situations logically in terms of cause and effect, think about their futures, evaluate alternatives, set personal goals and make mature decisions.

As their abilities to think and reason increase, adolescents will become increasingly independent, and take on increased responsibilities. They will also often challenge the ideas of the adults in their community and this can lead to friction (see Figure 1.2).



Figure 1.2 Son disobeying his father's commands.

1.4.2 Physical changes

Puberty is the time in which sexual and physical characteristics mature (see Figure 1.3). The exact age a child enters puberty depends on a number of different things, such as genes, nutrition and sex. Most girls and boys enter puberty between 10–16 years of age although some start earlier or later. Girls tend to enter puberty two years before boys.

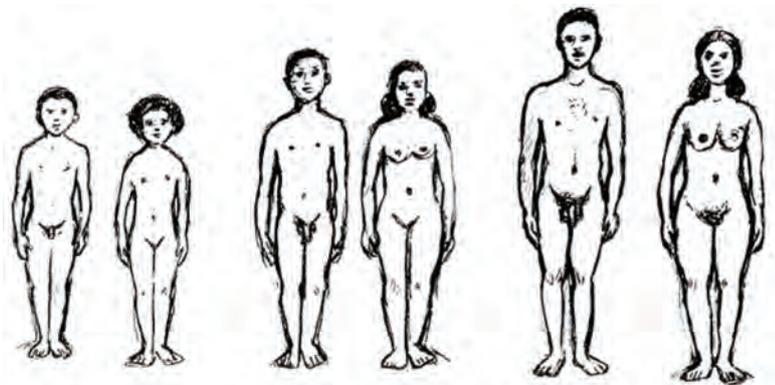


Figure 1.3 Young people at different age groups (showing physical changes) at ages 10–14, 15–19 and 20–24 from the left to the right.

Box 1.2 details the main physical changes that occur during puberty in males and females. It is the changing hormonal activity within their bodies that brings about these changes.

Box 1.2 Physical changes during adolescence

Physical changes observed in females:

- Skin becomes oily, sometimes with pimples and acne
- Hair grows under arms, pubic area, legs
- Breasts grow
- Hips broaden, weight and height increase, hands, feet, arms, and legs become larger
- Perspiration increases and body odour may appear
- Voice deepens
- Menstruation begins, more wetness in the vaginal area.

Physical changes observed in males:

- Skin becomes oily, sometimes with pimples and acne
- Hair grows under arms, pubic areas, legs, chest, face
- Muscles especially in legs and arms get bigger and stronger
- Shoulders and chest broaden, weight and height increase, hands, feet, arms and legs become larger
- Perspiration increases and body odour may appear
- Voice cracks and then deepens
- Penis and testicles grow and begin to hang down
- Wet dreams and erection occur frequently
- Ejaculation occurs during sexual climax.

1.4.3 Social and emotional changes

As adolescents grow physically they also think and feel differently. Box 1.3 details the main social and emotional changes that take place. Some of these changes in the way they think are a consequence of growing older and learning more about the world and the way other people think and behave. But changes in the way they feel are more likely to be a consequence of the hormonal changes in their bodies. These changed feelings can often be a source of confusion and unhappiness. In this Module you will learn how you can help young people to prepare for these changes and to understand them.

Box 1.3 Social and emotional changes during puberty

- Starting to think independently/make decisions for themselves
- Starting to have sexual feelings
- Experimentation and curiosity (sexual intercourse, alcohol, drugs and other stimulants)
- Friends may matter more than they used to (what they wear, do, how they speak and use language – e.g. slang and informal speech)

- Mood changes
- Need for privacy
- Concern about body image, need to be seen as attractive and able to sexually attract people
- Need to break social sanctions and laws
- Disrespect for authority including parental supervision
- Argumentative and aggressive behaviours become evident and often disturb parents and teachers
- Delinquency/law-breaking activities
- Political extremism.

1.5 Why adolescents are especially vulnerable to reproductive health risks

Stop reading for a moment and think about this from your own experience. Why do you think adolescents exhibit more risk-taking behaviour than children or adults?

Although adolescents tend to be less informed than adults they often have a sense of having unlimited power, feelings of invulnerability and impulsiveness that can lead to reckless behaviour. They are curious and have a natural inclination to experiment. There is conflict between their own emerging values and beliefs and those of their parents and so adolescents may be trying to demonstrate these differences by experimenting with drugs and law-breaking activities.

1.6 The reproductive health situation for adolescents in Ethiopia

According to the Census conducted in 2007, Ethiopia has a population that is predominantly young (40% below the age of 15) and rural, with a high level of fertility (5.4 children per woman), early age of marriage (16 years) and a low level of contraceptive use (14%). This signifies the potential for considerable population growth for the coming years.

Young people, aged 10 to 24 years, constitute 32% of the total population, which was estimated to be around 27 million in July 2010. Ethiopia has one of the highest population growth rates in the world (2.6% per year), which has put substantial pressure on the health sector to meet the needs of the population. Projecting from the 2007 census, around 62% of the Ethiopian population were estimated to be less than 25 years of age in 2010.

Close to half the Ethiopian population (47%) lives below the poverty line, earning less than one US dollar per day. Unemployment is high, the young accounting for the majority of job-seekers.

In Ethiopia, girls have their **sexual debut** (first sexual experience) on average at the age of 16 years – around 5 years earlier than boys. Most girls (94%) have their sexual debut within marriage. Over a quarter of pregnant young women have unwanted pregnancies and there are therefore high abortion rates. Studies indicate that girls in late adolescence (aged 15–19 years) are twice as likely to experience obstetric fistula (explained in Study Session 5) compared with other women of reproductive age. Over half (54%) of pregnancies to girls under 15 are unwanted compared with 37% for those aged 20–24.

- How would you explain the high rate of unwanted pregnancies for girls under 15?
- Limited knowledge and access to reproductive health information, early marriage, limited use of contraceptives, and girls' limited power over their sex lives all contribute to the high rate of unwanted pregnancy.

1.7 Reproductive health rights of adolescents and young people

Reproductive health rights refer to those rights specific to personal decision making and behaviour, including access to reproductive health information and services with guidance provided by trained health professionals.

The Ethiopian Government has endorsed all major international conventions concerning reproductive health rights, including those that are specific to adolescents and young people. For example, the Revised Family Law prohibits marriage of both boys and girls before the age of 18 years. Box 1.4 details all the rights for adolescents and young people which are applicable in Ethiopia.

Box 1.4 Reproductive health rights of adolescents and young people

- The right to information and education about sexual and reproductive health (SRH) services.
- The right to decide freely and responsibly on all aspects of one's sexual behaviour.
- The right to own, control, and protect one's own body.
- The right to be free of discrimination, coercion and violence in one's sexual decisions and sexual life.
- The right to expect and demand equality, full consent and mutual respect in sexual relationships.
- The right to the full range of accessible and affordable SRH services regardless of sex, creed, belief, marital status or location.

These services include:

- Contraception information, counselling and services (you will study the contraceptive options for young people in Study Session 8)
- Prenatal, postnatal and delivery care

- Healthcare for infants
- Prevention and treatment of reproductive tract infections (RTIs)
- Safe abortion services as permitted by law, and management of abortion-related complications
- Prevention and treatment of infertility
- Emergency services.

Summary of Study Session 1

In Study Session 1, you have learned that:

- 1 Adolescence is the period between 10 and 19 years of age (early adolescence is 10–14 years, late adolescence is 15–19 years and post-adolescence is 20–24 years old). Young people are those aged 10–24 years.
- 2 Adolescents undergo significant physical, intellectual and psychosocial changes as they move into adulthood.
- 3 In the process of moving toward independence, young people tend to experiment and test limits, including practising risky behaviour. This makes them especially vulnerable to reproductive health problems.
- 4 Not all young people are equally affected by negative reproductive health problems. Services need to be targeted toward the most vulnerable, who include young girls in rural areas and orphans.
- 5 Ethiopia has a population that is predominantly young and likely to grow considerably in the coming years because of the early age of marriage and low levels of contraceptive use.
- 6 Adolescents and young people have the right to accurate information and appropriate reproductive health services. Laws protect young people's rights.

Self-Assessment Questions (SAQs) for Study Session 1

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

First read Case Study 1.1 and then answer the questions that follow it.

Case Study 1.1 Abebe's story

Abebe is a 17-year-old boy living with his family and siblings. Recently he has become concerned by the erratic change in his voice which has embarrassed him when he is talking to people. He has also noticed that he is developing feelings of love and affection for one of the girls in his neighbourhood. His family are worried by the fact that he prefers to spend most of his time with his friends, occasionally coming back late at night without asking permission.

SAQ 1.1 (tests Learning Outcome 1.1)

How would you classify Abebe's age group?

SAQ 1.2 (tests Learning Outcome 1.3)

Read the description of Abebe again and identify one physical change associated with adolescence and one psychosocial change.

SAQ 1.3 (tests Learning Outcome 1.4)

Explain whether Abebe is at risk of engaging in risky behaviour.

SAQ 1.4 (tests Learning Outcomes 1.1 and 1.5)

What kinds of information and/or counselling might be most helpful to Abebe to protect his sexual and reproductive health?

SAQ 1.5 (tests Learning Outcomes 1.1 and 1.2)

How might the concerns of a girl of Abebe's age be different?

Study Session 2 Vulnerabilities, Risk-Taking Behaviours, and Life Skills

Introduction

In this study session you will learn about some specific physical, socioeconomic and emotional vulnerabilities that adolescents have and the reasons why they are so inclined to take risks. Specifically, you will learn about **risk taking behaviours** such as impulsive decision-making, reckless behaviour, experimentation with substances and antisocial or even criminal activities. During the period of adolescence young people also tend to argue a lot both with peers and with people in authority (parents and other adults). They seem to be trying to find out how far they can go with this behaviour by testing the limits. As you will learn, they can become very emotional during these arguments and this may lead them to behave stupidly and sometimes violently.

You will learn about some of the important psychosocial and behavioural concerns that young people have. These include gender roles, feelings about self-worth, and relationships with family and peers, especially those of the opposite sex. We will also discuss the strategies that young people need to learn in order to negotiate with others through this period of transition when they often have confused thoughts and feelings. The skills and competencies that are needed to enable people to deal effectively with the challenges of everyday life are called **life skills**. By understanding the concerns of these young people and the strategies that they need to learn you will be able to help them achieve healthy development during the period of adolescence.

Learning Outcomes for Study Session 2

When you have studied this session, you should be able to:

- 2.1 Define and use correctly all of the key words printed in **bold**. (SAQs 2.1 and 2.2)
- 2.2 Identify the physical, socioeconomic and emotional vulnerabilities of adolescents. (SAQ 2.1)
- 2.3 Describe risk-taking behaviours of adolescents and young people and the consequences for their reproductive health. (SAQ 2.2)
- 2.4 Discuss the implications of the psychosocial and behavioural concerns that adolescents and young people have in relation to their reproductive health. (SAQs 2.1 and 2.2)
- 2.5 Describe life skills and explain why they are important for healthy adolescent development. (SAQs 2.1 and 2.2)

2.1 Vulnerabilities

Adolescents and young people do not always act in ways that serve their own best interests. They can make poor decisions that may put them at risk and leave them vulnerable to physical or psychological harm (see Figure 2.1). Some risk-taking behaviours lead to serious lifelong consequences (for example adolescent pregnancy); while others can be corrected (for example peer pressure to consume alcohol).



Figure 2.1 Adolescents often take risks without being fully aware of the consequences.

These vulnerabilities can be categorised as physical, emotional, and socioeconomic (see Box 2.1).

By understanding young people's vulnerabilities, and the life skills that empower them, you will be in a better position to serve their needs.

Box 2.1 Vulnerabilities of adolescents

Physical Vulnerabilities:

- Adolescence is a time of rapid growth and development, creating the need for a nutritious and adequate diet.
- Adolescents often have poor eating habits which put them at risk of undernutrition as they may not be able to meet the increased demand of nutrition for growth.
- Poor health in infancy and childhood, often resulting from impoverished conditions, can persist into adolescence and beyond.
- Repeated and untreated infections and parasitic diseases, frequent diarrhoea and respiratory diseases, malnutrition, physical defects and disabilities can affect their physical and psychological development.
- Some young women may have undergone female genital cutting, which can result in significant physical and/or emotional difficulties, especially concerning sexual and reproductive matters (see Study Session 6).

Emotional Vulnerabilities:

- Mental health problems can increase during adolescence due to the hormonal and other physical changes of puberty, along with changes in adolescents' social environment.
- Adolescents often lack assertiveness and good communication skills, thereby rendering them unable to articulate their needs and withstand pressure or coercion from their peers or adults.
- Adolescents may feel pressure to conform to stereotypical/conventional gender roles.
- Young people are more vulnerable than adults to sexual, physical, and verbal abuse because they are less able to prevent or stop such manifestations of power (see Study Session 6).
- Often there are unequal power dynamics/relationships between adolescents and adults since adults sometimes view adolescents as children.
- Young people may lack the maturity to make good, rational decisions.

Socioeconomic Vulnerabilities:

- During adolescence, young people's need for money often increases, yet they typically have little access to money or money-making employment.
- Poverty and economic hardships can increase health risks owing to poor sanitation, lack of clean water, and the inability to afford healthcare and medications.

- Disadvantaged young people are also at a greater risk of substance abuse and may feel forced to resort to work in hazardous situations, including commercial sex work, (**prostitution**) which makes them likely to contract STIs, including HIV/AIDS, and have an unwanted pregnancy.
- Young women also face gender discrimination that affects access to healthcare, the ability to negotiate safer sex, and opportunities for social and economic wellbeing.
- Some young women marry very young to escape poverty, but as a result may find themselves in another difficult and challenging situation.
- Many young people are also at risk because of diverse socioeconomic and political reasons. These especially vulnerable young people include street children, child labourers, the internally displaced or refugees, those in war zones, young criminals, those orphaned because of AIDS and other circumstances, and other neglected and/or abandoned youth.

(adapted from *Adolescent and Youth Reproductive Health Trainers' Manual*, Ethiopian Federal Ministry of Health, 2008)

2.2 Types of risk-taking behaviour and its consequences

Adolescents can make impulsive decisions resulting in dangerous situations. For instance, reckless behaviours such as driving above speed limits or under the influence of alcohol or khat could result in motor vehicle injuries, which are quite a common problem in urban areas of Ethiopia.

Adolescents are also likely to be involved in provocative activities such as arguing and testing limits with peers and adults, resulting in emotional and physical damage (for example, unnecessary quarrelling with someone may be followed by physical violence and feelings of guilt or unhappiness). Experimentation with substances could result in short- and long-term consequences that include effects on most other risk-taking behaviour. For example, alcohol abuse can not only lead to reckless driving; it might also lead to early sexual activity, unprotected sexual activity or having non-regular sexual partners (one-night stands). All of these behaviours could have immediate and/or long-term health, emotional, psychological, social and economic consequences.

- What are the possible consequences of unprotected one-night stands?
- There is a very high chance that such risky behaviour will lead to multiple reproductive health problems. In the short term the adolescent might pick up a sexually transmitted infection such as gonorrhoea (which is curable if treated). However, they also carry the risk of getting infected by HIV and this is not curable, although it can be treated to slow the progression of the disease to full blown AIDs. If the girl also becomes pregnant there is a risk of transmitting the infection to the baby, which is likely to be born undernourished and prematurely. These are long-term problems which are likely to be passed on to the next generation.

In general, it is important to note that risk-taking among young people varies with cultural factors, individual personality, needs, social influences and pressures, and available opportunities. And when young people test their limits and underestimate the risks involved, you need to realise that this type of behaviour is age-appropriate, and encourage adults to help them avoid serious consequences.

2.3 Psychological and behavioural concerns

As children grow up they have concerns about their social relationships. They worry about the way others see and judge them and they often have doubts about their own self-worth. These feelings can become very strong during adolescence. These concerns, in turn, have a significant influence on sexual decision-making and reproductive health.

- What might these concerns be?
 - Adolescents want to be accepted by their peer group and they want to be liked. So they will be concerned to behave in a way that is admired by the rest of the group. They will worry over their appearance and their speech, often feeling unsure that what they say and do is appropriate. Their feelings toward the opposite sex will be changing in a way that most find confusing.

There are a number of important issues that emerge during the adolescent period. You will probably have experienced these yourself to a greater or lesser extent so will be in a good position to be able to help younger people understand their confused feelings. Letting them talk to you and just listening in a non-judgemental way can, in itself, be a tremendous help to them. It can be a relief to them to hear from you that their feelings are not abnormal.

The following list explains some of the areas where adolescents can feel confused.

Peer relationships and peer pressure. Adolescents develop very close relationships with their peers, conforming to language, dress and customs. This helps them feel safe and secure and gives them a sense of belonging to a large group. Given the significance of peer influence, this power can sway adolescents and young people toward greater or lesser risk taking. For example, studies show that adolescents and young people tend to match their sexual behaviour, including timing of sexual debut and use of contraceptives, to what they perceive their peers are doing. Peer pressure, combined with gender inequities within a sexual relationship, can mean that males have undue power to dictate sexual decisions to females.

Relationships with parents and other adults. During adolescence relationships with parents become more confrontational as the young person tests limits and moves toward greater independence. At the same time, parents have significant influence over, and responsibility for, adolescents. Parents or other caring adults tend to strengthen adolescents' resilience and flexibility and their ability to avoid risk-taking behaviour. Hence, when you get the opportunity, you can influence the family by encouraging communication between parents and their adolescent offspring.

Gender roles. Although boys and girls, worldwide, are treated differently from birth onward, it is during adolescence that gender role differentiation intensifies. More often than not, boys achieve more autonomy, mobility, and power, whereas girls tend to get fewer of these privileges and opportunities. Importantly, boys' power relative to girls' translates into dominance in sexual decision-making and expression, often leaving girls unable to fully assert their preferences and rights to protect their health.

Self-esteem. **Self-esteem** is the ability to feel confidence in, and respect for, oneself. It is a feeling of personal competence and self-worth. While self-esteem involves feelings about oneself, it develops to a great extent from interactions with family, friends and social circumstances throughout life. Self-esteem can be challenged during adolescence by rapid physical and social changes and the development of one's own values and beliefs. Yet self-esteem is critically important at this stage in life.

- Take a moment to think about why this might be so and what role adults might have.
- Specifically for reproductive health, self-esteem influences how young people make judgements about relationships, sex and sexual responsibility. Adults can help young people to strengthen their self-esteem by showing them respect and by demonstrating confidence in these young people's abilities.

2.4 Life skills

One of the reasons why a high number of adolescents and young people show risky behaviours is because they lack the skills necessary for adulthood: skills such as working and communicating with others, understanding themselves, and making decisions. **Life skills** in adolescents refer to the skills and competencies needed to build or adopt positive behaviours that enable them to deal effectively with the challenges of everyday life. The development of life skills allows adolescents to cope with their environment by making responsible decisions, having a better understanding of their values, and being better able to communicate and get along with others. Early adolescence is singled out as a critical moment of opportunity for building skills and positive habits, since at that age there is a developing ability to think abstractly, to understand consequences, and to solve problems.

- What period does early adolescence cover?
- Early adolescence is age 10–14. (See Study Session 1.)

Life skills translate into positive behaviours that promote health, mental wellbeing and good social relationships. Among the most important life skills are assertiveness and decision-making.

2.4.1 Types of life skills

Life skills fall into three basic categories, which complement and reinforce each other. These are social or interpersonal skills, cognitive skills and emotional coping skills (see Table 2.1 on the next page).

Table 2.1 Types of life skills. (Adapted from *Life Skills Approach to Child and Adolescent Healthy Human Development*, Pan-American Health Organisation, 2001.)

Social skills	Cognitive skills	Emotional coping skills
Communication skills	Decision-making and problem-solving	Managing stress
Negotiation and refusal skills	Understanding the consequences of actions	Managing feelings, including anger
Assertiveness skills	Determining alternative solutions to problems	Skills for increasing self-management and self-monitoring
Interpersonal skills (for developing healthy relationships)	Critical thinking	
Cooperation skills	Analysing peer and media influences	
Empathy/understanding and perception	Analysing one's perceptions of social norms and beliefs	
	Self evaluation and values clarification	

Research shows that interventions that address these specific skill areas (such as decision-making and assertiveness skills) are effective in promoting desirable behaviours, such as sociability, improved communication, effective decision-making and conflict resolution, and preventing negative or high-risk behaviours, such as use of tobacco, khat, alcohol, unsafe sex and violence.

For instance, decision-making has long been a part of pregnancy prevention; refusal skills are seen as critical to substance (e.g. khat) abuse prevention, and communication skills have been used to help aggressive or antisocial youngsters.

You are expected to explain and teach life skills to adolescents who come seeking your help. Examples of adolescents who could benefit from your messages include: a girl who is not feeling confident to end a relationship that she thinks will put her at risk of STIs, including HIV, because her partner doesn't like to use condoms; or a boy who is about to start or has already started khat chewing just because he wants to imitate what his friends are doing. These are just two instances where you could make a difference in adolescents' behaviours by telling them that it is perfectly OK to say 'No' when they have to. This could be done through individual or group counselling at your health post, in schools or in the community.

You need to explain the need to be **assertive**. Being assertive involves expressing beliefs, thoughts and feelings in a direct, clear way at an appropriate moment and does not mean imposing beliefs or views on another person. To be assertive implies the ability to say 'yes' or 'no' depending on what one wants. For example: 'I don't want to have sex' or 'Yes, I want to have sex but only if we use a condom'.

Being able to express what is truly felt or desired can have important consequences for adolescent reproductive health. Being clear and assertive can increase self-respect and help resist peer pressure to engage in sex, khat use, etc. Adolescents who are assertive can effectively negotiate safer sex to prevent unwanted pregnancy and STIs, including HIV, and resist unwanted sexual proposals from adults. They are also more likely to identify and obtain services needed for pregnancy prevention, prenatal and postpartum care, and STI/HIV diagnosis, counselling and treatment.

Decision-making skills focus on techniques involved in **critical thinking** and **problem solving** (these bold terms are defined below). Adolescents must

make decisions frequently, ranging from simple and marginally consequential ones such as ‘What shall I wear today?’ to major and very consequential decisions, such as, ‘Should I have sexual relations?’ Depending on the culture, the potential to make decisions varies, as does the young person’s sense of their ability to make decisions.

For instance, in some cultures, young people believe that external factors (such as fate or luck) determine what happens to them. In others, young people believe that their own capacity or skills and efforts determine what happens to them. In general young people who think they can determine what happens, within the range of available options, will be more likely to make their own decisions and thus feel greater commitment to these decisions and get more satisfaction from them.

Before making a sensible decision it is important to weigh the good and bad sides, strengths and weaknesses, advantages and disadvantages. **Critical thinking** is the ability to think through situations adequately, weighing the advantages and disadvantages so as to be able to make appropriate decisions concerning other people or one’s own situation. Adolescents are confronted by multiple and contradictory issues, messages, expectations and demands of a sexual nature or otherwise. They need to be able to critically analyse the challenges that confront them. Examples in critical thinking are ability to distinguish between myths and facts; assessing the promises of a partner; and judging a situation that may be risky.

Problem solving refers to one’s capacity to identify problems, their causes and effects as well as the capability to look for possible solutions. It is the ability to identify, cope with and find solutions to difficult or challenging situations. Problem solving is related to decision-making and the two may often overlap. It is only through practice in making decisions and then solving problems that adolescents can develop the skills necessary to make the healthiest sexual choices for themselves. Examples of abilities in problem solving are skills in planning how to prevent getting STIs and unwanted pregnancy by using condoms properly and consistently.

Negotiation or **conflict resolution** is a ‘win-win’ or ‘no lose’ method of settling disagreements. Every relationship has conflicts. However, conflicts do not have to end with someone losing and with both parties hating each other. Many do end this way. Adolescents need to begin by understanding that they have their own way of dealing with conflicts in their lives. Knowing their own style and motives as well as the style and motives of the person they are in conflict with will help them handle the situation.

They can negotiate their position by talking about it. This needs to be strengthened, especially in situations where it has not been usual to have a dialogue. Negotiation also means that both sides will compromise. Since it may not be advisable to compromise on certain issues, agreeing to negotiate may be a dangerous strategy used by those who have selfish interests. ‘Let’s talk about it’ may actually be a dangerous invitation (Figure 2.2).



Figure 2.2 A girl and an older man negotiating on condom use.

Box 2.2 shows important points that adolescents need to keep in mind when negotiating for safer sex.

Box 2.2 How to negotiate safer sex

- Be assertive, not aggressive
- Say clearly and nicely what you want (e.g. to use the condom from start to finish)
- Listen to what your partner is saying
- Use reasons for safer sex that are about you, not your partner
- Be positive
- Turn negative objection into a positive statement
- Never blame the other person for not wanting to be safe
- Practice ‘TALK’

Tell your partner that you understand what they are saying

Assert what you want in a positive way

List your reasons for wanting to be safe

Know the alternatives and what you are comfortable with.

The overall message of this study session is that in all of your activities aimed at promoting healthy adolescent behaviours, you need to focus on prevention, which means trying to build the skills of adolescents to make sound decisions that can protect their health. You should also educate the community that young people are vulnerable and need to be supported in their decisions, particularly regarding reproductive health matters.

Summary of Study Session 2

In Study Session 2, you have learned that:

- 1 Young people have physical, socioeconomic and emotional vulnerabilities that put them at risk of engaging in many risk-taking behaviours.
- 2 The fact that adolescence is a period of rapid growth means that their nutrition needs increase. This high demand for nutrition might be difficult to meet, particularly if they have poor eating habits. Poor nutrition can lead to poor physical and reproductive health.
- 3 Lack of assertiveness and poor communication skills, unequal power relationships between adolescents and adults, and lack of the maturity to make good, rational decisions increase emotional vulnerability during adolescence.
- 4 Many adolescents are socioeconomically disadvantaged. As a result, they have little negotiation power and may be engaged in more hazardous conditions such as prostitution (commercial sex work).
- 5 Some of the risk-taking behaviours young people show include: impulsive decision-making, which could result in injuries; provoking, arguing and testing limits with peers and adults, which may result in emotional and physical damage or violence; experimentation with substances; and unprotected sexual activity, which might result in unwanted pregnancy and possibly being infected by STIs, including HIV.

- 6 Young people are more likely to have significant concerns related to social relationships, self-perception and gender roles. For instance, boys achieve more autonomy, mobility and power, whereas girls tend to get fewer of these privileges and opportunities.
- 7 Assertiveness and decision-making are among the most important life skills that adolescents need to develop. Assertiveness involves expressing beliefs, thoughts and feelings in a direct, clear way at an appropriate moment, while decision-making involves a group of conclusions that are followed by actions.

Self-Assessment Questions (SAQs) for Study Session 2

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 2.1 (tests Learning Outcomes 2.1, 2.2 and 2.5)

First read Case Study 2.1 and then answer the questions that follow it.

Case Study 2.1 Hawa's story

Hawa is a 15-year-old girl living in a rural village. Her father and mother both died of AIDS when she was 4 years old. She was raised by neighbours until she reached 9th grade, at which time they left the area for good. Hawa then found it difficult to meet her daily expenses and married a rich 45-year-old man when she was 15. She was her husband's second and younger wife, and he had 5 children with his older wife. For a time she thought her problems were solved; however, a year later she had a low birth-weight baby and couldn't go to school as she had to take care of her child and do other household tasks.

- (a) Use Box 2.1 to identify Hawa's physical, emotional and socioeconomic vulnerabilities.
- (b) In your opinion, did Hawa made the right rational decision? Comment on her negotiation power.

SAQ 2.2 (tests Learning Outcomes 2.1, 2.3, 2.4 and 2.5)

First read Case Study 2.2 and then answer the questions that follow it.

Case Study 2.2 Kebede's story

Kebede is a 16-year-old boy who recently moved from the village where he grew up to a town to pursue his education at a preparatory school. In the new school he met new friends. Some of his friends chewed khat and smoked cigarettes and told Kebede that it was normal for a modern young person to do these things. So Kebede started chewing khat, drinking alcohol and smoking. With his friends he frequently went to a nearby bar where he met a **prostitute** (commercial sex worker). Over time, Kebede felt that he was doing the wrong things. He decided he could no longer copy his friends' behaviour just to get along with them. It took him a while to analyse his situation and decide to stop chewing khat, drinking alcohol, smoking cigarettes and going to prostitutes. Following his decision he was able to make friends who were free of such risky behaviours, which helped him to work towards achieving his dream, which was to perform well in his education.

- (a) Describe Kebede's risk-taking behaviours.
- (b) What consequences could Kebede face as a result of his behaviour?
- (c) What type of life skills did Kebede use to be free from risky behaviours?

Study Session 3 Unwanted Pregnancy and Abortion

Introduction

In this study session, you will learn about factors leading to unwanted pregnancy, the psychosocial impact of unwanted pregnancy and the magnitude (i.e. extent) of the problem. You will also learn that an unwanted pregnancy is often terminated by abortion (sometimes spontaneous but often unsafely induced) and that this may lead to complications. You will learn how you can support a young person with an unwanted pregnancy. You will learn how to provide her with post-abortion care if she needs it.

Learning Outcomes for Study Session 3

When you have studied this session, you should be able to:

- 3.1 Define and use correctly all of the key words printed in **bold**. (SAQs 3.1 and 3.2)
- 3.2 Discuss the various factors leading to unwanted pregnancies and some possible consequences. (SAQ 3.1)
- 3.3 Discuss the possible reasons why a young person might have an unsafe abortion and explain some of the consequences of unsafe abortion. (SAQs 3.1 and 3.2)
- 3.4 Describe your role as a Health Extension Practitioner in the support of young people who find they have an unwanted pregnancy or who have had an abortion following an unwanted pregnancy. (SAQs 3.1 and 3.2)
- 3.5 Describe your role as a Health Extension Practitioner in the prevention of unsafe abortion. (SAQ 3.2)

3.1 Unwanted pregnancy

Unintended or **unplanned pregnancies** are pregnancies that are reported to have been either **unwanted pregnancies** (i.e. the woman has no desire to have a child) or **mistimed pregnancies** (i.e. they occurred earlier than desired – perhaps the couple wished to have a family after they had completed their formal education or maybe they already had a child but wanted more time before having another baby). Pregnancies ending in induced abortion are generally assumed to have been unintended. Both married and unmarried adolescents experience unwanted pregnancies and births (Figure 3.1).

- Who do you think is more likely to use antenatal care: adolescents with wanted or unwanted pregnancy?
- Women with unwanted pregnancies are less likely than those with intended pregnancies to seek antenatal care during the first **trimester** (i.e. the first three months of the pregnancy).



Figure 3.1 A boy and girl who are worried after they have learned that she became pregnant following unprotected sexual intercourse.

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- Why do you think these young women do not seek antenatal care?
 - It might be that they do not realise they are pregnant because they have had irregular or scant **menses** (monthly bleeding/menstrual period). Or it might be that they are in denial – trying to ignore the signs and hoping they will have a **miscarriage** (spontaneous abortion).
 - What are the disadvantages of not seeking antenatal care?
 - Adolescents who have not obtained antenatal care from healthcare professionals may not have the opportunity to get sufficient information regarding the risk of terminating a pregnancy under unsafe circumstances. Hence they are less likely to get safe abortion care even when they are eligible to get the service.

3.1.1 The extent of unwanted pregnancy

Adolescent pregnancy occurs in all societies, although the extent and consequences vary from place to place. According to WHO estimates, in the year 2007 slightly more than 10% of all births worldwide were to girls in **late adolescence** (15–19 years old), with over 90% of these births occurring in developing countries such as Ethiopia. Many sexually active unmarried young women experience a pregnancy which is both unplanned and unwanted. A study in Ethiopia in the year 2000 showed that more than half of all births to women under the age of 15 (i.e. those in **early adolescence**), and more than one in three births to women aged 15–24 were unintended.

The same study indicates that 37% of young women aged 15–24 have begun childbearing – 34% of mothers having at least one child. In general, the older the adolescent, the more likely they are to be pregnant; for example, teenage pregnancy and childbearing increases from 1% among women aged 15 to 40% among women aged 19. Teenage pregnancy is higher among rural women (3%) than urban women (2%) and is highest in the Oromiya Region (4%) and lowest in Addis Ababa (1%) (*Youth Reproductive Health in Ethiopia, 2002*).

3.1.2 Factors related to unwanted pregnancy

Factors that can lead to unwanted pregnancy include: neglecting to use condoms with each act of intercourse; unplanned sex without the availability of contraceptives; incorrect use of the chosen method of contraception (e.g. condom breakage and slippage); not using contraceptives because of a lack of information on their availability and how to use them; not using an available contraceptive method because of some misconception (e.g. concerning its safety).

Some pregnancies result from **rape** (forced sexual intercourse) and **incest** (sexual activity between two people who are considered, for moral or genetic reasons, too closely related to have such a relationship, for example a brother and sister or a girl and her father). You will learn more about rape in Study Session 6.

Many adolescent girls do not discuss family planning with their partners due to fear of being abandoned because the man does not wish to bother with a condom, saying it takes away the pleasure. Or maybe she cannot discuss family planning because the man wishes her to have their baby and does not think of the consequences for a young mother.

As you have learned in Study Session 2 about *Life skills*, it is important that whenever you talk about the subject of unwanted pregnancy you help adolescents build their *self-esteem* and teach them how to use *negotiation skills*, but also to be *assertive* if necessary. You should also explain the appropriate use of contraceptives based on what you will study in Study Session 8 on contraception options for adolescents and young people. This is especially important with adolescents so that they begin practising safer and protected sex from an early age.

3.1.3 The consequences of unwanted pregnancy

There are many negative consequences of unwanted pregnancies: some are common to all unwanted pregnancies, others depend on the precise domestic situation of the young woman or the couple.

- What domestic situations might the young woman be in?
 - She might be married to an older man or to a young man. She may be unmarried but in a stable relationship and her partner may be willing to marry her or, she may be unmarried with no one willing to take responsibility for her or the baby.
- What particular problems will an unmarried mother and her child face?
 - In most communities both the mother and child face the stigma of illegitimacy. As a result, unmarried mothers resort to low-paid jobs such as domestic work or risky jobs such as prostitution to support their children.

An early marriage due to an unplanned pregnancy is frequently an unhappy, unstable one because partners blame each other for the situation they are in. This often leads to divorce and the single mother will have to deal with the stigma of divorce as well as all the practical problems of bringing up the child without the emotional or financial help provided by a husband.

Even if a young couple stay together, they are often ill prepared to raise a child, which may lead to childrearing problems like neglect or even child abuse.

Other problems for young couples relate to their formal education and career opportunities. An unwanted pregnancy often means the end of formal education for girls. Boys who become fathers lose opportunities for education and future economic advancement as they leave school to support their new families.

In Study Session 11 of this Module you will learn about the medical risks associated with becoming pregnant at a young age. Pregnancy during adolescence is associated with an increased risk of medical conditions such as anaemia or **hypertension** (high blood pressure), unsafe abortion, premature birth, obstructed and prolonged labour, stillbirth and maternal mortality.

Being aware of all these consequences will help you to decide how to provide both psychological and medical support for adolescents who have already become pregnant. It is important to realise that adolescents with unwanted pregnancy are already in significant psychological distress and they should receive appropriate counselling and support during pregnancy and after child birth. (Information on counselling young people is in Study Session 9.)

Some of the common conditions among adolescent pregnant women such as anaemia and hypertension are harmful to the growing fetus, which makes the need for proper follow-up even more essential. Hence, whenever you encounter an adolescent who is pregnant, you need to look for such medical risks (anaemia, hypertension, malnutrition), explain to them that these could harm their own health and that of their baby and refer them to the next higher health facility.

3.2 Abortion

- Give the correct definition of abortion. (Remember you studied this in Study Session 20 of the *Antenatal Care*, Part 2 Module.)
- **Abortion** is the termination or ending of a pregnancy before fetal viability, which is conventionally taken to be less than 28 weeks from the last normal menstrual period. It can happen on its own (spontaneous abortion or miscarriage), or it can be caused deliberately (induced). Abortion may be induced by medical procedure legally, or it may be an unsafe non-medical intervention, which is illegal.

The conditions under which abortion is legal in Ethiopia are indicated in Section 3.2.2.

In many countries, 30–60% of pregnancies among adolescents end in abortion. Studies show that almost 6 in 10 abortions in Ethiopia are unsafe. Women seeking induced abortion in 2008 in Ethiopia had a mean age of 23, the majority (54%) being single. Seeking care after a second-trimester abortion was more common among women who lived in rural areas than among their urban counterparts. According to another study, by the Ethiopian Society of Obstetricians and Gynecologists (ESOG) in the year 2000, three-quarters of patients had spontaneous abortions and one-quarter of them had an induced abortion. However, this figure may not be accurate as women who have an induced abortion do not always tell the truth because of fear and uncertainty of the reaction of other people.

Adolescents and young people are more likely to have an **unsafe abortion**, which is the termination or ending of a pregnancy by an unskilled, non-medical provider (Figure 3.2). It may be that a safe service is not accessible, affordable, or permitted by law. This might cause adolescents to try to self-induce an abortion or have the procedure carried out by an unskilled provider. Because of economic problems and/or other reasons, adolescent and young women are also more likely to postpone abortion until after the first trimester, which makes the procedure more risky.



Figure 3.2 A young woman having an abortion by an unskilled person. Unsafe abortion can result in life-threatening complications including bleeding and infections.

A study in Addis Ababa in 2001 showed that 28% of abortions were self-induced, while 35% were performed by health assistants and only 9% by medical doctors. Materials used to induce an abortion included plastic catheters (14% of surveyed women), plastic tubes (32%), ampicillin (32%), metallic rods (22%), and roots or herbs (5%). As these figures are from one study, variation is to be expected from region to region and between urban and rural areas.

3.2.1 Possible reasons for unsafe abortion

There can be various reasons why an adolescent with an unwanted pregnancy will resort to an unsafe abortion. Some of these reasons are shown in Box 3.1.

Box 3.1 Reasons why an adolescent or young woman might seek an abortion

Education: fear of dropping out of school or interrupting her studies.

Economic factors: fear of not having the financial ability to support herself and her child.

Social condemnation: fear of what her parents or other people might think or say; a wish to avoid bringing shame and condemnation or blame on herself and her family.

Not having a stable relationship: this is more common in adolescents than in adults.

Circumstances of sexual intercourse: an abortion may also be sought where the pregnancy is a consequence of coerced sex, including rape and incest.

3.2.2 Abortion law in Ethiopia

As you read in Study Session 20 of the *Antenatal Care*, Part 2 Module, abortion is now legal in Ethiopia in cases of rape, incest or fetal impairment. In addition, a woman can legally terminate a pregnancy if her life or her child's life is in danger, or if continuing the pregnancy or giving birth endangers her life. A woman may also terminate a pregnancy if she is unable to bring up the child, owing to her status as a minor (aged under 18 years) or to a physical or mental infirmity or illness.

Hence, if you encounter a pregnant adolescent fulfilling at least one of the above conditions, you need to refer her to the nearest health facility where an abortion service is available, to minimise the risk of unsafe abortion.

3.2.3 Complications from unsafe abortion

A young woman who has an abortion may face several negative consequences, including haemorrhage, infection, injury to her reproductive organs, intestinal perforation (if metallic or sharp materials are used), and toxic reactions to substances or drugs used to induce abortion. These complications may result in infertility or even death. A study in north Ethiopia in the year 2001 showed that adolescents who had had an abortion had the following post-abortion complications: anaemia 45%, shock 16%, genital tract infection 21%, injury 9%, incomplete evacuation 2%, peritonitis 6%, and renal failure 0.7%.

Whether there are medical complications or not, adolescent and young women may face negative psychological and social consequences after abortion. They may feel remorse, regret or guilt, or they may encounter negative reactions from peers, family, health care providers and society.

Peritonitis is inflammation of the peritoneum, which is the membrane that lines the walls of the abdominal cavity.

As a health worker, you need to inform and counsel any pregnant adolescent about the possible consequences (medical and psychological) of unsafe abortion. If a young woman with any of the above medical complications visits your health post, you need to immediately refer her to a higher health facility (often a hospital) where she can get sufficient care.

3.3 Post-abortion care

- What are the components of post-abortion care? (Remember you studied this in Study Session 20 of the *Antenatal Care*, Part 2 Module.)
- Post-abortion care has three important components:
 - 1 Emergency treatment of abortion and potentially life-threatening complications
 - 2 Post-abortion family planning services including counselling
 - 3 Making links between the post-abortion emergency services and the reproductive healthcare system.

3.3.1 Emergency treatment

Any adolescent or young woman who has an abortion should be provided with emergency treatment as specified in the national guidelines for care after abortion. Your role is to follow the guidelines you studied in Study Session 20 of the *Antenatal Care*, Part 2 Module. In general the management depends on the type of abortion and the seriousness of complications. If necessary you should refer the mother to the next higher health facility according to the guidelines.

3.3.2 Post-abortion services

You should also keep in mind that you need to provide counselling on contraceptive options and provide young women who have just had an abortion with the method of their choice. Box 3.2 shows you the important things that you can do at health post level (see also Figure 3.3 on the next page).

Box 3.2 Services you can provide for a young woman who has just had an abortion

- Provide reproductive health education, including family planning for adolescents
- Provide contraceptives
- Explain to her how to recognise the signs and symptoms of pregnancy
- Inform her of the legal provisions for safe abortion
- Educate her on the risks of unsafe abortion
- Explain to her how to recognise the signs and symptoms of abortion (e.g. vaginal bleeding).



Figure 3.3 A Health Extension Practitioner explaining about the risks of abortion and importance of family planning. (Source: WHO, *Adolescent Job Aid*, 2010)

3.3.3 Linkage to other reproductive health services

It is important to identify the range of reproductive health (RH) services needed by each adolescent and young woman and to be able to offer her as wide a range of RH services as possible. You may need to explain to her that you will be referring her to post-abortion services at another facility where they can diagnose and treat genital tract infections, screen for cervical cancer and investigate physical damage. If you can counsel her about what to expect and why these procedures are necessary she will be more reassured and likely to keep her appointments.

Overall your role as a Health Extension Practitioner is to educate adolescents and young people about the negative consequences of unwanted pregnancy and unsafe abortion so that they can prevent its occurrence. And if adolescents get pregnant through rape or incest, or if they meet the other conditions specified (in Section 3.3.2), they need to know that they can get safe abortion services in health facilities.

Summary of Study Session 3

In Study Session 3, you have learned that:

- 1 Adolescent pregnancy is a common occurrence in many societies including in Ethiopia.
- 2 A significant proportion of adolescent pregnancies (between 10 and 40%) are unintended. For instance, a study in Ethiopia showed that more than half of all births to girls below the age of 15 are unintended/unplanned.
- 3 There are many factors that may lead to unwanted pregnancy, including unplanned sex without the availability of contraceptives, incorrect use of the chosen contraceptive method and not using contraceptives due to lack of information or unavailability.
- 4 Abortion is the termination or ending of a pregnancy before fetal viability, which is conventionally taken to be less than 28 weeks from the last normal menstrual period. It can happen on its own (spontaneous abortion or miscarriage), or it can be caused deliberately (induced).
- 5 Studies in Ethiopia indicate that the majority (three-quarters) of abortions are spontaneous abortions; the remainder are induced. Other studies in Ethiopia suggest that the proportion of induced abortions may be much higher than this.

- 6 Providers of legal abortions include health assistants and medical doctors but abortion may also be self-induced or illegally induced by other persons.
- 7 In Ethiopia materials commonly used for the unsafe induction of an abortion include; plastic catheters, plastic tubes, Ampicillin, metallic rods and roots or herbs.
- 8 The reasons why adolescents seek abortions include fear of dropping out of education, financial difficulties, fear about what people might think or say, lack of a stable relationship and where the baby was conceived as a consequence of a non-consensual sexual act such as rape or incest.
- 9 Abortion is legal in Ethiopia only under certain conditions, which include cases of rape, incest or fetal impairment; if the mother's life or her child's life is in danger, if she is unable to bring up the child owing to her status as a minor (less than 18 years old) or to a physical or mental infirmity or illness.
- 10 Post-abortion care involves 3 important aspects of care, which include emergency treatment of abortion and potentially life-threatening complications, post-abortion family planning counselling and services, and linking between post-abortion emergency services and other reproductive healthcare services.

Self-Assessment Questions (SAQs) for Study Session 3

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 3.1 (tests Learning Outcomes 3.1, 3.2, 3.3 and 3.4)

First read Case Study 3.1 and then answer the questions that follow it.

Case Study 3.1 Azeb's story

Azeb is a 17-year-old girl living with her family. Azeb hopes to complete her education and pursue a college education in one of the universities. One day, she found out that her menstrual period had not started as expected and she went to the nearby health facility. After taking a urine sample the Health Extension Practitioner told her that she was three months pregnant. Azeb was shocked by the news as she was not prepared for it. However, Azeb admitted that she never used contraceptives when having sexual activity with her boyfriend.

- (a) How do you describe Azeb's pregnancy?
- (b) How do you react to her situation?

SAQ 3.2 (tests Learning Outcomes 3.1, 3.3, 3.4 and 3.5)

First read Case Study 3.2 and then answer the questions that follow it.

Case Study 3.1(continued) for SAQ 3.2

Azeb came to your Clinic complaining of having had severe vaginal bleeding. When she was asked what went wrong she admitted that she had attempted to end the pregnancy by inserting a sharp instrument as she was ill-prepared to have a child. When her boyfriend, who is also a student in high school, realised that she was pregnant, he stated that he had never had an affair with her.

- (a) What kind of abortion did Azeb have? What are the risks associated with the procedure she had?
- (b) In your opinion, what were the factors that predisposed her to have an abortion in the first place, and what advice would you give her to avoid repeating the same mistake?

Study Session 4 Sexually Transmitted Infections (STIs)

Introduction

In this study session, you will learn why young people are at risk of developing sexually transmitted infections (STIs), and the long-term health consequences of acquiring these infections. You will learn about the major STI syndromes, what biological and social factors influence their transmission and what advice to offer on how individuals can protect themselves from STIs.

STIs, including HIV are discussed in Study Session 28 in Part 3 of the Module on *Communicable Diseases*, but in this session you will learn about the peculiar features of these infections among young people. Note that you are not expected to treat STIs. The Ethiopian Ministry of Health has recommended that treatment of STIs using the syndromic approach will only be given at a health centre or hospital. You are, however, expected to identify young people with STIs and refer them to the appropriate health facility.

Learning Outcomes for Study Session 4

When you have studied this session, you should be able to:

- 4.1 Define and use correctly all of the key words printed in **bold**. (SAQ 4.1)
- 4.2 Explain why young people are at risk of acquiring STIs. (SAQ 4.1)
- 4.3 Describe the impact of STIs (including HIV) on young people. (SAQ 4.3)
- 4.4 Describe how you can work with young people to ensure that they understand prevention strategies that can be used to stop the transmission of STIs, including HIV. (SAQs 4.2 and 4.4)

4.1 Why are young people at risk from sexually transmitted infections?

According to the World Health Organization (WHO), the highest reported rates of STIs are found among 15–24 year olds, while about half of all of the people infected with HIV and 60% of all new HIV infections are also in that age group. WHO also estimates that in 2008 there were around one million Ethiopians living with HIV.

The most widely known STIs are gonorrhoea, syphilis and HIV – but there are more than 30 STIs and disease syndromes that result from STIs. It is important to note that certain STIs substantially increase the risk of transmission of HIV for both men and women. HIV, in its turn, facilitates the transmission of some STIs and worsens the complications of STIs because it weakens the immune system.

- Why do you think young people have a high risk of contracting STIs including HIV?
- There are many biological, psychological and social reasons that put young people at a high risk of acquiring STIs. The major ones are listed below.

Biological factors:

- Young women are biologically more susceptible to STIs than older women. This is because their vaginal mucosa and cervical tissue are immature, and this makes these tissues more vulnerable to STIs.
- Boys and girls may have immune systems that have not previously been challenged and have not mobilised defences against STIs and HIV.
- Young people may also be more prone to infection because of anaemia or malnutrition.

Another biological factor, though not exclusive to young people, is that women often do not show symptoms of chlamydia and gonorrhoea (the most common STIs), so they do not seek treatment. For example, up to 70% of women and 30% of men infected with chlamydia have no symptoms. Similarly, up to 80% of women and 10% of men infected with gonorrhoea also have no symptoms.

Psychosocial factors:

- Adolescents often lack basic information concerning their sexual health, or the symptoms, transmission and treatment of STIs.
- Often there is poor communication between young people and their elders, and there are few learning materials (books, magazines) designed for young people.
- Sexual intercourse is often unplanned and spontaneous among young people.
- They often have multiple, short-term sexual relationships and do not consistently use condoms.
- Young people may feel peer pressure to have sex before they are emotionally ready to be sexually active and they often confuse sex with love and engage in sex before they are ready in the name of ‘love’ (see Figure 4.1).
- Young men sometimes have a need to prove their sexual powers. Young men may have their first sexual experiences with **prostitutes** (commercial sex workers), while young women may have their first sexual experiences with older men, both of which increase the chance of getting STIs including HIV.
- Sexual violence and exploitation, lack of formal education (including sex education), inability to negotiate with partners about sexual decisions (in some cultures, girls are not empowered to say ‘No’) and lack of access to reproductive health services together put young women at especially high risk.
- Some adolescents are subject to early marriage, forced sex, trafficking and poverty, and may engage in sex work for money or favours.



Figure 4.1 Young boys and girls may not think beyond their love about the possible risks of unprotected sexual activity.

- Substance abuse or experimentation with drugs and alcohol is common among young people, which often leads to their making irresponsible decisions such as having unprotected sex.

Even when young people realise that they are infected they may be afraid to seek treatment for STIs and so go on to infect others unnecessarily.

4.2 Impact of STIs (including HIV) on young people

Sexually transmitted infections are of public health concern because of their potential to cause serious and permanent complications in infected people who are not treated in a timely and effective way. These can include cervical cancer, pelvic inflammatory disease, chronic pelvic pain, fetal death, **ectopic pregnancy** (pregnancy outside the uterus) and related maternal mortality. Chlamydial infections and gonorrhoea are important causes of infertility, particularly in women, with far-reaching social consequences including break-up of marriages. Chlamydial infection is an important cause of pneumonia in infants. Neonatal gonococcal infections of the eyes can lead to blindness. Congenital syphilis is an important and significant cause of infant morbidity and mortality. In adults, syphilis can cause serious cardiac, neurological and other consequences, which can ultimately be fatal.

Generally, the long-term health consequences of STIs are more serious among women.

- Why should this be so?
 - This is because, women and girls are less likely to experience symptoms, and so many STIs go undiagnosed until a serious health problem develops.

People who become ill from STIs may face loss of community credibility and even health workers sometimes treat them badly, being judgemental and refusing to provide services. It is important that you provide a good role model and become known for being sympathetic and non-judgemental.

4.3 STI prevention strategies for young people

As a Health Extension Practitioner, you should advise and encourage young people to adopt the following healthy behaviours:

- Delay onset of sexual activity. Abstain from sexual intercourse until married or in a stable relationship.
- Learn how to use condoms. If young people are already sexually active, it is important to make sure they know how to use condoms correctly. You should demonstrate the proper use of condoms in your education sessions related to sexually transmitted infections either individually or in group meetings (in schools, at the health post or in the community).
- Condoms should always be used except when pregnancy is desired or when partners in a stable relationship know for certain they are both disease-free.
- Avoid any kind of risky behaviour; try to stick with one partner. Boys should avoid having contact with prostitutes.



Figure 4.2 A girl having pelvic pain which might be indicative of an STI and a boy having pain during urination caused by an STI.

- Discuss sexual issues. Young men and women must feel comfortable communicating with their partners and family about sex and their sexual histories. A communicative relationship is essential to emotional and physical health.

When you discuss these sexual issues with young people it is also a good idea to tell them how to recognise the symptoms of STIs (Figure 4.2). For example, you should explain that if they experience burning with urination, have a discharge from the penis/vagina, and/or have genital sores then they and their partner should not have sex but should go to the higher level health facility for treatment.

4.4 Young people with HIV

There are two groups of young people living with HIV: those who were infected around birth and have survived into adolescence and those young people who have been infected during adolescence, usually through unprotected sex. This infection history has an impact on many features of how HIV affects a young person, including prevention strategies and their HIV care and management (e.g. progression of HIV disease, treatment with antiretroviral therapy (ARV drugs), knowledge and disclosure of HIV status, access to care). For example, young people who have acquired the HIV infection at birth will have symptoms earlier than those infected after adolescence.

Young people who are infected before entering puberty often grow slowly and enter puberty later than is normal. Girls have irregular menstrual periods. This delay in growth and sexual maturation may also have an impact on the psychosocial development of the individual.

For young people infected after puberty, the infection can remain asymptomatic for a longer period of time than for adults. The younger the age at infection (after puberty), the longer the virus remains asymptomatic.

4.4.1 Prevention of the HIV epidemic

HIV prevention among young people is the key to reducing infection rates and slowing the epidemic. Those between the ages of 15 and 24 are at the greatest risk of acquiring and transmitting HIV. They are both the most threatened and the greatest hope for reversing the HIV epidemic, by changing attitudes and behaviours. The future epidemic will be shaped by the action and behaviour of young people.

The major aims of HIV prevention include:

- Prevent transmission of HIV for all people (HIV-negative, HIV-positive or of unknown status), to reduce the number of new infections.
- Help people who are HIV negative to stay negative.
- Promote testing and counselling for people who do not know their status.

Young people everywhere report that the education they receive about HIV and sexual reproductive health is too little and too late. Adults are often hesitant to provide young people with the facts about HIV prevention and sexual health, often because they fear this will encourage sexual activity. But there is convincing evidence from studies in many different cultures that, in fact, sex education encourages responsibility. Knowledgeable young people tend to postpone intercourse or, if they do have sex, to use condoms.

4.4.2 Who has a role in HIV prevention?

HIV prevention requires active involvement from all members of society to ensure an environment where young people feel safe and supported and able to protect themselves from HIV at home, school and work and in their community.

Young people

HIV prevention must focus on young people because young people have an essential role in slowing the epidemic. Many young people listen to their peers and believe their peers. Young people can be trained to spread messages and promote responsible behaviour among their friends and colleagues. This is known as **peer education** and is discussed in Study Session 12. As a Health Extension Practitioner you can help by raising the awareness of young people about STIs including HIV through peer education and education in schools.

Parents and other adults in the community

All adults have a role to play in their personal capacity as parents, members of extended families and adult role models. They may also have a professional role as teachers, sports coaches and religious leaders. Studies have identified that having a positive relationship with parents, teachers and other adults in the community and having spiritual beliefs helps adolescents avoid behaviour that puts them at risk of HIV.

Targeted strategies must be available that focus on individual needs. (e.g. safer sex information and free condoms for young prostitutes; outreach information programmes for young people who have left school).

Public idols who are role models for young people

Musicians, film stars and sports figures provide role models for young people through their personal lives and through their performances. The images and messages they portray should encourage young people to adopt and maintain healthy behaviours. You can use known examples to help you deliver safer sex messages and to discourage risky behaviour.

Government leaders and the media

Politicians, journalists and public servants can affect the social, economic, and political factors that determine the risk environments for HIV infection in which young people live and work. Public images of sexual behaviour and HIV in the media influence young people. You should look out for those that can help you achieve the aims of HIV prevention.

People living with HIV

People living with HIV and those with AIDS have a role in HIV prevention. They have a personal role to ensure they do not transmit HIV to any other person. People living with HIV are frequently subject to discrimination and human rights abuses. A strong movement of people living with HIV and AIDS can develop a network that provides mutual support and a voice at local and national levels and can be a particularly effective method of tackling HIV stigma. If there are such people living in your community you can work with them to teach young people about ways of preventing HIV infection and also offer your support by showing that you are not judgemental in your dealings with such people.

4.4.3 Key HIV prevention strategies for young people that you can offer at health posts

HIV prevention services must be offered to young people whenever they come for health services (STI, antenatal care, family planning, etc). Key prevention strategies for young people cannot be the same for all but need to be adapted to their different needs. For example for boys and girls in primary school (**early adolescence** age 10–14), it is appropriate to talk about the changes during puberty and the benefits of abstinence and delaying sexual activity. By contrast, for **post-adolescents** (aged 20–24) education about faithfulness and safer sex using condoms is relevant as they are likely to have started sexual activity anyway. Similarly, you need to provide appropriate messages for adolescents in and out of school and young people both married and unmarried based on their needs for information and services.

Postponing the first sexual activity and reducing the number of sexual partners can significantly protect young people from HIV. **Behavioural change communication** can help young people to develop positive behaviours. Behavioural change communication is the process of using communication approaches and tools to develop the skills and capabilities of individuals to promote and manage their own health and development. It promotes positive change in their behaviour, as well as in their knowledge and attitudes. The messages and the way the messages are given are very important for young people, as they do not want to only hear what they cannot do, but also what they can do. Figure 4.3 shows the stages of behaviour change that an individual passes through, from being completely unaware to making positive behaviour changes.

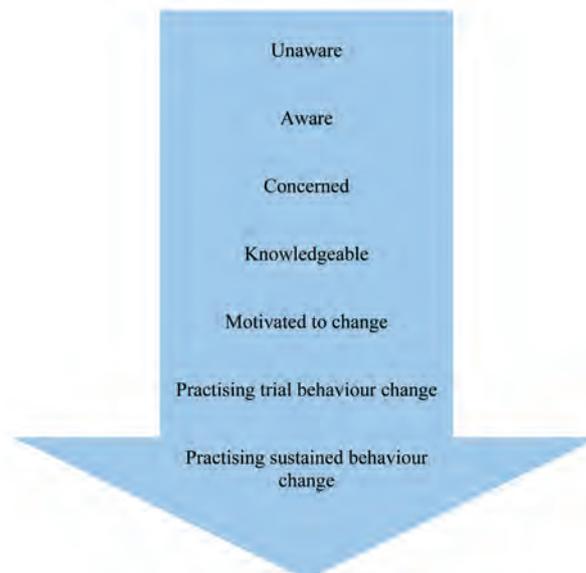


Figure 4.3 Stages of behaviour change.

As you can see in Figure 4.3, behaviour change doesn't immediately follow awareness. It takes some time for individuals to change their behaviour even after they have the necessary knowledge. Hence, whenever you counsel young people who are already engaged in some form of risky behaviours (such as having multiple sexual partners, chewing khat, or drinking alcohol), it is important that you tell them they shouldn't expect everything to change overnight. Behaviour change is a process that needs to be continuously supported and reinforced in order to bring the desired change.

Provider-initiated testing and counselling and voluntary counselling and testing (VCT) services need to be available at all health facilities and in the community. These methods can be used both for giving information on sexual behaviour and HIV and also for opening the discussion on many sensitive issues faced by young people (e.g. peer pressure, condom negotiation, unwanted pregnancy, decision making, how to be an adult, disclosure of HIV status). There are more details on provider-initiated testing and counselling in Study Session 26 of the *Communicable Diseases, Part 2* Module.

The use of latex condoms to prevent the exchange of body fluids during sex is an essential element of all HIV prevention activities. Safer sex depends on the correct and consistent use of condoms, so condom provision must be accompanied by clear instructions on condom use for every act of penetrative sex. Female condoms offer women an option that may give them more control but they also require more counselling and assistance with respect to their proper use and they are also more expensive and less available. Condom promotion also supports **dual protection**.

- What is meant by dual protection?
- Dual protection is the simultaneous protection against unwanted pregnancy and the possible transmission of STIs including HIV.

STIs greatly facilitate HIV transmission and acquisition between sexual partners, so treating and preventing them is an important step in HIV prevention. Effective and early treatment of STIs is an essential part of HIV prevention. Hence, it's important that you refer adolescents with STIs to minimise the risk of transmission and complications.

Summary of Study Session 4

In Study Session 4, you have learned that:

- 1 STIs including HIV are common among young people for biological and psychosocial reasons. Biologically, young women are more susceptible to STIs than older women because of their immature vaginal mucosa and cervical tissue.
- 2 Adolescents are likely to engage in unsafe sexual practices (including having multiple sexual partners, using prostitutes and not using condoms), which predisposes them to STIs including HIV. This is because they often lack basic information concerning their sexual health, including ignorance of the symptoms, transmission, and treatment of STIs.
- 3 In most rural areas girls are married at a very early age and they are not empowered to say 'No'. As a result, young women may have their first sexual experiences with older men while young men may have their first sexual experiences with prostitutes; both behaviours increase the chance of getting STIs including HIV.
- 4 STIs in young people can lead to multiple long-term negative consequences for their health and social life and can even result in early death. Health problems include pelvic inflammatory disease, chronic pelvic pain, fetal death, ectopic pregnancy, cervical cancer and related maternal mortality. Chlamydia and gonorrhoea can also result in infertility, particularly in women. Chlamydia can cause pneumonia in infants, while neonatal gonococcal infections of the eyes can lead to blindness. Syphilis in adults can cause serious heart and brain disease which can be fatal.

- 5 Young people can acquire HIV in two ways through infection from their mothers at birth or through unprotected sex during adolescence. This infection history has an impact on how HIV affects a young person and on their HIV care and management.
- 6 HIV prevention requires active involvement from all members of society including young people themselves, parents, role models, government leaders, the media and people living with HIV and those with AIDS.
- 7 In general, behaviour changes take time and don't always automatically follow awareness. Hence, it is important that you provide continuous support whenever you counsel young people who are already engaged in some form of risky behaviours to adopt healthy behaviours.
- 8 In addition to awareness raising and education of young people on ways of STI prevention, there is a need to provide condoms and refer them for appropriate counselling and HIV testing.

Self-Assessment Questions (SAQs) for Study Session 4

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

First read Case Study 4.1 and then answer the questions that follow it.

Case Study 4.1 The marriage of Tessema and Meselech

Tessema (23 years) and Meselech (16 years) had been attracted to each other for some time. Meselech had to drop out from school when she was a 5th grade student as her parents felt she was not safe going to school alone; Tessema only completed 4th grade as his father decided that he had to take care of the farm and domestic animals. When they finally began to date, things moved very quickly and they decided to have sex. They were married 6 months later. Neither of them had any information about contraceptive use or STIs.

Almost a month later Tessema comes to see you because he has developed a small sore (blister) on his penis.

A year later Meselech comes to you complaining of having an unusual vaginal discharge and pain during urination. She thinks her problems may be related to the problem Tessema had because she has had similar symptoms many times in the preceding year. She says she has not seen any health worker but has been buying some (unidentified) antibiotics from the nearby drug shop but there has been little improvement. She is also concerned because she has not become pregnant even though she was expecting to conceive any time. She is particularly worried that her inability to conceive might damage her marriage. In addition, she is worried about the possibility of having HIV.

SAQ 4.1 (tests Learning Outcomes 4.1 and 4.2)

Tessema and Meselech may have an STI. Suggest factors that could have put them at risk.

SAQ 4.2 (tests Learning Outcome 4.4)

What should Tessema do and what help can you offer?

SAQ 4.3 (tests Learning Outcome 4.3)

Explain whether any of Meselech's problems could be a consequence of having an STI.

SAQ 4.4 (tests Learning Outcome 4.4)

What advice would you now give to Meselech and Tessema to prevent such problems in the future?

Study Session 5 Harmful Traditional Practices (HTPs)

Introduction

In this study session, you will learn about traditional practices that can be harmful to young people's sexual and reproductive health. These practices include; female genital mutilation, early marriage, marriage by abduction, and polygamy. You will also learn some of the reasons that are given to explain why communities practise these harmful acts and what you can do to minimise or eliminate harmful traditional practices in your community.

Learning Outcomes for Study Session 5

When you have studied this session, you should be able to:

- 5.1 Define and use correctly all of the key words printed in **bold**. (SAQs 5.1 and 5.2)
- 5.2 Describe common harmful traditional practices (HTPs) and the consequences they have for sexual and reproductive health. (SAQs 5.1 and 5.2)

5.1 Harmful traditional practices (HTPs)

Traditions are long-established patterns of actions or behaviours, often handed down within a community over many generations. These customs are based on the beliefs and values held by members of the community. Traditions are often protected by **taboos**, which are strong social prohibitions (or bans) relating to human activity or social custom based on moral judgement and religious beliefs. This means that traditions are not easy to change, because people adhere to these patterns of behaviour, believing that they are the right things to do. Ethiopia has both beneficial traditional practices (such as breastfeeding, relieving women from work after delivery, providing special care and a nutritious diet for a newly delivered mother) and harmful traditional practices.

Harmful traditional practices are those customs that are known to have bad effects on people's health and to obstruct the goals of equality, political and social rights and the process of economic development.

Harmful traditional practices affecting young people in Ethiopia are very common. Among these, female genital mutilation (FGM), early marriage, and marriage by abduction, forced marriage and polygamy are particularly important for you to understand because of their effect on reproductive health. Examples of other which we will not discuss here because they are not very much related to reproductive health include uvulectomy (excision of the uvula), bloodletting through vein puncture (called *wagemt* in Amharic), and milk tooth extraction.

5.1.1 Female genital mutilation (FGM)

The World Health Organization (WHO) defines **female genital mutilation** (also called '**female genital cutting**' or '**female circumcision**') as any procedure which involves the partial or total removal of the external female genitalia (see Figure 5.1) or which causes any other injury to the female genital organs whether for cultural or any other non-therapeutic reasons. Instruments used include knives, scissors, razors, and pieces of glass. Occasionally sharp stones and cauterization (burning) are used.

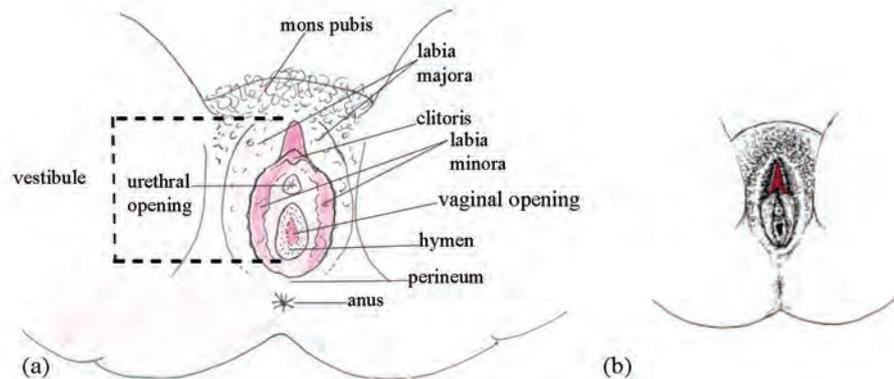


Figure 5.1 (a) Female external genitalia. (b) Female genitalia after cutting showing total removal of the clitoris and/or the prepuce (clitoridectomy).

FGM has no known benefits; instead, it can have both short- and long-term bad consequences for health.

- Thinking about the instruments that are used, suggest one short-term bad physical consequence of FGM.
- An immediate physical effect of FGM might be bleeding and injury to nearby genital tissue. Since FGM is usually conducted under unhygienic circumstances, it may also result in tetanus or sepsis (bacterial infection) developing very soon.

In the long term, FGM can cause repeated recurrent urinary tract infections, increased risk of childbirth complications and newborn deaths and the need for later surgery. For example, the FGM procedure that seals or narrows a vaginal opening needs to be cut open later in life to allow for sexual intercourse and childbirth. Sometimes it is stitched again several times, e.g. after childbirth, hence the woman goes through repeated opening and closing procedures.

There are often psychosocial consequences of FGM (see Box 5.1).

Box 5.1 Consequences of FGM

Short-term physical consequences

- Severe pain (see Case Study 5.1)
- Injury to the adjacent tissue of urethra, vagina, perineum and rectum
- Bleeding
- Infection
- Failure to heal.

Long-term physical consequences

- Difficulty in passing urine
- Recurrent urinary tract infection
- Difficulties in menstrual flow
- Fistula.

Psychosocial consequences

- Mutilation is an occasion marked by fear, and the suppression of feelings. More often the bad memory never leaves the victims.
- Some women report that they suffer pain during sexual intercourse and menstruation.
- The experience is associated with sleeplessness, nightmares, loss of appetite, weight loss or excessive weight gain.
- As they grow older, women may develop feelings of incompleteness, loss of self-esteem/confidence, and depression/sadness.

Now read Case Study 5.1.

Case Study 5.1 Almaz

Almaz is a seven-year-old living in Southern Ethiopia. Her parents have decided that she will be ‘circumcised’ because they believe that without it, she won’t be married (Figure 5.2). They believe it is a kind of ‘cleaning’. No one has explained to Almaz exactly what will happen to her on the day of her circumcision. Abebech, a 65-year-old known traditional practitioner, used a new razorblade to cut her genitalia. The practitioner needed six women to hold Almaz down.



Figure 5.2 FGM is nearly always carried out on minors under 18 years of age in violation of their rights. Parents believe they are doing the right thing (Case Study 5.1) (Photo: *UNICEF information sheet*)

Almaz almost lost consciousness because of the pain, and shortly after the procedure she was taken to her parents as she was not able to walk on her own.

Stop reading for a moment. Have you yourself experienced FGM or do you know someone in your village who has undergone the same procedure? If so, what are the reasons for it? What is the usual age at which girls undergo FGM in your community? What roles can you play to stop the practice?

Although FGM is recognised as a violation of human rights under Ethiopian law, it continues to be practised in many regions of Ethiopia. A study in 2005 indicated that three in four Ethiopian women aged 15–49 had undergone some form of FGM.

The age at which girls are made to undergo FGM varies from region to region. In Amhara and Tigray, for example, FGM is performed at infancy, usually on the eighth day after birth. In Somalia, Afar and Oromia, girls are subjected to FGM between the ages of seven and nine, or just before marriage between the ages of 15 and 17. According to the same study (in 2005), FGM is highest in Afar, where 85% of women have a daughter with genital mutilation, and lowest in Gambela, where 11% of women have a daughter with mutilation. It is a shocking measure of deep-rooted gender inequality that one in three rural women believes that the practice should continue.

There are a variety of reasons why FGM continues to be practised. You have already reflected on the reasons that are given for FGM in your community. Box 5.2 gives reasons that are commonly reported.

Box 5.2 Reasons given by communities for practising FGM

- *Sociocultural reasons:* in some communities, FGM is believed to ensure a girl's virginity and thereby her family's honour, because virginity is often a prerequisite for marriage.
- *Psychosexual reasons:* in some communities the unexcised girl is believed to have an overactive and uncontrollable sex drive which makes her likely to lose her virginity prematurely, disgracing her family and damaging her chances of marriage.
- *Spiritual and religious reasons:* for some communities, removing the external genitalia is necessary to make a girl spiritually clean and is therefore required by religion. Muslims who practise FGM tend to believe that it is required by the Koran. However, FGM is not mentioned in the Koran.
- *Hygienic and aesthetic reasons:* in some cultures, woman's external genitalia are considered as ugly and dirty and removing these parts of the external genitalia is believed to make girls hygienically clean.

It is important to note that all the above reasons for practicing FGM are based on false beliefs that FGM has advantages for the girls and their community. You will learn and teach others that none of these reasons are true. In fact, FGM harms women's sexual and reproductive health. In particular it can cause difficulties during childbirth.

As a health worker, you need to acknowledge the fact that it is not easy to change such a tradition when it has been believed by many generations of people in your community. That is why it needs constant teaching and society's support to stop the practice. It is especially helpful if men can accept that it is damaging to their daughters and if the women who perform the procedure can be convinced that it needs to stop. (Remember that this will be very hard for them as they would lose a source of income).

5.2 Early marriage

Early marriage is a common practice in many regions, particularly in rural Ethiopian communities where it is thought to ensure virginity. Parents often wish to see their daughters married and to see grandchildren before they die. People also practise early marriage for traditional reasons. If a girl is not married at an early age, other members of the community may think she must be too unattractive or ill-behaved to get a husband. This attitude usually causes shame to both the girl and her family.

In Northern Ethiopia, girls as young as seven are married to teenage boys or older men. Studies show that the average age at marriage in Ethiopia is around 16 years. Hence marriage happens when the young adolescent or preadolescent girl is not ready, physically and psychologically, for intercourse, pregnancy, or childbearing and rearing.

I hate early marriage. I was married at an early age and my in-laws forced me to sleep with my husband and he made me suffer all night. After that, whenever day becomes night, I get worried thinking that it will be like that. This is what I hate most. (UNFPA, *State of World Population 2005*)

This quote from an Ethiopian girl, aged 11, married at age five shows the long-term psychological damage caused by early marriage. Now read Case Study 5.2, which describes the problems another young girl had because of early marriage.

Case study 5.2 Emebet

Emebet is a 15-year-old girl who got married in a rural village to Tola, a 24-year-old. Following her marriage she became pregnant. However, she was not fully grown herself and had a very prolonged labour. After three days labour with no health professional to assist her, the baby was stillborn. She became **incontinent** (unable to control her urine) due to a **fistula** (a hole that formed in the wall of the vagina communicating with the bladder) (see Box 5.3).

A few days later Emebet was taken to a hospital where she was able to get medical care, but she was told that her condition needed prolonged treatment and follow-up in the hospital. As a result she was forced to live confined to her house for a long time.

In the meantime, her husband left her and married another young woman from the same village. Emebet was very sad when she realised that it would be very difficult to remarry in her present situation.



Figure 5.3 A young woman suffering from obstetric fistula.

Box 5.3 Obstetric fistula

Obstetric fistula is a condition in which a woman continuously leaks urine and/or faeces, which often follows prolonged obstructed labour. An obstetric fistula is a hole or a defect that forms in the wall of the vagina communicating with the bladder (**vesico-vaginal fistula**) or with the rectum (**recto-vaginal fistula**) as a result of obstructed labour. A fistula is created when the vaginal tissues are crushed between the bony plates formed by the fetal head and the pelvic bones for prolonged periods of time. Obstetric fistula is more common among young women as they are likely to have prolonged and obstructed labour because of their underdeveloped pelvis.

Because of the constant leakage of urine and/or faeces, and frequent urinary tract infections, victims of fistula have a terrible odour, which is one of the reasons why their communities isolate them (Figure 5.3).

Fistula victims suffer profound psychological trauma resulting from their complete loss of status and dignity. The majority of women who develop fistulas are abandoned by their husbands because of their inability to have children. Facing familial and social rejection and unable to make a living by themselves, the women who develop fistula live for years without any financial or social support. Many fall into extreme poverty.

If you encounter a young woman suffering from such condition, you need to refer her to a hospital where the fistula can be repaired.

Early marriage is associated with many health and social consequences. These include:

Health impacts of early marriage:

- Early pregnancy, which may lead to nutritional deficiencies for the mother and child
- Increased risk of death due to pregnancy-related causes
- Risks to baby include premature birth, low birth weight (reflecting poor nutritional status), fetal loss, and **neonatal mortality** (death of the newborn within the first 28 days of life)
- Vaginal tear and fistula
- Sexual abuse (see quote from Ethiopian girl on page 44)
- Young married girls are less likely to participate in decision making.

Social impacts of early marriage:

- Disrupts life of the victim
- Limited opportunity for education and employment (see Figure 5.4)
- Higher likelihood of broken marriage
- Rural-urban migration (which may predispose them to prostitution, STIs, HIV and AIDS)
- Stigma, and low self-esteem.

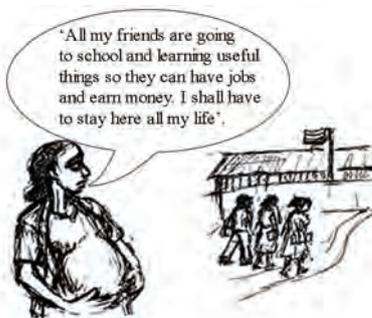


Figure 5.4 Pregnant girl watching other children setting off to school.

5.2.1 Legal aspects of early marriage

- What is the legal age for marriage in Ethiopia? What would you do if you encountered an adolescent girl being married before the legal age for marriage?
- In Ethiopia, any marriage arrangement made when either of the couple is underage, and/or without their consent or approval, is illegal and punishable by law. The law forbids the marriage of boys and girls under the age of 18 years. If you become aware that a young girl is going to marry before she turns 18, you need to advise the families that early marriage has many harmful consequences and is against Ethiopian family law. If you can't contact the families or if they ignore your advice and seem likely to continue with such a marriage you need to notify the appropriate government agencies, including the Office of Women's Affairs or nearby police, so that early marriage can be prevented and the law is respected.

As you have seen, early marriage is associated with many health and social consequences which could be prevented if the community has sufficient knowledge and the law is enforced.

5.3 Marriage by abduction

Marriage by abduction is the unlawful carrying away of a woman for marriage. It is a form of sexual violence against the woman. The would-be abductor forms a group of intimate friends and relatives to kidnap the girl without the slightest clue or information being given to the girl's family, relatives or friends. In some cases abduction is followed by rape.

Marriage by abduction is prevalent in Ethiopia. According to a study conducted in 2005 8% of women of reproductive age reported that they had been married by abduction. Figure 5.5 shows that it is more common in Oromia (11%) and SNNPR (13%) but less common in some other region, e.g. Tigray (1.4%), and Amhara (2.4%).

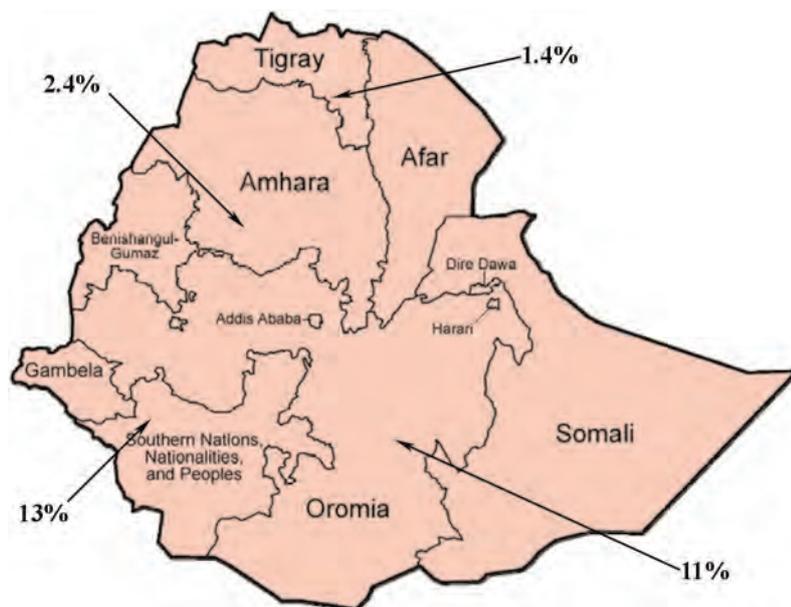


Figure 5.5 Map of Ethiopia showing the prevalence of marriage by abduction in some regions in the year 2005.

The reasons for marriage by abduction include:

- Refusal or anticipated refusal of consent by the parents or the girl
- To avoid excessive wedding ceremony expenses and ease the economic burden of the conventional bride price
- To outsmart rivals when the girl has many suitors or potential spouses and/or the inclination of the girl or her parents is not predictable
- Difference of economic status of partners.

Some of the harmful effects include:

- Maltreatment of the girl including beating, inflicting bodily harm, severe disabilities and death
- Conflicts between families may lead to quarrels lasting for generations
- Unhappy, unstable and loveless marriage
- Psychological stress on the girl resulting in suicide
- Expenses related to conflict resettlements as compensation to the family or for court cases
- Discontinuation of schooling and other opportunities for the girl.

5.4 Polygamy

Polygamy is a common practice in Ethiopia. It is a form of marriage in which a person marries more than one spouse. Polygyny (from Greek words: poly = many; gyny = woman) refers to a polygamy in which a man has two or more wives. About 12% of married women in Ethiopia are in polygynous unions (see Figure 5.6). It is usual for a young girl to be married to an older married man.



Figure 5.6 A young woman with older co-wives and her husband.

Who do you think should choose the husband for a young girl: the girl or her parents?

In most rural parts of Ethiopia, girls have no power to choose their husbands. It is usually their parents, particularly their father, who decides who they will marry and the marriage is usually arranged by the parents. It is the legal right of Ethiopian women to choose whom to marry and when to do it. However, their right is not respected and is almost always violated (usually by their parents).

- What bad consequences can polygamy have on the sexual and reproductive life of young women?
- Polygamy has multiple impacts on the reproductive health and overall life of young women, as you have just learned. It is usually a young woman who is given to a married man. That means the second or third wife is usually younger than the first wife. The young woman usually has less access to resources, little autonomy and no input into family decision making. This exposes her to many health problems including malnutrition of herself and her children. As her husband has multiple sexual partners (i.e. more than one wife), she may be at risk of STIs, including HIV, and then developing AIDS.

5.5 Intervention strategies to minimise and eliminate HTPs

This is obviously a difficult and sensitive subject for you to discuss with people in your community. It may help if you make it widely known that the Ethiopian government and religious leaders, including Islamic and Christian, have taken a lead internationally in condemning HTPs.

- When raising awareness who should you target?
- Everyone in the community but especially young people, men, community leaders, religious leaders and the women who perform FGM or encourage HTPs.

In particular, you need to work with both Islamic and Christian religious leaders as some of the justifications for practising harmful traditional practices are incorrectly linked to religions. Most religious leaders teach their followers about the position of their religion with regard to such practices which will help your effort in educating your community. It is crucial that you attempt to educate practitioners of HTPs about the dangers of such practices.

You should also mention that the Ethiopian law is against FGM, marriage by abduction and early marriage.

It is important to use educational activities to address the community's perceptions that there are advantages to practising FGM. This can often be done effectively if you can describe a case study of one of the traditional harmful practices. It is even more effective if a girl who has first hand experience of a HTP is willing to discuss her problems as an example to others.

If people in your community have suffered from HTPs and are willing to talk to you, you can help by listening in a sympathetic and non-judgemental way. There may also be some medical assistance you can offer, but you need to refer them to the next level of facilities for better psychosocial support and medical assistance.

Summary of Study Session 5

In Study Session 5, you have learned that:

- 1 There are both useful (such as breastfeeding; relieving women from work after delivery) and harmful traditional practices in Ethiopia that affect the health of adolescents and youth.
- 2 Among the harmful traditional practices affecting young people in Ethiopia, female genital mutilation (FGM), early marriage, marriage by abduction and polygamy affect reproductive health.
- 3 Communities have reasons for practising some of the harmful traditional practices. Some of the reasons for practising female genital mutilation include sociocultural reasons (such as ensuring girls' virginity and hence the family's honour), hygienic and aesthetic reasons (to make girls hygienically clean), spiritual and religious reasons (wrongly believing that it is required by their religion), and psychosexual reasons (to control the sex drive of uncircumcised girls).

-
- 4 Parents desire early marriage for their daughters so that they can see many grandchildren before they die. Early marriage is also preferred by parents to ensure their daughters are virgins when they marry and hence live up to traditional expectations.
 - 5 Harmful traditional practices have multiple negative health consequences for adolescents (and, if they became pregnant, for their children). These consequences range from long- and short-term physical problems such as unwanted pregnancy, severe pain, bleeding and infections, to psychological problems such as mental disorders like depression and social consequences such as limited educational opportunities.
 - 6 HTPs and their complications are completely preventable. However, it is not easy to change traditions which have been practised for a long time. Hence, you need to raise awareness not only about the bad consequences of HTPs but also about the legal implications of such practices.

Self-Assessment Questions (SAQs) for Study Session 5

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 5.1 (tests Learning Outcomes 5.1 and 5.2)

Kedija is a 15-year-old girl living with her parents in a rural village. Her father and mother decide she should marry an older merchant in his 50s who lives in the neighbouring town. Her parents are convinced that she would have a better future if she married an older man.

- (a) What does Ethiopian law say regarding forced and early marriage?
- (b) Does Kedija have the right to say 'No' to the suggestions made by her family?

SAQ 5.2 (tests Learning Outcomes 5.1 and 5.2)

In Case Study 5.2 you read that Emebet was married when she was 15-years-old. Explain how this early marriage caused her harm.

Session 6 Gender-Based Violence

Introduction

Violence against women is a very common problem in Ethiopia and can happen to any woman in any culture. It is a violation of human rights. It is also a public health problem, though it has not been given due considerations as a public health problem. It affects every aspect of the woman's life and has many complex sexual and reproductive health consequences. In this session, you will learn about the consequences of the major forms of violence against women. You will also learn how you can help girls and women who are victims of violence.

Learning Outcomes for Study Session 6

When you have studied this session, you should be able to:

- 6.1 Define and use correctly all of the key words printed in **bold**. (SAQs 6.1, 6.2, 6.3 and 6.6)
- 6.2 Describe types of gender-based violence. (SAQs 6.1, 6.2, 6.3 and 6.6)
- 6.3 Explain some of the factors that contribute to gender-based violence. (SAQs 6.1, 6.2 and 6.3)
- 6.4 Discuss barriers to reporting sexual violence. (SAQs 6.1 and 6.3)
- 6.5 Describe the sexual and reproductive health consequences of gender-based violence. (SAQs 6.1 and 6.4)
- 6.6 Describe your role in the prevention and management of gender-based violence. (SAQs 6.1 and 6.5)

6.1 Gender related terminologies

- What is the difference between sex and gender? (If necessary re-read the definition of gender given in Study Session 1 of this Module).
- **Sex** is the biological characteristic that defines humans as female or male. These characteristics do not change from time to time and are found in every culture.

Gender refers to socially and culturally defined roles for males and females. These roles are learned over time, can change from time to time, and vary widely within and between cultures. Gender is not only about girls/women. However, the traditionally defined gender roles in Ethiopia disadvantage girls and women (see Figure 6.1). Now that you understand that gender roles can be changed you will learn what types of gender-based violence may be occurring in your community.



Figure 6.1 The boys play while the girls work in this Ethiopian village.

6.2 Gender-based violence

Gender-based violence (GBV) is any form of deliberate physical, psychological or sexual harm, or threat of harm, directed against a person on the basis of their gender.



Figure 6.2 Woman attempting to escape from a man who is trying to throw her to the ground and rape her.

Although gender-based violence is not exclusively directed against females, they do suffer from it the most, which is why the focus of this study session is on women and girls (see Figure 6.2). GBV is a violation of fundamental human rights. Violence against girls and women prevents them from enjoying their rights, such as those shown in Box 6.1.

Box 6.1 Fundamental human rights to which everyone is entitled without distinction based on race, sex, language, religion, political or other opinions

- Everyone has the right to life, liberty and security of person.
- No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.
- Everyone has the right to a standard of living adequate for health and wellbeing.
- Everyone has the right to social security and personal development.
- Everyone has the right to education.
- Everyone has the right to freedom of opinion and expression.

When violence occurs against girls and women, it is usually committed by boys or men. Violence against women stems from the unequal power relations between men and women. A person with more power has many choices, while a person with less power has few choices. There are many types of power, such as economic power (control or access to money and other resources) and physical power (strength or weapons). The person with less power is vulnerable in many ways. Women have less power than men and as a consequence are more vulnerable to violence (see Figure 6.3).

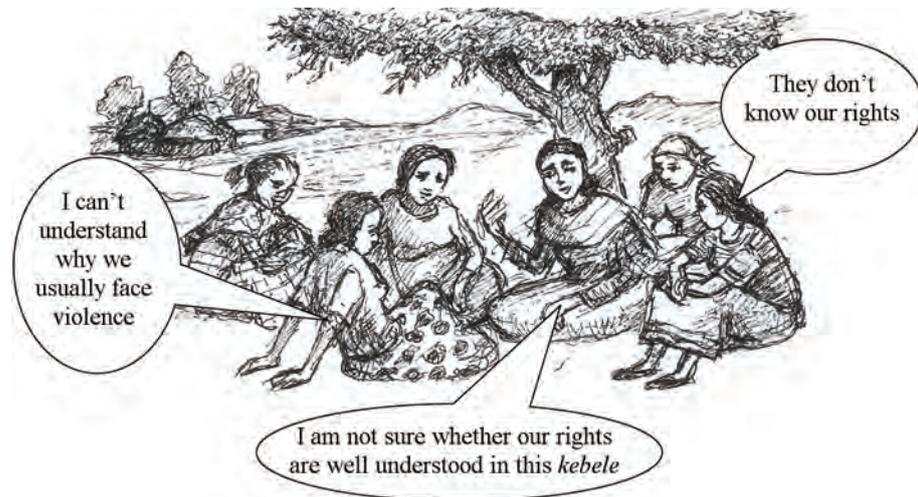


Figure 6.3 Women discussing rights and violence.

The most common form of violence is the violence against girls and women at the household level. In most communities in Ethiopia, this GBV is accepted as normal behaviour and there is little awareness of GBV as an issue that needs attention. It is not treated as a serious crime but as a private matter even though it has serious consequences for girls and women.

Violence against women and girls takes place throughout their lives, starting in infancy and continuing to old age. Examples include the preference for a male child, trafficking for labour and sexual abuse, rape, wife beating, food restriction, early marriage, marriage to a man who already has a wife, abduction, female genital mutilation and wife inheritance.

There are various factors that make girls and women vulnerable to acts of violence, such as:

- They lack power
- They have low status
- They are often less educated
- They are often poor and economically dependent on men and this inequality places them in a situation where they are easily abused
- Cultural beliefs and values reinforce rigid gender roles and the low status of women. Most of the violence against girls and women is perpetrated under the cover of culture
- Limited awareness (among both females and males) about the rights of girls and women
- Boys and men commonly drink alcohol and use other mind-altering substances which impair judgement and/or make them violent.

Stop reading for a moment and think about this from your own experience.

What sort of violence against girls and women happens in your community?

6.3 Types of gender-based violence

Table 6.1 shows that GBV can be physical, psychological or sexual.

Table 6.1 Types of gender-based violence.

Physical	Psychological	Sexual
Beating	Insulting	Harassment (any type of unwanted sexual attention)
Biting	Yelling	Touching sexual parts of the girl's/woman's body
Kicking	Recalling past mistakes	Touching in a sexual manner against the will of the girl/woman (e.g. kissing, grabbing, fondling)
Restraining	Constant criticism	Rape (forced sexual intercourse)
Pulling hair	Expressing negative expectations	Use of a weapon to force into a sexual act
Choking	Humiliation	Forced prostitution
Throwing objects	Denying opportunities	Sexual trafficking
Using weapons	Discriminating	

Stop reading for a moment and think about this from your own experience. Are any of these types of violence common in your community?

Although same-sex physical violence (even including stabbing) can be common among adolescents, the unequal power relationship results in most physical violence being directed at girls by boys.

Psychological GBV can be hidden, but you might uncover it if you ask some questions, for example, you could ask a very under-confident young girl whether she is receiving a lot of criticism from her family for being a girl.

You can see from Table 6.1 that **sexual violence** includes a wide variety of undesired sexual acts, ranging from **sexual harassment**, which includes unpleasant sexual comments or physical gestures, to **sexual abuse**, which is any type of unwanted sexual contact (Figure 6.4) and includes all forms of sexual coercion (emotional, physical, and economic) against an individual.



Figure 6.4 An example of sexual abuse: young woman receiving unwanted sexual contact.

Rape is defined by the Ethiopian law as having sex with a woman or girl without her consent or with consent obtained under threat, force, intimidation, fear of bodily harm or misrepresentation. Many adolescents are forced to have sexual relations with men or boys they know and are assaulted if they refuse to have sex. If a boyfriend forces his girlfriend to have sex against her will this is called **date rape** while **acquaintance rape** is committed by someone who is known to the girl, such as a neighbour, teacher, religious leader, family friend or relative. But sometimes a stranger commits an act of sexual violence.

All types of GBV can have damaging consequences, as you will learn in the next section.

6.4 Consequences of gender-based violence

Stop reading for a moment and think about this from your own experience. Try to remember a girl in your community who experienced any form of GBV. What were the consequences for her?

GBV that involves physical violence could lead to a physical injury, from a simple wound to loss of body parts and even death. There are lots of reported cases of deaths due to GBV in Ethiopia so you may have thought about such a case from within your own community.

GBV also causes psychological trauma such as fear, anxiety, self-blame, depression and suicidal thoughts. It is not usually visible (unlike physical trauma) but girls/women suffer a great deal from it and the effects can be

longer-lasting than a physical injury (see Figure 6.5) and affect behaviour and interpersonal relationships. For example, women who are sexually abused during their childhood tend to feel guilty about the abuse. They develop negative feelings about themselves and lose self-esteem. These bad feelings about themselves often causes them to engage in high-risk behaviours and practices. This makes them more vulnerable to STIs including HIV, unwanted pregnancies and infertility.



Figure 6.5 This woman has become depressed after being raped. She feels isolated and that she has no one who understands her situation.

Sexual violence also contributes to the spread of STIs. For example, a girl or woman who is raped by an infected person can get infected. She could also have an unwanted pregnancy leading to a number of negative outcomes including unsafe abortion. Girls who have experience GBV (particularly when physical and sexual violence is involved) may make frequent visits to health facilities with various complaints which could include escalating pain, pelvic and back pain, gastrointestinal problems, and repetitive episodes of STIs or unintended pregnancies (Table 6.2). But they may not tell health workers of the sexual violence they have experienced and health workers fail to recognise that undiagnosed GBV is underlying all these complaints and problems, so they do not ask about violence. Thus, these girls and women do not get the help that they need from the health facilities.

Table 6.2 Effects of gender-based violence.

Physical	Psychosocial/mental	Sexual and reproductive
Partial or permanent disability	Anger, anxiety, fear	Sexual disorders and risky behaviours
Poor nutrition	Shame, self-hate, self-blame	Early sexual experiences (for those who are victims of childhood sexual abuse)
Exacerbation of chronic illness	Post traumatic stress disorder (nightmares, recurrent distressing thoughts)	Unprotected sex
Chronic pain	Depression	Abortions
Gastrointestinal problems	Sleep disorders	Bad pregnancy outcomes, low birth weight, neonatal death
Organ damage	Suicidal thoughts	Maternal death
	Substance abuse	Suicide
	Social stigma	STIs including HIV
	Social rejection and isolation	AIDS
		Infertility
		Chronic pain

GBV has various interrelated effects on health, so it seems strange that girls and young women do not report the GBV when they come to the health facility.

6.5 Barriers to reporting sexual violence

Stop reading for a moment and think of your experience in your community. What inhibits victims from reporting rape?

Reasons for not reporting GBV include:

Fear of stigma and discrimination. Someone who has been raped may be seen by others as unclean. She will be blamed for what has happened to her and may experience discrimination.

Blame. Society expects girls and women to be able to avoid sexual violence including rape. If any form of sexual violence occurs, society often blames the woman for the way she behaves and dresses, saying that the rape is her fault because she has provoked sexual desires in boys and men.

Fear of disbelief. Many girls do not think anyone will believe them, particularly if they have been abused by someone they know. For this reason, many people who have experienced sexual violence, including children, remain silent.

Fear of revenge. Many girls and women who are raped are intimidated by their attacker, who threatens that he and his family and friends will cause her further harm if she makes a police report. They may even make death threats.

Ineffective policing. Even when young women who have been raped do report the case to the police they may not achieve much. They are not often protected by the police and if the wrong doer is not imprisoned they may be in greater danger than before.

Health workers' attitudes. People who have experienced sexual violence can recover from the trauma if they find someone who will acknowledge their experience and provide support. One way they could heal is through hearing encouraging words from healthcare providers. However, health workers are not usually understanding and supportive when someone who has been raped seeks care from health facilities. They often tend to be judgemental. This is why many girls who experience GBV will seek practical help for health issues but will not talk about the violence that has caused them to attend at the health post.

It is important that you as a Health Extension Practitioner recognise these effects and offer help. In the next section, you will learn what roles you can play to prevent and manage GBV in your community.

6.6 Your role in preventing gender-based violence

- Look at the list of factors that make GBV likely (Section 6.2). How can you help to make girls and women in your community less vulnerable?
- Educating women and involving community members, particularly men, are good ways to prevent GBV in your community.

Educated women are less likely to have undesired life outcomes. Providing girls with educational opportunities improves their status in the community. You can help by encouraging parents to send their daughters to school and by encouraging girls to go to school and to continue with their schooling. Girls and women often lack information on reproductive health issues, but education gives them necessary knowledge. You could also involve women as members and leaders of community-based health committees.

Involving boys and men in fighting GBV will have a lasting effect. As you have already learned, it is usually boys and men who inflict violence on girls and women, so any effort to abolish GBV without their engagement will not be successful. Ensure that you talk to them about GBV (Figure 6.6). Help young boys to understand that boys and girls are different but equal and everyone deserves equal respect.



Figure 6.6 A Health Extension Practitioner talking to a group of girls and boys about GBV.

As most types of GBV are carried out under the cover of culture and tradition, and are deeply rooted in the community, addressing this issue requires engagement of the community as a whole. You can use various methods to mobilise the community and improve their awareness and behaviour.

Community conversation is a good medium to fight GBV. It is also useful to get an influential community or *kebele* leader to tell community members of the advantages of improving women's health by fighting GBV and to explain that Ethiopia's ministers and religious leaders want all Ethiopians to have full and equal rights (Figure 6.7).

There is more discussion on the use of community conversation in Study Session 12 of this Module.



Figure 6.7 A village meeting to discuss the importance of respecting the rights of girls and women. (Photo: Basiro Davey)

In the next section, you will learn about the care that should be given to victims of sexual abuse.

6.7 Care and support for survivors of sexual abuse

Survivors of sexual abuse are persons who have lived through sexual violence. Table 6.2 showed the effects that they might experience as a result of the abuse. Immediately after a violent act there may be physical indicators which show that a girl has just been sexually abused (see Box 6.2).

Box 6.2 Physical indicators of recent sexual abuse in young women

Difficulty in walking or sitting

Torn, stained, or bloody underclothing

Pain or swelling in genital area

Lacerations of the hymen, labia or perineum

Bruises or bleeding in external genitalia, vaginal or anal areas.

As the girl is likely to have washed and changed her clothes before coming to see you, most of these physical signs that could indicate the presence of sexual abuse will not be there. However, if you do suspect GBV, ask in a straightforward way ‘Have you been forced to have sexual intercourse when you did not want it?’ If you say ‘Have you suffered GBV’ the girl may not understand what you mean.

Addressing sexual abuse may seem overwhelming to you, but there are a lot of things you can do. Many adolescents are reluctant to acknowledge a history of abuse. Some of them may only disclose their experience over a period of time. You need to ensure confidentiality and reassure the girl that any course of action will only be taken with her permission. Ensuring confidentiality, listening and asking questions in a non-judgemental way encourages the girl to reveal if there is a history of sexual abuse. If there is, ask whether it is still going on. Does she still have contact with the abuser? How old is he and what is his relationship to her? What is the nature of the abuse? What type of coercion was used?

If she says she was raped, give her emergency contraception if it has been less than 120 hours since the rape occurred. Rape is a medicolegal case. It needs investigation and care at a health centre or hospital. Anyone who has been raped should seek care within five days of the violence so that good quality and strong evidence can be collected for the legal process. A complete medical history and physical examination is needed for every rape case. In addition, evidence collection and laboratory investigation for both the legal process and the provision of medical care is required. Depending on their condition, someone who has been raped may need the following: care for acute injuries, psychosocial care and support, prevention of pregnancy after rape through emergency contraception, post-exposure prophylaxis for HIV, prophylaxis for STIs, and a follow-up. You should counsel anyone who has been raped to the best of your ability but if possible refer her to legal or social services that deal with sexual abuse.

Evidence needs to be well recorded and reported to the police. This should be done by a skilled person. For this reason, it is important that you refer a rape case to the nearest health centre or hospital. However, this doesn't mean that there is nothing you can do about it yourself. In addition to emergency contraception you may be able to give a screen for STIs and a pregnancy test.

Under Ethiopian law, rape is a crime and not only the person who has been raped but also their relatives and any other knowledgeable person has a duty to report it. Therefore, you have a duty to encourage and help them to report the case to the police, in addition to the care and support you give them.

Summary of Study Session 6

In Study Session 6, you have learned that:

- 1 Sex is the biological characteristic that defines humans as female or male, while gender refers to socially and culturally defined roles for males and females.
- 2 Gender-based violence is any form of deliberate physical, psychological, or sexual harm or threat of harm directed against a person on the basis of their gender.
- 3 The consequences of gender-based violence could include increased risk of STIs including HIV, unwanted pregnancy and unsafe abortions, physical injuries, and psychosocial trauma including fear, anxiety and depression.
- 4 The community should be mobilised and educated; and males and females should be equally engaged in the fight against GBV.
- 5 Anyone who has experienced GBV, particularly rape, should be counselled, referred to health centres or hospitals and supported to report to the police.



Figure 6.8 It is important to counsel anyone who has experienced GBV in a non-judgemental manner.

Self -Assessment Questions (SAQs) for Study Session 6

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering the questions below. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

First read Case Study 6.1 and then answer the questions that follow it.

Case Study 6.1 Bekelu's story

Bekelu is a 14-year-old girl. A young man in her neighbourhood has repeatedly asked her to sleep with him. She has always refused but he then beats her and forces her to have sex. He drinks a lot and fights with other community members when he gets drunk. Bekelu knows he frequently goes to the town and spends many nights there. She thinks he probably sleeps with women in the town and could have contracted HIV/AIDS. She is afraid to tell her parents because she fears they will say that it is her fault.

SAQ 6.1 (tests Learning Outcomes 6.1, 6.2, 6.3, 6.4, 6.5 and 6.6)

What type(s) GBV has Bekelu experienced?

SAQ 6.2 (tests Learning Outcomes 6.1, 6.2 and 6.3)

What factors are contributing to the GBV in this case?

SAQ 6.3 (tests Learning Outcomes 6.1, 6.2, 6.3 and 6.4)

What barrier is there for Bekelu in reporting the GBV?

SAQ 6.4 (tests Learning Outcome 6.5)

What risks and consequences of the GBV is Bekelu concerned about?

SAQ 6.5 (tests Learning Outcomes 6.6)

What will you do to help Bekelu if she tells you about her problem?

SAQ 6.6 (tests Learning Outcomes 6.1 and 6.2)

Activity 6.1 The glossary game

Write down each of the key words printed in bold in this study session. Cut the paper into strips, with one word on each strip; fold them and put them into a bowl. Take a strip, read the word and write a definition in your Study Diary. Then check your definition with those in the study session.

Session 7 Substance Abuse

Introduction

There are many interrelated factors that affect the sexual and reproductive health of young people in Ethiopia. In Study Sessions 3–6 of this module you have learned about some of the major problems that affect young people’s sexual and reproductive health. In this session you will learn how young people’s sexual and reproductive health can be affected by the use of substances like alcohol, khat, cannabis and cigarettes. There are some direct effects on sexual and reproductive functions but there are also important indirect effects whereby the abuse of substances are shown to be strongly associated with risk-taking behaviours that impact negatively on sexual and reproductive health.

Learning Outcomes for Study Session 7

When you have studied this session, you should be able to:

- 7.1 Define and use correctly all of the key words printed in **bold**. (SAQs 7.1 and 7.2)
- 7.2 Describe the types of substances that can be abused and the adverse effects they can have on sexual and reproductive health. (SAQ 7.1)
- 7.3 Explain why some young people abuse substances. (SAQ 7.2)
- 7.4 Describe your role in preventing substance abuse. (SAQ 7.3)

7.1 Substance Abuse

As you learned in Study Session 2 of this module, adolescents and young people are vulnerable to many health problems because of their risk-taking behaviour. They tend to experiment with substances without fully understanding what the consequences are likely to be for their future life and health. In particular their curiosity and peer pressure can lead to their experimenting with psychoactive substances. A **psychoactive substance** affects the functions of the brain, altering mood and distorting perception. A consequence of this is that the person’s behaviour changes. Repeated use of psychoactive substances can result in **substance abuse**. Substance abuse is defined as a pattern of harmful use of any mood-altering substance. When a person becomes unable to function normally without using these substances, they are described as being **addicted** or dependent on the substance.

Substances that could induce dependence are numerous and include substances that are popular with young people, such as: alcohol (e.g. Tella, Tej, Arakie, Beer), khat, nicotine (found in tobacco and cigarettes), cannabis (marijuana or hashish), cocaine, heroin and petrol fumes (Figure 7.1). These substances are categorized as: 1) **Licit**: those which are not regulated or prohibited and 2) **Illicit**: those which are prohibited by law. The substances which are not prohibited by law include alcohol, khat, tobacco, cigarettes and coffee. The substances restricted by regulations include cannabis (marijuana or hashish), cocaine and heroin.



Figure 7.1 Group of young people chewing khat and smoking.

You will learn in detail about substance abuse in Study Session 14 of the *Non Communicable Disease*, Part 2 Module in the mental health section; here you will learn a little bit about psychoactive substances that can be abused and the consequences of substance abuse on the health of young people. Also you will find out some of the reasons why young people are tempted to try psychoactive substances and the ways in which you can work in your community to try to prevent substance abuse.

7.1.1 Alcohol



The effects of alcohol are noticeable in all spheres (physical, psychological, social, and economic) of the lives of alcohol drinkers. Alcohol has immediate effects leading to intoxication (drunkenness), and long-term effects which can include addiction. Many years of heavy alcohol use can lead to chronic diseases and early death. Alcohol is a major avoidable risk factor for cardiovascular disease, liver disease and cancer. It is also associated with STIs, including HIV, and unwanted pregnancy because alcoholic intoxication leads to risky sexual behaviour. Alcoholic intoxication is also the cause of violent behaviour and accidents, which can result in deaths and disability and intoxicated young people are also predisposed to commit suicide.

Stop reading for a moment and think whether you know any young person in your community who is affected by alcohol? In what ways is this person affected? Who else is affected by their behaviour?

If you know of a young person who is inclined to drink too much or is very often drunk you might have had the thought that the effects of alcohol go beyond the individual drinker. The drinker's behaviour can affect other family members and the community. Some of these adverse effects are presented in Table 7.1.

Table 7.1 The Effects of Alcohol on Young People.

School	Family	Social	Legal
Inefficiency	Frequent fights	Distance from friends	Disobeying rules
Poor performance	Neglect of family duties	Misbehaviour with others	Thefts and petty crimes
Frequent absence	Physical violence with family members	Decreased social reputation	Involvement with criminal gangs
Accidents in school	Long absence and running away from home	Social isolation	Arrests and court cases
Suspension from school	Rejection	Constant borrowing	Conviction
		Inability to return borrowed money	Imprisonment
		Fights, quarrels, theft	

As you see from the table, alcohol use affects more than the health of the individual user; it has multiple effects on all aspects of the drinker's life.

- In what ways does alcohol affect sexual and reproductive health?
- Alcohol consumption exposes the drinkers to risky sexual behaviours involving sexual intercourse without using a condom. When intoxicated young people are also more likely to indulge in casual sex (one night stands) with multiple partners and sex with prostitutes; again, they are unlikely to use a condom in these situations. Gender-based violence particularly sexual violence is more common among people who are under the influence of alcohol. Behaviours such as these make the drinkers (and those with whom they interact) vulnerable to HIV infection.

Alcohol affects sexual and reproductive health in less visible ways too. Excessive drinking can shrink the genitals. It can lead to infertility in men because it kills the cells that are producing sperm. It also makes a woman less fertile and she may have difficulty conceiving. If she does become pregnant she is at a greater than normal risk of miscarriage or bearing an underweight baby that is either stillborn or born pre-term. Alcoholic mothers have a very high risk (around 40%) of their child suffering from fetal alcohol syndrome. These children are mentally retarded and have other growth defects; they have heart and brain abnormalities and behavioural problems. Many have a somewhat strange facial expression (Figure 7.2).

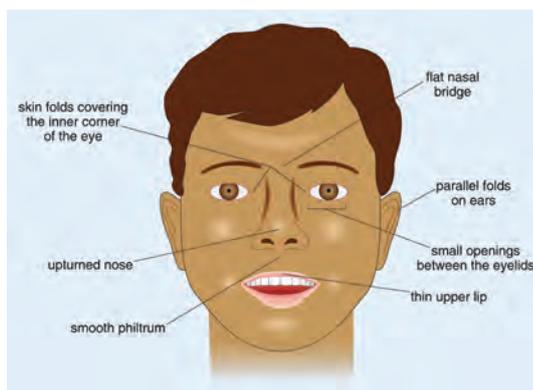


Figure 7.2 Characteristic facial features in a child with fetal alcohol syndrome. (Adapted from: The Open University, 2007, *Introducing Health Sciences*, Book 3, *Alcohol and Human Health*, Figure 5.7)

If a young person who has been drinking too much ceases their drink habit they should find their fertility is restored within a few months. A young woman who finds she is pregnant should stop drinking through the rest of her pregnancy, however, if she was drinking heavily when she conceived and in the weeks before she realised she was pregnant her baby's brain may already be damaged. Maternal over consumption of alcohol is the major non-genetic cause of mental retardation.

7.1.2 Khat

Khat is a plant grown in Ethiopia containing psychoactive substances that have a stimulant effect on the brain. This has been used for many years by Ethiopians for its ability to stimulate the brain so that the user does not feel tired or hungry. Ethiopians have commonly stuffed the leaves of the khat plant into their mouth and chewed whilst continuing to work. Khat consumption is widespread in Ethiopia and its use is increasing among young Ethiopians who may use it with others for recreation (see Figure 7.1). If they are gathered together socially, rather than working in the fields, the stimulant effect will make them feel excited and talkative.



Stop reading for a moment and think whether the young people in your community consume khat. What harmful effects of khat consumption have you observed among young people?

Although being talkative and not feeling tired may seem harmless the active substance in the khat leaves increases respiratory rate, heart rate and blood pressure all of which can cause long-term physical problems for some users. Not feeling tired can become a long-term problem where the user finds they are unable to sleep and this can result in mental problems such as depression or mania. The adverse effects of loss of appetite can include gastric irritation and constipation. As already mentioned, khat consumption alters the mood or emotional state of the users making them talkative and excitable. During this time of mood change khat users are more likely to engage in risky sexual behaviours that could expose them to HIV infection.

Long-term, over-use of khat can be addictive and it also reduces the desire to have sex.

There is more than one psychoactive ingredient in khat, the major substance found is called cathinone and it degrades and loses its power within 48 hours of the leaves being picked. This is why fresh leaves are preferred. However, khat leaves are also powdered and transported (for use in urban areas for example) and in this form the psychoactive ingredients are less powerful.

7.1.3 Tobacco and Cigarettes



Tobacco is a plant originally grown in the Americas. The leaves are chewed or smoked in cigarettes or a pipe. Tobacco contains a psychoactive substance called nicotine which produces a feeling of happiness but can become addictive. Smoking tobacco also produces many other harmful substances such as tar, toxic chemicals similar to those found in hair dye and rat poison, and carbon monoxide. It is these substances that damage the smoker's health. Some immediate effects of smoking include shortness of breath, coughing blood, lungs burnt by the chemicals in cigarettes. Smoking causes yellow teeth and nails, dull hair, and wrinkled skin.

Cigarette smoking harms nearly every organ of the body, causing many diseases and affecting the health of smokers in general. Cigarette smoking increases the risk for many types of cancer, including cancers of the lip, oral cavity, pharynx, esophagus, stomach, pancreas, larynx (voice box), lung, uterine cervix, urinary bladder, liver and kidney. But smokers are particularly at risk of dying from lung cancer.

Cigarette smoking causes reduced circulation by narrowing the blood vessels (arteries). This can lead to high blood pressure and heart diseases. Circulatory problems can also make it difficult for a man to obtain and maintain a penile erection. If he does get an erection he may reach orgasm too quickly or be unable to have an orgasm. High blood pressure seems to also affect male hormones, such as testosterone and low levels of testosterone affect his semen; he makes few sperm and those he does produce are of poor quality. His sperm have low motility and many are malformed.

Smoking also makes women less fertile and reduces their chance of conceiving. Smoking causes damage to the baby, they are underweight at birth and tend to have blood pressure problems later in life.

Passive smokers (non smokers who are exposed to the cigarette smoke from smokers), are also adversely affected and could develop the same health problems that smokers have. Passive smokers inhale and are affected by the same smoke containing cancer causing and poisonous chemicals. One in five young people in Ethiopia are exposed to passive smoking at home.

The vast majority of tobacco users and smokers are hooked when they are young. Once hooked, the majority of tobacco users become hopelessly addicted. Young people are easily influenced by peer pressure and advertising on cigarettes.

The great thing about quitting smoking is that the negative effects on sexual and reproductive health are rapidly reversed – including the effects on the unborn baby. The risk of developing the adverse effects (cancers, heart disease, chronic respiratory tract diseases) of cigarette smoking also reduces when smokers quit smoking. You should counsel and encourage young smokers to quit smoking. However you also need to acknowledge that it may be difficult for them to do this immediately. Many people who aim to quit are not successful the first time they try but will be successful later.

Nicotine is a psychoactive substance that can become addictive. An addict experiences **withdrawal symptoms**. When smokers quit smoking, they often experience one or more of the following withdrawal symptoms:

- A strong urge to smoke
- Feeling angry
- Feeling anxious
- Feeling depressed
- Finding it hard to concentrate
- Feeling headachy, restless or tired
- Feeling dizzy
- Chest pains, cough or nasal drip
- Being hungry or gaining weight
- Having trouble sleeping.

These symptoms are temporary, and they vary from person to person. During the first week, these symptoms may be strong and the chance of relapse is great. The following could help smokers after they quit smoking:

- Drinking a lot of water and fruit juice and avoiding drinks that contain caffeine or alcohol.
- Trying sugar-free gum or hard candies, or carrots.
- Staying busy: engaging in activities that are hard to combine with smoking
- Avoiding situations and places which the smoker strongly associates with the pleasure of smoking.

7.1.4 Cannabis (marijuana or hashish)

Cannabis is a plant grown in many parts of the world. A resin is prepared from the plants or the leaves are dried and smoked. They produce a happy feeling in most users, most times. The effect is relaxing but for some people using cannabis can result in feelings of anxiety or paranoia, described as having a “bad trip”. It is the most common illicit psychoactive substance used. Its use among young people in Ethiopia both in rural and urban areas is increasing.



Stop reading for a moment, do young people in your community use hashish? What adverse effects have you observed or heard of?

Smoking cannabis disrupts short-term memory. Long-term exposure to cannabis may produce long-lasting cognitive impairment. The risk of exacerbation of mental illness such as schizophrenia and bipolar disorder is associated with cannabis use. A link between cannabis use and ectopic pregnancy has been suggested but more certain is the link between cannabis use by men and their inability to have a satisfactory orgasm (they may reach orgasm too quickly or too slowly, if at all).

Cannabis users rapidly develop **tolerance** to most effects of cannabis. The user has tolerance when increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses. As with cigarette smoking cannabis users may experience similar withdrawal symptoms when trying to quit.

7.2 Adverse consequences of substance abuse

Substance abuse by young people can have economic, social, physical, psychological, and most importantly health consequences. Many of these have already been mentioned in relation to each specific substance.

- What specific consequences of substance abuse in general are likely to affect young people's sexual and reproductive health?
- Some specific consequences of substance abuse you may have thought of are:
 - All the psychoactive substances affect the mind and its rational decision making ability. Adolescents who use these substances could stop thinking rationally and may easily lapse into unsafe sexual practices that expose them to long term consequences like STIs, including HIV, and unwanted pregnancy.
 - Substance abuse often leads to poor school performance. They are frequently absent from schools; they are violent in school, engage in fighting, and usually this results in their being suspended from schools because of their violent and aggressive behaviours. (Figure 7.3) Less education is associated with risky sexual practices.
 - Relationships with parents, friends, and teachers could be affected. Young people who abuse substances may neglect family duties and engage in frequent violence; fighting with family members or with their friends; their social reputation is reduced. Without support from family and friends they may indulge in risky sexual behaviour, for example visiting prostitutes.
 - Many psychoactive substances are expensive, an adolescent who uses these drugs needs to find the means to get money to buy them. This leads to stealing, dealing in drugs or becoming a prostitute to get enough money to buy drugs. They often break rules or commit crimes as a result of which they could be arrested and imprisoned.



Figure 7.3 Substance use could lead to poor school performance and suspension from school.

7.3 Reasons why young people take substances

There are so many negative consequences of taking psychoactive substances that it might seem strange that many young people are abusing substances (Figure 7.4).

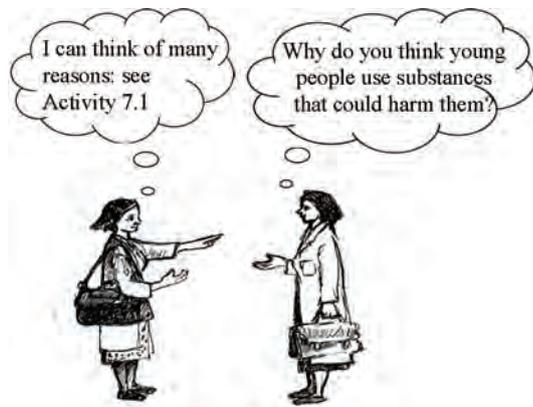


Figure 7.4 Shows two women discussing why young people use substances.

Activity 7.1

Make a list of reasons why young people use substances and compare your list with the list at the end of the study session.

One reason that young people do not worry about the possibility of substance abuse affecting their health is that they are not educated about the negative consequences. Giving them this education is a very important role for you.

7.4 Your role in prevention of substance abuse among young people

Most young people lack awareness of the negative consequences of substance use. Raising their awareness of the various ill effects of substances could help in the prevention of substance abuse.

Some young people may persist in substance use even if they are aware of the negative consequences. Helping them to think critically of the perceived effects of substances will help. Young people's perceptions and expectations of substances includes pleasure, courage, relaxation and increase in sexual ability.

- Do substances fulfill these expectations?
- Most of the substances discussed in this study session have an adverse effect on sexual ability and also decrease fertility. Pleasure and relaxation does not last long and once the effect has worn off the user is left feeling worse than they did before. So mostly young people cannot get what they expect from substance use.

Involving young people themselves in the fight against substance use is important. The community should also be mobilized for successful prevention. It is good to use young persons to educate their peers on substance use (Figure 7.5).



Figure 7.5 Young people learn best from peers in informal settings. (Photo: Aleks Budimer).

In Study Session 1 of this Module you learned that not all young people are equally at risk of reproductive health problems. For example, in Study Session 6 you learned that young girls in rural areas are particularly at risk of gender-based violence.

- Who do you think are most likely to abuse alcohol:
 - young boys or young girls?
 - young people in school or young people out of school?
 - those in rural areas or those in urban areas?
 - young people who have been trafficked or those who are living with their families?
- Young boys who are out of school and living without their families in urban areas are the most likely to abuse alcohol (and other substances).

These young men may be alone in urban areas because they have migrated in the hope of finding employment or they may have been trafficked. Many young people in Ethiopia are trafficked (Figure 7.6). Trafficking is a condition where young people are taken from their homes by people who intend to sell them to others. Sometimes the children are deceived and go willingly, other times they are taken by force. The young people suffer from exploitive labour, sexual exploitation, abuse and prostitution. Because they lose hope in this situation, most of them (girls as well as boys) engage in substance abuse.



Figure 7.6 Trafficking affects the lives of young people.

Migration brings both new possibilities and new risks to young people. Many young people from rural areas migrate to urban areas in search of better employment opportunities. Some of them succeed in getting jobs. However, some end up in the streets because they do not get the jobs they were hoping for and they have no one in the towns to support them (Figure 7.7). For both groups (those who get jobs and those who live in the streets), there are several risks that could affect their reproductive health. The fact that they are away from their home and families means they lack the traditional family influence and support when exposed to substance use.



Figure 7.7 Some of the young who migrate end up in the streets.

You as a health extension practitioner have many roles in reducing the risks of the most vulnerable groups in your community. In addition to raising awareness and supporting those who wish to quit their habit you may need to find opportunities to reach and educate young people who have dropped out of school. If they are thinking of migrating to the town you can provide counselling services on how to avoid substance use and also on protecting themselves from unwanted pregnancy and sexually transmitted infections. They should also learn of the dangers of HIV and how it can rapidly develop into AIDS with fatal consequences. Encourage them to be aware that psychoactive substances will impair their judgment and place them at multiple risk of impairing their health.

Summary of Study Session 7

In Study Session 7, you have learned that:

- 1 Psychoactive substances that can alter mood and distort perceptions include: alcohol, khat, nicotine (found in cigarettes), cannabis (marijuana or hashish), cocaine, heroin and petrol fumes.
- 2 Substance abuse can have negative economic, social, physical, psychological, and most importantly health consequences for young people.
- 3 It can be difficult for young people to alter a habit of substance abuse as these substances can be addictive.
- 4 Trafficking and migration may expose young people to various forms of abuse. When they perceive their situation as hopeless they may resort to substances.
- 5 You can help to prevent substance abuse through a programme of education and support for those who wish to quit.

Self-Assessment Questions (SAQs) for Study Session 7

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering the questions below. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

First read Case Study 7.1 and then answer the questions that follow it.

Case Study 7.1 Difficulties with Alemu

Alemu is a 19 year old man living in your community who uses khat and hashish. He also drinks a lot and often fights other community members when he gets drunk. He has multiple sexual partners and is not married. He stopped going to school because his school performance became very poor. Sometimes he steals to pay for the alcohol, khat and hashish. Although he has realized that substance abuse is affecting him adversely, he can't quit consuming these substances. You are planning to initiate a community conversation programme in your community.

SAQ 7.1

Which of the substances that Alemu uses could badly affect his sexual and reproductive life? Explain your answers.

SAQ 7.2

If Alemu realizes that substance abuse is affecting him adversely why doesn't he stop using alcohol, khat and hashish?

SAQ 7.3

What could you do to help Alemu?

Notes on Activity 7.1

Young people may initially try substances because they are:

- curious
- pressured by their peers
- want to become part of the peer group
- looking for fun and entertainment
- unaware of the dangers to their health.

They may continue because:

- they think it will change them into someone different
 - it gives them confidence to face different challenges
 - to get away from their problems
 - to cope with sadness
 - to escape from hopelessness.
-

Study Session 8 Contraceptive Options for Young People

Introduction

In the *Family Planning* Module, you have learned about different methods of contraception. In this session you will learn about contraceptive options that are suitable for **young people** (remember that by young people we mean those aged 10–24). If a girl becomes pregnant when she is very young, it can be damaging to her physically and can also have bad social and economic consequences for her and her partner. You will help young people by counselling them on delaying pregnancy and childbearing and by providing appropriate contraceptive methods. Many young people avoid using contraceptives or discontinue using them either because they have misinformation about contraceptive methods or because they are worried by side effects. It is important to dispel misinformation about contraceptives and address the side effects of contraceptive use to ensure that young people choose a suitable method of contraception and continue to use it properly.

Learning Outcomes for Study Session 8

When you have studied this session, you should be able to:

- 8.1 Define and use correctly all of the key words printed in **bold**. (SAQs 8.1, 8.2, 8.3, 8.4 and 8.5)
- 8.2 Explain why it is important for young people to delay pregnancy and childbearing. (SAQ 8.1)
- 8.3 Identify and explain contraceptive methods appropriate for young people. (SAQs 8.2, 8.3, 8.4 and 8.5)
- 8.4 Review emergency contraception and its role in prevention of unwanted pregnancy. (SAQs 8.5 and 8.6)

8.1 Why it is important to delay pregnancy and childbearing

8.1.1 Health risks of early pregnancy

Pregnancy before the age of 18 has several health risks (Fig 8.1). Some of these health risks include:

Prolonged or obstructed labour: adolescents younger than 18 often have not reached physical maturity and when they become pregnant, their pelvises may be too narrow to accommodate the baby's head during delivery. In these cases, obstructed delivery and prolonged labour are more likely, thereby increasing the risk of haemorrhage (bleeding), infection and fistula.

Pre-eclampsia (hypertension in pregnancy) is common in adolescent pregnancy. If it is left uncontrolled, it can progress to extreme hypertension. This condition could lead to the death of both the young mother and the baby.

Premature birth and still birth: infants born to adolescent mothers are more likely to be premature, of low birth weight, and to suffer consequences of retarded fetal growth. Stillbirth is more common among adolescent mothers than older mothers.



Figure 8.1 Health worker talking with a young married woman.

Pregnancy in adolescents, especially if they are unmarried, is almost always unwanted.

- What do you think unwanted pregnancy could lead to in young girls?
- Unwanted pregnancy in adolescents could cause them to resort to unsafe abortions. As you have seen in Study Session 4, unsafe abortion is among the common causes of maternal deaths in Ethiopia.

Stop reading for a moment and think about the following question from your experience in your community. What other consequences of early pregnancy in adolescent girls can you think of? (You can answer this by thinking about what you have learned in Study Session 3 of this Module.)

In addition to the health risks, early pregnancy has psychological, social and economic consequences for both girls and boys, some of which are presented below.



Figure 8.2 A young pregnant girl watches sadly as her friends go to school.

8.1.2 Psychological and other consequences of early pregnancy for girls

Some of the consequences are:

- Pregnancy often means the end of formal education for adolescents because they drop out of school when they become pregnant. (Figure 8.2)
- Adolescent pregnancy changes a girl's choice of career, opportunities and future marriage. Mostly unmarried mothers resort to low-paying and risky jobs, domestic work, and even prostitution to support their children.

- Early marriage due to an unplanned pregnancy is frequently an unhappy, unstable one that leads to divorce. Both mother and child face the stigma of illegitimacy when marriage doesn't take place or when divorce occurs.
- Young mothers are often ill-prepared to raise a child, which may lead to childrearing problems like child abuse or neglect.
- Girls resorting to prostitution due to early and unwanted pregnancy are at higher risk of gender-based violence, substance abuse, and STIs such as HIV.

8.1.3 Psychological and other consequences of early pregnancy for boys

Some of the consequences are:

- Some boys refuse to take responsibility for the pregnancy, which can contribute to hardship for the mother and child and also can lead to future regret.
- Boys who become fathers lose opportunities for education and future economic advancement. Those who marry leave school to support their new families.
- Young fathers are often ill-prepared to raise a child, which may lead to childrearing problems like child abuse or neglect.
- Premature marriages which occur because of early pregnancy are frequently unstable and end in divorce.

As you have seen, pregnancy in adolescence has several bad effects. For this reason, it is important to prevent pregnancy in adolescents or delay it until a couple is in a secure and loving relationship. (Figure 8.3)



Figure 8.3 Young couple discussing family planning after the birth of their first child.

- What should adolescents do to prevent pregnancy?
- As you have learned in the *Family Planning* Module, they should use contraceptives to prevent pregnancy and childbearing.

In Section 8.2 you will learn which contraceptive methods are the most appropriate ones for young people.

8.2 Contraceptive methods for young people

8.2.1 Combined oral contraceptives (COCs)

COCs are appropriate and safe for young people. Many young people choose a COC because this method has a low failure rate and also offers relief from **dysmenorrhea** (pain during menstruation). It is a straightforward method that does not interfere with sexual intercourse. This is a good method for you to recommend when it is clearly appropriate for the girl; the particular COC you would suggest will depend on what is available. Some pills are more oestrogen-dominant and others are more progestin-dominant. A COC with more progestin is helpful for girls who have painful and excessive menstrual bleeding.

Failure rates are higher for young girls than for older women. This is because young girls often fail to take pills regularly. Failure to take pills regularly is often due to lack of knowledge about pill taking. You should encourage condom use in addition to COCs for STI/HIV protection.

- Will a COC protect the girl from sexually transmitted infections (including HIV)?
 - No, it offers no protection against STIs.
- What further advice would you give to the girl to help prevent STIs?
 - That she should ensure that her partner uses a condom, or that she should use female condoms if they are available.

You can help young girls figure out where to keep pills and how to remember to take them at the same time daily by linking pill taking to a routine activity that they do on daily basis. COCs are available in 21-day or 28-day packages (Figure 8.4). Most girls do better using the 28-day pill because it is easier to remember to take a pill every day rather than stopping for 7 days. Carefully discuss with them when they should start taking the pill so that you both are clear about when she begins taking the pills. This will make it easier to determine later whether the pills are being taken correctly.

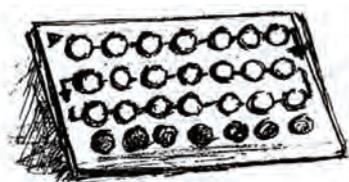


Figure 8.4 Contraceptive pills.

- Do you remember when a woman should begin her daily COCs? (You have learned this in the *Family Planning* Module.)
 - A woman can start using COCs any time she wants if it is reasonably certain she is not pregnant. One common way is to start on the first day of menstruation (the monthly period) or the first day after an abortion.

The most important issue is to make sure that young girls understand the necessity of taking pills correctly. Using the knowledge you gained in the *Family Planning* Module, show the girl the pill packet and explain how to take the pills. Review with her the possible side effects of COCs to make sure that she understands side effects very well and will return to you if she has any problems.

8.2.2 Progestin-only pills (POPs)

POPs are appropriate and safe for young girls. But POPs must be taken daily at approximately the same time every day to be effective in preventing pregnancy, because the progestin levels in the blood peak about two hours after they are taken and then rapidly decline.

If a girl is three hours late taking the pill, she will not be protected and so she should use a back-up form of contraception. POPs may not be the best choice for young girls who cannot remember to take POPs at the same time every day.

POPs are a good choice for girls who cannot tolerate the oestrogen in COCs or have a medical contraindication to the use of COCs.

Stop reading for a moment and think about this from what you learned in the *Family Planning* Module. What are the medical contraindications to the use of COCs? (You can refer to your *Family Planning* Module.)

If it is necessary for a girl to switch from a COC to a POP, she should start taking the POP at the end of the active 21 COC tablets. Because POPs do not protect against STIs/HIV, you should encourage condom use in addition to POPs. Remember that this is known as **dual protection**.

8.2.3 Depo-Provera (DMPA) injectable contraceptive

DMPA (Figure 8.5) is a safe and appropriate method for young girls and is particularly good for those who might have difficulty remembering when to take oral contraceptives. Since it may be difficult for young people to remember to return at regular intervals it may be helpful to use a reminder system that encourages clients to return 12 weeks after the previous injection. This allows for a two-week grace period where the injection can still be given up to 14 weeks without fear of pregnancy. DMPA does not protect against STIs/HIV; therefore you should encourage condom use as well.



Figure 8.5 Syringe with needle and vial containing DMPA. Remember to shake the vial vigorously before drawing the liquid into the syringe.

8.2.4 Implants

- What types of implants do you know that could be used by a young woman. How long does each of them prevent pregnancy?
- As you learned in the *Family Planning* Module, there are two types of implants that are being widely used in Ethiopia. These are: (1) Implanon: one rod, effective for three years, (2) Jadelle: two rods, effective for five years.

Implants (Figure 8.6) are safe and appropriate for young girls and can be safely used by those who are infected with HIV or have AIDS, or are on antiretroviral (ARV) therapy. However you should urge these women to use condoms with implants.



Figure 8.6 An implant.

- These girls are already infected, so why should they use condoms?
- They should use condoms to prevent the spread of infection to their partner and also protect themselves from infection by a new strain of HIV, which the doctors call cross-infection.

You see some of the reasons why young people like implants in Box 8.1 below.

Box 8.1 Why some young girls say they like implants

- Implants do not require the user to do anything once they are inserted.
- Implants prevent pregnancy very effectively.
- They are long-lasting.
- They do not interfere with sex.

- Why do you think young people discontinue using implants?
- The main reason for the discontinuation of implants is menstrual problems, especially irregular bleeding.

You have learned how you can respond to misconceptions and rumours in the *Family Planning* Module. Do you remember what misunderstandings on implants exist?

Young people think that implants move to other parts of the body, stop menstrual bleeding, lead to pregnancy outside the uterus (ectopic pregnancy), and make the woman unable to become pregnant even if removed (Figure 8.7).

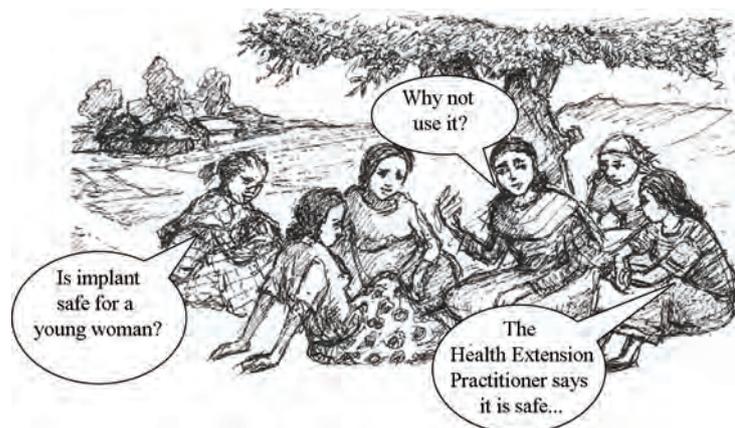


Figure 8.7 Women discussing using contraceptive implants.

Young girls often have misunderstandings concerning implants. You need to identify what specific misunderstandings they have during your discussion with them on contraceptives and correct them.

Remember it is important to provide information about side-effects, to correct misunderstandings and to give counselling before providing contraception (Figure 8.8).



Figure 8.8 A Health Extension Practitioner explaining different methods of contraception and giving counselling on their advantages and side-effects.

- Why must you give information about side-effects and provide counselling before giving contraception.
- The woman may not return to seek your help/advice once she has the implant.

In Box 8.2 below, you see some of the points you can use to correct young people's misunderstandings about implants.

Box 8.2 Correcting common misunderstandings about implants.

- Implants do not make women infertile.
- Implants stop working once they are removed, and the woman can become pregnant again; after removal of the implant, fertility returns within 4–6 months — or sooner.
- Implants can stop monthly bleeding, but this is not harmful.
- Implants do not move to other parts of the body.
- Implants substantially reduce the risk of ectopic pregnancy.

Counselling is essential because young girls must be prepared for irregular bleeding and must make plans about how they and their partner will react to the irregular bleeding. You should counsel them very thoroughly on the potential side effects of implants, mainly the irregular bleeding.

- From your own experience say which type of girls are most likely to choose and use implants?
- Girls who select implants are most likely to want three to five years of contraceptive protection, have often experienced failure of other methods, can tolerate a small surgical procedure, and have access to services.

If a young girl chooses to use implants, you should make sure that she will have access to services to remove the implant whenever necessary.

Remember, you should also encourage girls who choose to use implants to use condoms as well because implants do not protect against STIs/HIV.

8.2.5 Intra-uterine contraceptive devices (IUCDs)

IUCDs (Figure 8.9) are appropriate for adolescents in stable, mutually monogamous marriages. Women under the age of 20 who have not given birth appear to have greater risk of expulsion and painful menstruation (monthly periods). After you inform them of the characteristics of IUCDs and counsel them, if adolescents who are married would like to use this method, you should refer them to the nearest health centre for further counselling and service provision.

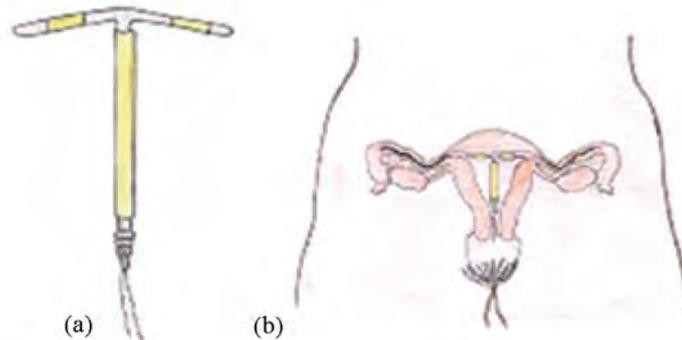


Figure 8.9 (a) An IUCD; note the strings for easy removal (b) shows the position of the IUCD within the uterus.

8.2.6 Condoms

Condoms (Figure 8.10) are safe and appropriate for young people. Because they are available without a prescription and provide protection against STIs/HIV, they are a good method. There are male and female condoms, as you have learned in the *Family Planning Module*.

Young girls frequently are not assertive about the use of condoms when their partner rejects the idea. You should give them ideas about how to negotiate condom use.

Young people often lack the skills to use condoms correctly. You need to develop their skills so that they will use them properly (Figure 8.11).

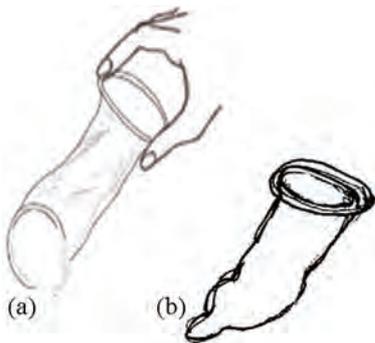


Figure 8.10 (a) Femal condom (b) male condom.

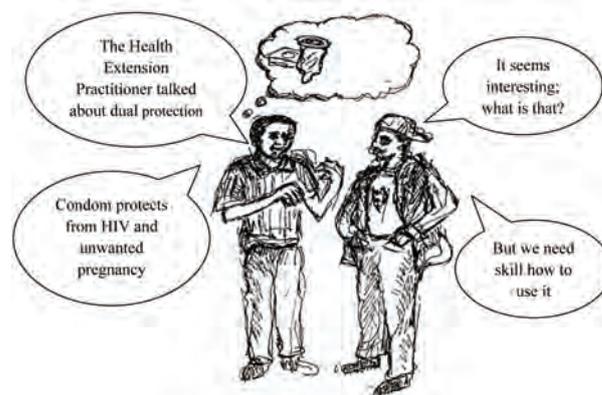


Figure 8.11 Men talking about condom use.

Activity 8.1

Stop reading for a moment and think of what you have learned from the *Family Planning* Module. What are the five basic steps of using a male condom? (Figure 8.10 (b)). Write down the five basic steps in your Study Diary.

8.2.7 Other female barrier methods (spermicides, cervical caps, diaphragms)

These female barrier methods are appropriate methods for young people, but they do require a high level of motivation for correct and consistent use. Use is related to intercourse and some young people find this inconvenient or feel it interferes with sexual pleasure.

8.2.8 Lactational amenorrhea method (LAM)

- What are the three conditions that must be fulfilled for LAM to be effective?
- LAM is appropriate for any young woman who has given birth no more than six months ago, is postpartum, fully or nearly fully breastfeeding (Figure 8.12), and whose periods have not yet returned (she is **amenorrhoeic**). This method may be difficult for young people unless they have a stable lifestyle that is conducive to frequent breastfeeding. The LAM method does not provide protection against STIs/HIV, therefore you should encourage condom use as well.



Figure 8.12 Prevention of pregnancy through exclusive breastfeeding during the first six months after birth.

8.2.9 Female and male sterilisation

While there is no medical reason to deny sterilisation, it is generally not recommended for people at the beginning of their childbearing years. This is because if they decide to have sterilization, in the future they may be sad about their decision. Once they undergo sterilisation they can have no more children-this is why it is called irreversible contraception. However, there may be mitigating circumstances, such as HIV or the presence of some genetic diseases, which means that a young person may wish to consider sterilisation. Therefore when you encounter a young person who wants to have sterilisation, you should refer them to a higher health facility where further counselling could be provided. Sterilisation does not provide protection against STIs/HIV.

8.2.10 Abstinence

Abstinence is appropriate for young people who have not yet begun sexual activity, as well as those who are already sexually experienced. There may be emotional or social advantages to delaying sexual intercourse until they are older, more mature, or married (Figure 8.13). Abstinence provides protection against STIs and HIV/AIDS.

In the next section you will be able to review what you learned about emergency contraceptives in the *Family Planning* Module.



Figure 8.13 A young couple discussing abstinence.

8.3 Review of emergency contraceptives (ECs)

In this section we would like you to review a few points about emergency contraceptives to remind yourself of its importance in preventing pregnancy.

- What is emergency contraception?
- Emergency contraception is a contraceptive method used to prevent pregnancy in the first few days after unprotected intercourse or a contraceptive accident such as leakage or slippage of a condom. These pills used for emergency contraception are also called ‘morning-after’ or ‘post coital’ pills. EC should be given in the first five days after unprotected sex.

Emergency contraceptive pills (ECPs) (Figure 8.14) should be available to young girls who have unprotected sex. The earlier ECPs are taken after unprotected sex, the greater the chances are that they will be effective. ECPs can be provided in advance to young girls so that they could use whenever needed, but they should be counselled that ECPs are *for emergency use only*. ECPs do not provide protection against STIs/HIV.

8.3.1 Some counselling issues of ECPs

You should consider the following important points when you counsel young people on ECPs. (Figure 8.15)

- Show her the pills and explain how to use them.
 - She should swallow the first dose as soon as convenient, but no later than 120 hours after having unprotected sex.
 - She should swallow the second dose 12 hours after the first dose. *Important:* if more than 120 hours have passed since she had unprotected sex, she should not use ECPs.
 - If she vomits within two hours of taking a dose, she should take two tablets as soon as possible. If the vomiting occurs after the first dose, she will still need to take a second dose 12 hours later (you can give her extra pills). To reduce nausea she should take the tablets after eating or before bed.
 - Instruct her not to take any extra ECPs unless vomiting occurs. More pills will not decrease the risk of pregnancy further.

Important: if more than 120 hours have passed since she had unprotected sex, she should not use ECPs. ECPs do not interrupt or abort an established pregnancy.

- ECPs should not be used as a regular contraceptive method. After use of the ECPs a regular method should be started or resumed if pregnancy is not desired.
- ECPs do not protect from STIs/HIV/AIDS.
- ECPs can be used at any time during the menstrual cycle and more than once during a cycle if necessary.
- Review what to expect after using ECPs. Women will not see any immediate signs showing whether the ECPs have worked. The menstrual period should come on time (or a few days early or late). Tell her that if her period is more than a week later than expected, or if she has any cause for concern, she should return to you.



Figure 8.14 Emergency contraception pills.



Figure 8.15 A Health Extension Practitioner counselling a girl on ECP.

- Instruct her to return to you when she has her period if she wishes to use a contraceptive method to prevent future pregnancies.

In Box 8.3 we have presented the EC regimen for your review. This will help you provide ECPs for young girls who are in need of ECPs when you have no pre-packed ECPs.

Box 8.3 Emergency contraceptive pills (ECPs) regimen:

There are two types of ECP regimen in use:

- 1 **Combined oral contraceptive pills:** contain ethinyl estradiol and levonorgestrel or comparable formulations.
 - When high-dose pills containing 50 µg (micrograms) of ethinyl estradiol and 0.25 mg of levonorgestrel are available, two pills should be taken as the first dose as soon as convenient, but not later than five days (120 hours) after unprotected intercourse. The second two pills should follow 12 hours later.
 - When low-dose pills containing 30 µg ethinyl estradiol and 0.15 mg of levonorgestrel are available, four pills should be taken as the first dose as soon as convenient but not later than five days (120 hours) after unprotected intercourse, to be followed by another four pills 12 hours later.
- 2 **Progesterone-only pills:**
 - When pills containing 0.75 mg of levonorgestrel are available, one pill should be taken as the first dose as soon as convenient, but not later than five days (120 hours) after unprotected intercourse, to be followed by another one pill 12 hours later.
 - When pills containing 0.03 mg of levonorgestrel are available, 20 pills should be taken as the first dose as soon as convenient but not later than five days (120 hours) after unprotected intercourse, to be followed by another 20 pills 12 hours later.

Summary of Study Session 8

In Study Session 8, you have learned that:

- 1 Pregnancy before the age of 18 year has several health risks, which include obstructed or prolonged labour, pre-eclampsia (hypertension in pregnancy), unsafe abortion and premature and stillbirth. It also has economic, social and psychological consequences for both girls and boys.
- 2 As pregnancy in adolescence has several bad effects, it is important that adolescents prevent or delay pregnancy through the appropriate use of contraceptive methods.
- 3 Contraceptive methods that are safe and appropriate for adolescents' use include combined oral contraceptives, progestin-only pills, Depo-Provera (DMPA) injectable contraceptive, implants and condoms.
- 4 IUCDs are appropriate for young people when they are in a stable, mutually monogamous marriage.

-
- 5 The lactational amenorrhea method is appropriate for a young woman when the following three conditions are fulfilled: under six months postpartum, fully or nearly fully breastfeeding, and amenorrhaeic.
 - 6 Abstinence is appropriate for young people who have not yet begun sexual activity, as well as those who are already sexually experienced. As abstinence provides protection against STIs and HIV/AIDS, it is good method for young people.
 - 7 Emergency contraceptives should be available for young girls who have unprotected sex but must be used with in the first 120 hours (five days) following unprotected sexual intercourse.
-

Notes on Activity 8.1

- 1 Use a new condom for each sex act.
 - 2 Before any physical contact, place the condom on the tip of the erect penis with the rolled side out.
 - 3 Unroll the condom all the way to the base of the erect penis.
 - 4 Immediately after ejaculation, hold the rim of the condom in place and withdraw the penis while it is still erect.
 - 5 Dispose of the used condom safely.
-

Self-Assessment Questions (SAQs) for Study Session 8

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering the questions below. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 8.1 (tests Learning Outcomes 8.1, 8.2 and 8.3)

- (a) What are the health consequences that a 16-year-old girl could face if she becomes pregnant?
- (b) What should the girl do to prevent or delay early pregnancy?

SAQ 8.2 (tests Learning Outcomes 8.1 8.2 and 8.3)

For each of the following contraceptive methods, say whether it is appropriate or not appropriate for a 15-year-old unmarried girl who is sexually active. In each case, explain why it is appropriate or not appropriate.

- (a) Combined oral contraceptive pills
- (b) Depo provera (DMPA)
- (c) IUCD
- (d) Sterilisation.

SAQ 8.3 (tests Learning Outcomes 8.1 and 8.3)

For each of the following contraceptive methods, say whether it is appropriate or not appropriate for a 19-year-old married woman who wants to delay pregnancy. Explain why it is appropriate or not appropriate.

- (a) Implants
- (b) Condom
- (c) Lactational amenorrhea method
- (d) Abstinence.

SAQ 8.4 (tests Learning Outcomes 8.1 and 8.3)

What three conditions should be fulfilled if a young woman who has given birth a month ago want to prevent pregnancy by breastfeeding?

SAQ 8.5 (tests Learning Outcomes 8.4 and 8.5)

A 17-year-old young woman comes to you saying that she had unprotected sex two days ago and does not want to become pregnant.

- (a) What will you give her?
- (b) What instructions will you give her?
- (c) What important points will you consider when counselling her?

SAQ 8.6 (tests Learning Outcomes 8.4)

You don't have any pre-packed ECPs and you have only combined oral contraceptive pills containing 50 µg of ethinyl estradiol and 0.25 mg of levonorgestrel.

- (a) How many pills will you give to a girl who is in need of ECPs?
- (b) At what interval should she take the pills?

Study Session 9 Counselling Young People

Introduction

Clear and effective communication is basic in helping young people to achieve healthy sexual and reproductive lives. In this session you will learn how you can establish good relationships with young people to enable effective counselling on sexual and reproductive health issues to take place. The basic principles of communication and counselling are taught in the *Health Education, Advocacy and Community Mobilisation* Module. Also the *Family Planning* Module has a study session on counselling for family planning. However, this study session will focus on the particular circumstances and needs of young people. Understanding the young person's perspective on sexual issues will enable you to respond appropriately in discussions. Having a good relationship with your young clients will make them feel more relaxed and able to talk about their sexual and reproductive health problems. This in turn will enable you to effectively counsel and serve the needs of the young.

Learning Outcomes for Study Session 9

When you have studied this session, you should be able to:

- 9.1 Define and use correctly all of the key words printed in **bold**. (SAQ 9.1)
- 9.2 Describe ways to establish trust with young people. (SAQs 9.1, 9.2 and 9.3)
- 9.3 Identify behaviours conducive to counselling young people. (SAQs 9.1, 9.2 and 9.3)
- 9.4 Describe good counselling techniques to be used with young people. (SAQs 9.1, 9.2 and 9.3)

9.1 The purpose of counselling young people

The purpose of counselling young people on reproductive health issues is to help them to:

- Make rational decisions
- Cope with their existing situation.

The more a young person can be made comfortable, the more likely they are to express their sexual and reproductive health problems. This enables you to effectively counsel and serve them so that they can achieve control over their own behaviour, understand themselves, anticipate the consequences of their actions, and making long-term plans.

In counselling there are two actors: you the counsellor and the young person. Your behaviour as well as the characteristics of the young person can affect the counselling process. **Counselling** is a person-to-person, two-way communication during which you:

- Provide adequate information to help the young person make an informed decision

- Help the young person evaluate their feelings and opinions regarding the problem for which help was sought
- Act as emotional support for them.

Counselling is not:

- A method of providing solutions to the young person's problems
- A method of giving instructions
- The promotion of a life plan that has been successful for you.

9.2 General principles of counselling

Adolescents are going through dramatic biological and psychological changes, as described in Study Session 1 of this Module, and, as a result of these changes, seeking healthcare may be challenging and difficult for them. In the first instance you need to remember and apply the general principles and concepts of counselling before thinking of the additional considerations required to meet the needs of this special group.

Stop reading for a moment and think about the general guidelines for effective counselling.

- What are the general principles that you should follow for a successful outcome to a counselling session?
- These are the important principles and conditions necessary for effective counselling:
 - Privacy. You need to find a quiet place to talk where you cannot be seen or overheard and where the interaction is free from interruptions.
 - Confidentiality. You need to make it clear that you will not tell other people about the discussions you have with your client.
 - Respect. You need to conduct the discussion in a helpful atmosphere. You should show respect for your client and be non-judgemental.
 - Time. You need to allow sufficient time so that the client can relax and feel confidence in you.
 - Keep it simple-use words the young person will understand.
 - First things first. Do not cause confusion by giving too much information.
 - Say it again. Repeat the most important instructions again and again.
 - Use available visual aids like posters and flipcharts.



Figure 9.1 A girl can't disclose her reproductive health needs in an environment where there is no privacy.

You need to remember these guidelines when you are counselling young people about sexual and reproductive health matters, but there are additional considerations because these are particularly sensitive issues for them. The first three points on the list above need special attention. The young person will not feel comfortable talking with you if they think their conversation can be overheard (Figure 9.1) or if they think you might discuss their personal matters with someone else. If, in some circumstances, you believe it is necessary to share information with others (for example, to prevent further sexual abuse), you should explain why it is important and when, how, and with whom the information will be shared.

Many young people are unsure of themselves and lack confidence in their own ability. They will warm to you if you show them respect and demonstrate that you regard them as capable of making good decisions. Respect also assumes that the young person can be different and have varying needs that are legitimate and deserve a professional response. To be in the best position to help them you need to understand their feelings and the changes they are going through.

9.3 Establishing trust with young people

9.3.1 Feelings of the young

If you can understand the feelings of your young client and appreciate their needs, you will be in a good position to answer questions and help with anxieties that they may have concerning their sexual and reproductive health.

- How might a young person feel when they first come to see you?
- Figure 9.2 shows a young girl outside a health post, hesitating to enter. She might be feeling:
 - Shy about needing to discuss personal matters.
 - Embarrassed that she is seeking sexual or reproductive healthcare.
 - Worried that someone she knows might see her and tell her parents.
 - Unsure that she has the right words to describe what is concerning her and ill-informed about reproductive health matters in general.
 - Anxious that she has a serious condition that will have significant consequences (e.g. that she has a sexually transmitted infection (STI) or that she is pregnant).
 - Resistant to receiving help because of overall rebelliousness, discomfort or fear.



Figure 9.2 Young girl outside the health post unsure of what she will say when she meets the Health Extension Practitioner.

These points apply equally to a boy or young man who comes to see you.

9.3.2 Attitudes likely to promote trust

There are a number of things you can do to encourage a young person to trust you in addition to following the general guidelines for effective counselling.

Stop reading for a moment and think about the things you can do to encourage young people to trust you.

Try to understand the way young people feel (Section 9.2.1); remember how you felt in **early adolescence** (10–14 years of age) and how your feelings and ideas changed as you got older. When you are face to face with a young person, try to:

- be genuinely open to their questions or needs for information
- avoid judgemental words or body language that suggests disapproval of the young person or their questions and needs
- understand that the young person has various feelings of discomfort and uncertainty. Be reassuring in responding to the young person, making them feel more comfortable and confident
- demonstrate sincerity and willingness to help

- reinforce their decision to seek counselling and/or healthcare; do not give them the impression that you think their visit was unnecessary
- exhibit honesty and forthrightness, including an ability to admit when you do not know the answer
- demonstrate responsibility in fulfilling your professional role
- exhibit confidence and professional competence in addressing adolescent and youth reproductive health issues.

9.3.3. Behaviour likely to promote trust: non-verbal communication

Without you realising it, your true feelings can be expressed by your body language or non-verbal communication (Figure 9.3). By this means you can communicate to your young clients the level of interest, attention, warmth and understanding you feel towards them. There are ways that you can take control of your body language and you should remember the acronym ROLES (Box 9.1) when you are communicating with young people. (There is more information on non-verbal communication in the *Health Education, Advocacy and Community Mobilisation* Module.)



Figure 9.3 Notice the warmth shown by this body language.
(Photo: Heather McLannahan)

Box 9.1 ROLES

R = **Relax** the client by using facial expressions that show interest

O = **Open up** the client by using a warm and caring tone of voice, i.e. help them to talk

L = **Lean** towards the client, not away from them

E = Establish and maintain **eye contact** with the client

S = Smile.

9.3.4 Behaviour likely to promote trust: practical arrangements

Here are some practical tips to create a good, friendly first impression.

- Start on time.
- Smile and warmly greet the client.
- Introduce yourself and explain what you do.

It will help to establish rapport during the first session if you:

- face the young person, sitting in similar chairs
- use the young person's name during the session
- begin the session by allowing the young person to talk freely before you ask questions
- congratulate the young person for seeking help.

Before the session begins, make sure you have printed or other materials that are developmentally and culturally appropriate readily available. There may be opportunities to reinforce health messages from other settings (Figure 9.4) and you may wish to give, some leaflets at the end of the session for the young person to read before they come to see you again.



Figure 9.4 This Health Extension Practitioner is explaining contraceptive methods.

9.4 Challenges in counselling young people

In previous sections you have learned how your behaviour can affect counselling the young client. Now you will learn how some young people's behaviours can affect the counselling process. Specifically, we will teach you some of the challenging behaviours that you may face in counselling young people and how you should handle these challenges. They are presented in Box 9.2.

Box 9.2 Counselling challenges

- Silence
- Crying
- Threat of suicide
- Need to talk.

Each of these situations requires appropriate handling.

9.4.1 Silence

This can be a sign of shyness or anxiety. If it occurs at the beginning of a session, you can say, 'I realise it's hard for you to talk. This often happens to people who come for the first time.'

If the client is shy, you can legitimise the feeling by saying, 'I'd feel the same way in your place. I understand that it's not easy to talk to a person you've just met.'

If the young person has difficulty expressing their feelings or ideas, you can use some brochures or posters to encourage discussion or refer to a story so that they can talk about others rather than themselves.

If the young person cannot or will not talk, you should propose another meeting.

9.4.2 Crying

If the young person cries while you are counselling, try to evaluate what provoked the tears and assess if it makes sense in the given situation.

If they are crying to relieve tension, you can give them permission to express their feelings by saying, 'It's OK to cry since it's the normal thing to do when you're sad.'

If they are using crying as manipulation, you can say, 'Although I'm sorry you feel sad, it's good to express your feelings.'

If the crying is consistent with the situation, you should allow them to freely express emotions and not try to stop the feeling or belittle its importance.

9.4.3 Threat of suicide

Attempted suicide is any attempt by the young person to kill themselves. If you believe that a young person has made suicide threats or attempts, you should take it seriously. It is essential that you find out whether they have made any attempts in the past and what reasons they might have had. Consider whether it seems likely that they are really considering suicide now or if it is something that they have said without thinking.

If you are in any doubt it is best to refer the young person to the nearest health facility that provides psychiatric or mental health services. When you decide to refer a young person, make sure that he/she is accompanied to the health facility by somebody from their family.

9.4.4 The need to talk

Challenges in counselling may also include a situation where the young person is very vocal and wants an outlet to express other concerns that may not be directly related to the immediate counselling need as you perceive it.

Give young people the opportunity to express their needs and concerns. If you cannot help them, show that you are listening to the concerns that they are trying to express. When possible, refer them to someone who can help with the problem.

If you cannot help or refer them to someone who can provide assistance, then demonstrate care and concern about the problem. However, be clear that you cannot help.

9.5 Communicating with and counselling young people about sexual issues

Communicating with and counselling young people about sexual issues can be challenging because you are dealing with sensitive topics about which they often feel emotional, defensive and insecure.

Young people must often make significant decisions on the following sexual and/or reproductive health matters:

- How to discourage and prevent unwanted sexual advances.
- Whether or when to engage in sexual relations.
- How to prevent pregnancy and STIs, such as HIV.
- Whether or when to conceive a child.
- Whether to continue or terminate a pregnancy.
- How to deal with sexual abuse and/or violence.

You can work through most of these decisions together if you use good communication and counselling skills. During counselling sessions with young people you need to:

- consider the young person's age and sexual experience
- demonstrate patience and understanding of the difficulty young people have in talking about sex
- assure privacy and confidentiality
- respect the young person's feelings, choices, and decisions
- ensure that the young person feels able to ask questions and tell you about their concerns and needs
- respond to expressed needs for information in understandable and honest ways
- explore feelings as well as facts
- encourage the young person to identify possible alternatives
- lead an analytical discussion of the consequences, advantages, and disadvantages of the available options
- assist the young person to make an informed decision
- help the young person to implement their choice.

If you develop and use these approaches, it will foster good decision making by the young people you counsel.

Summary of Study Session 9

In Study Session 9, you have learned that:

- 1 The purpose of counselling is to help young people make rational decisions and cope with the situation they find themselves in. Counselling is a two-way communication process during which you give adequate information and help the young person to evaluate their feelings about their problems. You can also provide emotional support, but you need to understand that counselling is not a method of giving solutions or instructions to the young person.

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- 2 In counselling there are two actors: you the counsellor and the young person. The behaviours of both of you and the young person could affect the process of counselling. You need to develop behaviours that allow the young person to relax and feel comfortable with you, then they will also trust you.
 - 3 The more a young client can be made comfortable, the more likely they are to express their sexual and reproductive health problems. This enables you to effectively counsel them and serve their needs.
 - 4 When a young person is face-to-face with you they may have various feelings which could include shyness, embarrassment, anxiousness, and inadequacy to describe their problems and worries. Understanding their feelings will foster better communication between you.
 - 5 Conditions that could encourage trust and a good relationship with the young people include allowing sufficient time for the counselling, showing understanding, honesty and willingness to help them, expressing non-judgemental views and showing confidence and professional competence. These are the behaviours that you need to have and develop to effectively respond to the needs of young people.
 - 6 It is good to remember ROLES when counselling young people. ROLES is abbreviation for:
 - R** = **Relax** the client by using facial expressions that show interest
 - O** = **Open up** the client by using a warm and caring tone of voice
 - L** = **Lean** towards the client, not away from them
 - E** = **Establish** and maintain **eye contact** with the client
 - S** = **Smile.**
 - 7 Techniques for good counselling include creating a good, friendly first impression, establishing rapport during the first session, and providing simple information in an appropriate way.
 - 8 While counselling young people you may face some challenges which require you to respond appropriately. It can be particularly difficult when the young person is silent, cries, threatens suicide or talks at length about issues that you do not perceive to be relevant.
 - 9 When you are counselling a young client on sexual and reproductive health issues, use the following approaches: consider their age and sex; be patient; ensure privacy and confidentiality; respond to expressed needs; explore feelings as well as facts; encourage them to identify possible alternatives and then consider the advantages, disadvantages and consequences of these options and assist them to make an informed decision and plan how to implement their choice.

Self-Assessment Questions (SAQs) for Study Session 9

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 9.1 (tests Learning Outcomes 9.1, 9.2, 9.3 and 9.4)

Would you use ROLES if you were counselling a young man who had come to ask you about using condoms? Explain your answer.

SAQ 9.2 (tests Learning Outcomes 9.2 and 9.3)

A 15-year-old girl comes to your health post for help. There are many older women present and you have to see her in front of these other older clients.

- (a) Explain whether this girl would be comfortable telling you about her reproductive health problems.
- (b) What are the three most important characteristics for creating a comfortable environment for counselling a young person?

SAQ 9.3 (tests Learning Outcomes 9.2, 9.3 and 9.4)

A 13-year-old girl who thinks she may be pregnant has come to talk to you. She is wondering whether she might also have an STI and is considering whether she might be able to terminate her pregnancy. When discussing these issues with her you have used approaches that foster good communication. You are pleased because this has resulted in a good decision being made. Which of the following approaches would you not have used? Why not?

- (a) Respecting her views
- (b) Ensuring privacy and confidentiality
- (c) Exploring her feelings
- (d) Responding to her expressed needs
- (e) Making decisions for her.

Study Session 10 Adolescent- and Youth-Friendly Reproductive Health Services

Introduction

Adolescent and youth reproductive health services should have distinctive features so that they will attract, meet the needs of, and retain young people as clients. Adolescent-and youth-friendly reproductive health (AYFRH) services are services that are accessible to and acceptable by young people. In this session you will learn about the characteristics of adolescent and youth-friendly services in terms of relevance to the providers, the health facility itself, and the programme design. You will also learn how you can interact with young people when consulting them on reproductive health (RH) issues.

Learning Outcomes for Study Session 10

When you have studied this session, you should be able to:

- 10.1 Define and use correctly all of the key words printed in **bold**. (SAQs 10.1, 10.2 and 10.3)
- 10.2. Describe characteristics of AYFRH services. (SAQs 10.1 and 10.2)
- 10.3 Discuss and identify barriers to the utilisation of AYFRH services and strategies to address them at your level. (SAQ 10.1)
- 10.4 Describe the elements included in assessing young people for RH needs. (SAQ 10.3)

10.1 Reproductive health services for young people

10.1.1 Characteristics of adolescent-and youth-friendly reproductive health services

Reproductive services that are accessible to, acceptable by and appropriate for adolescents and youth are called **adolescent- and youth-friendly reproductive health services**. They are in the right place, at the right price (free where necessary), and delivered in the right style to be acceptable to young people. The characteristics of AYFRH services relate to the service providers, the health facility itself, and the programme design. You see these characteristics in Boxes 10.1–10.3 below.

In Box 10.1 you see the characteristics related to the health facility.

Box 10.1 Health facility characteristics

- Convenient space/location
- Convenient hours
- Comfortable surroundings
- Peer counsellors available.

Box 10.2 Characteristics of the service provider

- Specially trained staff. The service provider is trained in adolescent- and youth-friendly services.
- Respect for young people. The service provider has respect for young people.
- Privacy and confidentiality. The service provider ensures that there is privacy and keeps the matters regarding the RH problems of the young person confidential.
- Adequate time for client–provider interaction. The service provider gives enough time to interact with the young person.

The four characteristics in the above box relate to the service provider.

Stop reading for a moment and think about this for yourself. You are the service provider. Do you think you have the above four characteristics?

Health facilities that are adolescent- and youth-friendly have a convenient space or room which young people who are in need of sexual and reproductive health services can use without being seen and heard by others. If there is no such space for the young people, they will be waiting for services in the midst of older clients and this will make them uncomfortable.

Stop reading and think of your health post. Is it possible to arrange a convenient room or space for young people?

Arranging a convenient space or room for young people is not enough by itself. The room should have enough space to ensure privacy and it should be located in a convenient area where the young person can feel comfortable. Otherwise, they may be too embarrassed to come for the services.

Young people also need to have services in hours that are convenient for them.

Stop reading and think about this from your experience. Are the service hours at your health post convenient for young people?

The third set of characteristics relates to the overall programme design of the reproductive health services for adolescents and youth. This is presented in Box 10.3 below.

Box 10.3 Programme design characteristics

- Involvement of young people in design and continuing feedback. In addition to their involvement during the design, the young people are allowed to give their feedback on the services/programme and their feedback is addressed.

- Involve the young in the health committee to improve the adolescent-friendly services.
- No overcrowding and short waiting times.
- Affordable fees.
- Publicity and recruitment that inform and reassure the young people. The services at the health facility are publicised and young people are made aware of the services.
- Both young men and young women are welcomed and served.
- Wide range of services available.
- Necessary referrals available.
- Educational material available on-site and to take away.
- Group discussions available.
- Alternative ways to access information, counselling and services.
- Parents and community involved to promote and support AYFRH services.

Stop reading and think of your experience. Which of the above programme design characteristics exist at the health post in your community? Could you do anything to improve the service offered by your health post?

In Study Session 13 you will learn how you can assess whether the services provided at your health post are adolescent- and youth-friendly or not.

10.1.2 Ethiopian AYFRH service standards

Following the development of the National Adolescent and Youth Reproductive Health Strategy, the Federal Ministry of Health has developed standards for youth-friendly services.

We have presented the standards in Box 10.4.

Box 10.4 Ethiopian adolescent- and youth-friendly service standards

- 1 The service outlet provides service supported by the existing national policies and processes that give due attention to the rights of young people.
- 2 Appropriate health services that cater to the reproductive and sexual health needs of young people are available and accessible.
- 3 The service outlets have a physical environment that is organised in a way that is conducive to the provision of AYFRH services.
- 4 The service outlet has drugs, supplies and equipment necessary to provide the essential service package for youth-friendly health care.
- 5 Information, education and communication (IEC)/behavioural change and communication (BCC) consistent with the minimum service package is provided.

- 6 The service providers in all service outlets have the required knowledge, skills and positive attitudes to effectively provide youth-friendly RH services.
- 7 Young people receive an adequate psychosocial and physical assessment and individualised care based on the national standard case management guidelines/protocols.
- 8 The service outlet has a system that ensures that the necessary referral linkage is made and ensures continuity of care for young people.
- 9 Young people participate in designing and implementing youth-friendly services, and mechanisms are created to enhance the participation of parents and members of the community in contributing towards sustainable youth-friendly services in their localities.

10.1.3 Services to be provided in adolescent- and youth-friendly services

Stop reading and think of the services you would wish to provide for young people as part of an AYRFH service at your health post.

The Ethiopian AYFRH service guidelines say that the services that should be provided in AYFRH services include those which are presented in Box 10.5.

Box 10.5 Services intended to be provided in adolescent- and youth-friendly services

- Information and counselling on sexual and reproductive health issues
- Promotion of healthy sexual behaviours through various methods including peer education
- Family planning information, counselling and methods including emergency contraceptive methods
- Condom promotion and provision
- Testing services: pregnancy, HIV counselling and testing
- Management of STIs
- Abortion and post-abortion care
- Antenatal care (ANC), delivery, postnatal care (PNC) and pregnant mother-to-child transmission (PMTCT) services
- Appropriate referral linkage between facilities at different levels.

Stop reading and think of your experience. Looking at the list of the services in Box 10.5, is there any service that you can't provide at your level?

In the previous sessions in this Module you have learned how to provide most of these services. In Study Session 11 you will learn how to provide care during pregnancy, labour and the postnatal period. If you feel unsure about your ability to provide the services, you should re-read the relevant sessions. Make a note to ask your Tutor about any remaining uncertainties.



Figure 10.1 This Health Extension Practitioner is not offering a friendly service.

10.2 Barriers to RH service utilisation

10.2.1 Barriers to utilisation of RH services for young people

- What factors could affect the utilisation of reproductive health services by young people in your area?
- There are many factors that affect the utilisation of available sexual and reproductive health services by young people. We can categorise these as: individual/personal factors, institutional factors, and social/cultural factors. Some examples of these factors are presented in Table 10.1.

Table 10.1 Barriers to RH service utilisation.

Individual/personal factors	Cultural/social factors	Institutional factors
Marital status	Awareness level of the communities	Judgemental health workers (Figure 10.1)
Gender norms	Attitudes towards young people's sexual behaviour	Locations: distant facilities, services very close to where adults are being served
Sexual activities	Attitude towards AYRH services	Timing: RH services being provided may not have convenient times for young people. If it takes an unreasonably long waiting time to get the service, it is likely that they won't use it.
Schooling status	Parent-child interactions	Cost: if the RH services are not provided at reasonable cost, young people can't access them
Childbearing status	Peer pressure	Space: if young people are not counselled and served in a private space, they will be afraid that they will be seen by adults
Economic status		
Rural/urban residence		

Stop reading and think of your experience. How does each of the factors listed under the individual/personal and cultural/social categories affect service utilization by a young person? For instance, if the young person is unmarried and female, she will be less likely to use RH services. In communities where the awareness level is high and people are supportive of RH services for young people, it will be easier for young people to use RH services.

We believe that you have important roles in addressing these barriers to RH service utilisation. In the next section we will suggest some specific things you could do to reduce these barriers.

10.2.2 Your roles in addressing these barriers to RH service utilization

As you have already learned in previous sessions of this Module, young people face major physical, psychological and social changes in life during which they may have many questions and concerns about what is happening in their life. While this period of life is generally considered as a healthy time of life, it is also a period when many behaviours that negatively affect health start. As a Health Extension Practitioner you have important contributions to make in helping those young people who are well to stay well, and those who develop health problems get back to good health.

In this section you will learn how you can do this and thereby reduce the barriers to RH service utilisation by young people. You can do this in a number of ways. Some of the things you can do include:

- Recognising that young people have the right to access RH information and services.
- Improving and developing a positive attitude towards young people's sexual and RH needs. If you encounter a young person who is already sexually active, you need to help them in a non-judgemental manner.
- Providing them with appropriate information, counselling and services aimed at helping them maintain safe behaviours and modify unsafe ones (i.e. those that put them at risk of negative health outcomes).
- Identifying and managing health problems and unsafe behaviours.
- Referring them to nearby health centres/hospitals for further help when necessary.
- Educating the community so that they can understand the needs of adolescents, and the importance of working together to respond to these needs.

10.3 The interaction with young people at the health post

10.3.1 Establishing good rapport with young people

Some young people may come to your health post on their own, alone or with their friends. Other young people may be brought to the health post by a parent or a relative. Depending on the circumstances and the nature of the problem, the young person could be anxious or afraid. In addition, young people may be reluctant to disclose information on sensitive matters if their parents or guardians, or even spouse are also present.

If you do the following, you will be able to establish good rapport with young people. This will help the young people to disclose their RH problems.

- Greet the young people in a friendly manner. (Figure 10.2)
- Explain to the young people that:
 - you are there to help them, and you will do your best to understand and respond to their needs and problems
 - you would like them to communicate with you freely and without hesitation
 - they should feel at ease and not be afraid because you will not say or do anything that affects them negatively
 - you will not share with anyone any information that they have entrusted you with, unless they give you permission to do so.



Figure 10.2 The Health Extension Practitioner welcomes the young people with warm greetings.

- If the young person is accompanied by an adult, explain to the accompanying adult in the presence of the young person that you want to develop a good working relationship with the young person and this means that at some stage you may need some time to speak to the young person alone.

10.3.2 Taking the history of the young person's problems

As the health issues of young people are mostly sensitive in nature, it is good to start with the least sensitive or non-sensitive issues. For example, instead of asking at the start 'Are you sexually active?' which is very threatening to the young person, starting with 'Where do you live?', 'Do you go to school?' will help to open up the young person. Where possible, *use the third person (indirect questions)*. It is good to ask first about friends' activities rather than directly about their own activities. For example, rather than ask a young person directly, 'Do you drink alcohol?' you could ask, 'Do any of your friends drink?' If the young person replies, 'Yes', you could then ask, 'Have you ever joined them?' This can lead to other questions, such as 'How often do you drink?', etc.

In addition to the presenting problems, the young people may have other health problems and concerns but may not say anything about them unless directly asked to do so. It is useful to go beyond the presenting problem and ask them if they have any other health problem. Consider using the **HEADS** assessment to help you do this.

HEADS is an acronym for:

- H** Home
- E** Education/employment
- E** Eating
- A** Activity
- D** Drugs
- S** Sexuality
- S** Security
- S** Suicide/depression

Table 10.1 (on the next page) suggests issues you can raise and discuss with the young person using HEADS.

Table 10.1 Information that can be obtained from the HEADS assessment. (Source: Adapted from *Adolescent Job Aid: A Handy Desk Reference Tool for Primary Level Health Workers*, WHO, 2010.)

Home	Where they live and with whom they live Whether there have been recent changes in their home situation How they perceive their home situation
Education or employment	Whether they study/work How they perceive how they are doing How they perceive their relations with their teachers and fellow students/employers and colleagues Whether there have been any recent changes in their situation
Eating	How many meals they have on a normal day What they eat at each meal What they think and feel about their bodies
Activity	What activities they are involved in outside study/work and what they do in their free time
Drugs	Whether they use substances like tobacco, alcohol, or others If they use any substances, how much do they use; when, where and with whom do they use them
Sexuality	Their knowledge about sexual and reproductive health Their knowledge about their menstrual periods and any questions and concerns that they have about their menstrual periods Their thoughts and feelings about their sexual behaviour Whether they are sexually active, and if so, the nature and context of their sexual activity Whether they are taking steps to avoid sexual and reproductive health problems Whether they have in fact encountered such problems (unwanted pregnancy, infection, sexual coercion), and if so, whether they have received any treatment for this
Safety	Whether they feel safe at home, in the community, in their place of study or work, on the road (as drivers and as pedestrians), etc. If they feel unsafe, what makes them feel so
Suicide/depression	Whether their sleep is adequate and whether they feel unduly tired How they feel emotionally Whether they have had any mental health problems (especially depression) and if so, whether they have received any treatment for this Whether they have had suicidal thoughts and whether they have attempted suicide

You can use the points in the table mainly for those young people who come to your health post for the first time. Depending on their context, you may need to adjust the points you discuss with them when they are not first-timers. Besides, you may not need to discuss all the points in the table if the young person is courageous enough to disclose their needs directly. In this case you can directly discuss their concerns. For example, if the young person tells you that they want you to give them condoms, you can now start discussing sexual behaviour instead of asking them about home, education, activity, etc.

Even if young people come to the health post for health problems other than RH, you should assess them for sexual activity (whether they are at risk of STIs/HIV or pregnancy), substance abuse, and sexual abuse.

10.3.3 Doing physical examinations

It is only necessary to do a physical examination in some contexts. If a young person comes to you for condoms and cannot spend time with you, it is enough to briefly discuss sexual behaviour with them and then give them what they want. Sometimes, you may need to do a physical examination in order to diagnose the problem the young person has and to help them. Some parts of the physical examination can cause embarrassment. For example, vaginal examination for a vaginal discharge may cause embarrassment in a young woman. Therefore avoid doing vaginal examination unless there is a strong indication of need for this. For example, for a young woman in labour you should do a vaginal examination to assess the progress of labour. You should not do a pelvic examination of a virgin.

As part of the physical examination, check the following:

- Temperature
- Pulse rate
- Presence of anaemia
- Presence of undernutrition
- Presence of swelling or tenderness in the abdomen.

You have learned how to do these in the *Antenatal Care* Module.

In Box 10.6 you will see ways to make the physical examination less stressful for the young person.

Box 10.6 How to make the physical examination less stressful a young person

- Respect the young person's sensitivity about privacy.
- Explain what you are doing before you begin each step of the examination.
- Protect their physical privacy as much as possible. Allow them to keep their clothes on except for what must be removed. Make sure to cover the parts of the body that are exposed. Never leave any part of the body exposed when not being examined.
- Reassure the client that any results of the examination will remain confidential.
- A good rapport and relationship between you and the young person is essential. Try to establish trust.
- Provide reassurance throughout the examination.
- Give constant feedback in a non-judgemental manner, 'I see you have a small sore here, does it hurt?'

Based on what you get from the history taking and physical examination, you should counsel and provide services for each specific problem the young person has. For STIs, HIV/AIDS, unsafe abortions, contraception, emergency contraception, sexual abuse and substance abuse refer to the respective sessions on how to respond to the specific needs of the young person. For pregnancy, childbirth and postpartum-related needs, you will learn how you should provide care in the next session.

Summary of Study Session 10

In Study Session 10, you have learned that:

- 1 Reproductive services that are accessible to, acceptable by and appropriate for adolescents and young people are called adolescent- and youth-friendly reproductive health (AYFRH) services.
- 2 The characteristics of AYFRH services relate to the service providers, the health facility itself, and the programme design.
- 3 The service provider characteristics include specially trained staff, respect for young people, privacy and confidentiality, and adequate time for client-provider interaction.
- 4 Health facility characteristics include convenient space/location, convenient hours, comfortable surroundings, peer counsellor availability.
- 5 Programme design characteristics include involvement of young people, no overcrowding and short waiting time, affordable fees, wide range of services available, and necessary referrals available.
- 6 Services intended to be provided in AYFRH services include information and counselling on family planning, promotion of healthy sexual behaviours, SRH issues management of STIs, antenatal care, delivery care, PMTCT, postnatal care, post-abortion care, testing for HIV and pregnancy, and referral services.
- 7 There are many factors that affect the utilisation of available sexual and reproductive health services by young people and these include individual/personal factors, institutional factors and social/cultural factors.
- 8 You have important roles in reducing these barriers to service utilisation.
- 9 You need to establish good rapport while interacting with young people in order to properly identify and respond to their needs.
- 10 You can consider using the HEADS (HEADS is an acronym for Home, Education/employment, Eating, Activity, Drugs, Sexuality, and Suicide/depression) assessment for proper history taking in a young person.

Self-Assessment Questions (SAQs) for Study Session 10

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering the questions below. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

First read Case Study 10.1 then answer the questions that follow it.

Case Study 10.1 Fatima

Fatima is a 16-year-old young woman who lives in Roda *kebele*. The health post in Roda *kebele* is just 30 minutes' walk from Fatima's home. Fatima is sexually active but wants to delay pregnancy until she reaches 20 years old and finishes school. She knows the health post in her vicinity provides reproductive health services including contraceptives. She doesn't want to visit the health post at times when most adults will be there for services.

One day after school she went to the health post only to find it was closed. She tried on another day but this time the guard at the gate shouted at her, saying the services were not for school girls of her age. As she was in desperate need of contraceptives she tried once more to visit the facility but this time along with adult clients. She had to sit and wait a long time until all the adults had received services. The adults' expressions were discouraging but she managed to get into the consultation room and told the health worker that she was in need of contraceptives. The health worker at the health post, without taking Fatima's full history, said she was already exhausted and had to close the facility. In addition, she said contraceptives were not for girls of her age and asked her why she was sexually active at this age. The health worker has never been trained in adolescent- and youth-friendly reproductive health service provision. Fatima is married and is her husband's third wife. But the health worker had no interest in exploring Fatima's history.

SAQ 10.1 (tests Learning Outcomes 10.1, 10.2 and 10.3)

- (a) Is Roda health post providing adolescent- and youth-friendly reproductive health services? If yes, explain why. If not, explain why not.
- (b) What are the barriers to Fatima's utilisation of RH services? Categorise them under individual, cultural/social and institutional factors.

First read Case Study 10.2 then answer the questions that follow it.

Case Study 10.2 Adane

Adane is an 18-year-old man who wants to get tested for HIV. He went to the nearest health post, which is an hour's walk from his home. When he reached it he found that it did not provide a testing service. The health worker at the facility told him that she had no idea where he could get this service.

While he was at school discussing it with his peers, he learned that there was a health centre in town which provided the service, but it was about four hours walk from his home, i.e. an eight-hour round trip. He wanted to visit the health centre but had no money to pay for the transport.

SAQ 10.2 (tests Learning Outcomes 10.1, 10.2 and 10.3)

- (a) What required standard is missing from this facility?
- (b) What could be done to respond to the needs for HIV testing young people in Adane's *kebele*?

SAQ 10.3 is on the next page.

SAQ 10.3 (tests Learning Outcomes 10.1 and 10.4)

A 17-year-old girl comes to the health post with a cough. Explain what other conditions you will assess her for in addition to the cough?

Study Session 11 Care During Pregnancy, Labour and the Postnatal Period

Introduction

Every pregnancy is an unique experience for a woman. During this unique period, a woman has many emotional and physical needs that must be addressed in order for her to have a happy, comfortable and safe pregnancy which culminates in the birth of a healthy baby. You have already learned how you can help ensure these needs are met in the *Antenatal Care, Labour and Delivery Care* and *Postnatal Care* Modules. However, young women who are pregnant may have different needs from those of older women and you need to know these special needs in order to effectively help young women during this period. In this session you will learn to identify the special emotional and physical needs of young women during pregnancy, labour and the postpartum period and you will learn how to develop strategies to address their needs.



Learning Outcomes for Study Session 11

When you have studied this session, you should be able to:

- 11.1 Define and use correctly all of the key words printed in **bold**. (SAQ 11.1)
- 11.2 Describe the physical and emotional needs of young women during pregnancy, childbirth and the postpartum period. (SAQs 11.1, 11.2 and 11.3)
- 11.3 Explain how to develop strategies to respond to the special needs of young women during pregnancy, childbirth, and the postpartum period. (SAQs 11.2 and 11.3)

11.1 Care for young women during pregnancy

- What are the risks for a young woman's health if she becomes pregnant?
- If a young woman becomes pregnant, she could face many health risks including malnutrition and **hypertension** (raised blood pressure). Then there is the danger that she has a premature baby, a prolonged and obstructed labour leading to complications like fistula and/or that her baby is stillborn.
- What is the reason for these problems?
- As you learned in Study Session 3 of this Module, young women may not have completed their growth so the **pelvis** (the bone surrounding the birth canal) is often still growing and immature which makes giving birth difficult. They may not have enough food and when the baby starts to grow, mother and baby will be in competition for what little food there is, so both will be malnourished.

In Study Session 13 (Providing Focused Antenatal Care) of the *Antenatal Care* Module you learned that pregnancy is particularly risky for girls who are less than 16 years old. For them, in particular, childbirth may be difficult if the pelvis is still growing because it will be too small for the baby to pass through it easily (remember this is called **obstructed labour**).

In areas where health facilities are inaccessible, the young woman may face an unassisted and lengthy labour which can lead to tearing or rupture of the uterus. She may die of blood loss (**haemorrhage**).

During a lengthy labour, the baby's head can stretch or tear the vagina causing a hole between the vagina and the bladder or between the vagina and the rectum. This hole is called a **fistula**.

If the baby can't pass out of the body a cut in the woman's abdomen will be made so that the baby can be lifted out of the uterus. The doctors call this operation a **Caesarean section**.

To avoid complications in pregnancy young women need to go for antenatal care as soon as they know they are pregnant. If you are aware of any pregnant young women in your area, you should encourage them to follow a schedule of regular antenatal care visits. If they are under 16 years old you should refer them to a higher facility for antenatal care.

- What is the basic number of visits provided with focused antenatal care (FANC)?
- A woman should commonly have four FANC visits and the first visit should ideally be during the first **trimester** (the first three months of the pregnancy) but certainly by 16 weeks. The second visit should be made during the fourth to sixth months of pregnancy. Third and fourth visits should be in the eighth and ninth months respectively.



Activity 11.1 The FANC plan

Do you remember what you should do for the pregnant women during each visit?

In Table 11.1 write down the specific activities you should carry out at each visit.

Here are some principles that will help you complete the table.

- Every pregnancy is a risk.
- Antenatal care (ANC) should be used as a main gate for health promotion and disease prevention.
- ANC must be used as an opportunity to detect and treat existing problems.
- ANC must be used to prepare pregnant women, their partners and families to plan the birth preparedness and complication readiness plan.

You should also remember that the ANC service should be individualised: every woman should be counselled and treated according to her specific needs.

Table 11.1 Activities carried out during each FANC visit.

First visit (when pregnancy is confirmed)	Second visit (4–6 months)	Third visit (8 months)	Fourth visit (9 months)

When you have completed Table 11.1 refer to Table 11.2 at the end of this study session to see the things that you need to do at each visit.

When you are planning the care for a pregnant young woman, you should follow the same guidelines as for any other pregnant woman (i.e. use the chart that is shown in Table 11.2). However, you should give much more attention to your counselling role as a young woman has more specialised needs than an adult.

- On what specific issues should you counsel a pregnant woman? (You have learned this in the *Antenatal Care* Module.)
- You should educate and counsel pregnant women on the following topics:
 - Protecting themselves from malaria by sleeping under an insecticide-treated bed net (ITN)
 - Eating a balanced diet with nutritious food (refer to the *Nutrition* Module)
 - Prevention of mother to child transmission of HIV (PMTCT)
 - Personal hygiene
 - Taking adequate rest
 - Breastfeeding
 - Harmful traditional practices (HTPs) that relate to pregnancy, birth and care of the baby
 - Warning signs and danger symptoms during pregnancy.

All these topics are discussed in the *Antenatal Care* Module.

Stop reading and think about whether there are specific HTPs practised in your community that could damage the health of the pregnant mother or the baby.

If the young woman is in a polygamous marriage she may not be given enough to eat; malnutrition is damaging to her and her baby. The baby will be at risk if **colostrum** (the thin, watery fluid produced by her breasts during the first three days of her new baby's life) is thrown away and the baby is fed other liquids and honey. You may have thought of other HTPs.



Figure 11.1 Burning gastric pain is a danger symptom.

You need to counsel young woman on danger symptoms without frightening them. They should know the symptoms for which they should seek immediate help. Give reassurance and tell them about only the danger symptoms that it is appropriate to know about for the stage of their pregnancy.

- What are the danger symptoms they should seek help for in the period up to 20 weeks?
 - Symptoms that are dangerous and should be taken seriously and responded to include vaginal bleeding, persistent vomiting, fever, no change in abdominal growth.
- What are the additional danger symptoms they should seek help for in the period after 20 weeks?
 - Convulsions, leakage of amniotic fluid, headache, burning epigastric pain (see Figure 11.1).

Every woman should deliver with the assistance of a skilled attendant. Although you can provide good help during childbirth you need to make every effort to enable young women to deliver in a higher health facility. Pregnant adolescents who are under 16 years of age are at particularly high risk and should always be referred for delivery to the next higher level health facility (Figure 11.2).



Fig 11.2 Refer her if you cannot manage the labour at your level.

During antenatal visits you should help young women to develop a birth plan that focuses on:

- What to do if any danger symptoms occur
- How they will get to the healthcare facility
- When to check in with the health facility if they suspect that labour is beginning
- Who will provide physical and emotional support during labour.

You also need to prepare the young woman and her supporter(s) by giving them all the necessary information and techniques to make labour more comfortable.

11.2 Physical and emotional needs of adolescents during labour and delivery

The birthing process is both physically and emotionally demanding. The woman's body goes through transformations of tissues and organs and tremendous changes in hormones that affect every bodily system. The combination of these changes can have a negative impact on a woman's

emotions and this can be particularly true for young women. These emotions range from anticipation and anxiety during early labour to fear, a sense of being overwhelmed, loss of control, and exhaustion leading to a desire to end the process immediately towards the end of labour.

The cardinal rule for birthing care for a young woman is *Never leave her alone*. Support, comfort, and explanations of what is happening or going to happen will break the cycle of fear that produces tension and thereby increases the intensity of pain.

The young mother in labour also has physical feelings and needs, which could include finding a comfortable position, experiencing thirst, feeling too hot or too cold. You should try to identify her physical needs and respond to them. You should explain the different options and allow her to choose a comfortable position. Some women prefer kneeling; some want to squat and others may choose a lying position. A labouring woman who is thirsty could be allowed to take sips of fluid. If she feels too cold she needs to be covered with clean clothing.



11.2.1 Your role in caring for young women during labour

- What proportion of Ethiopian women deliver in health facilities? (You learned this in the *Antenatal Care* Module.)
- Out of 110 women, only six give birth at health facilities.

Stop reading for a moment and think about this from your own experience. Why do most women deliver at home even though there are health facilities that provide safe and clean delivery services?

One of the major reasons for women not coming to health facilities for delivery services is the lack of emotional care during labour. At home they are surrounded by lots of caring people, both family members and neighbours, who can give emotional support during labour. This is very important for a woman who is in labour pain. For them, the emotional care is superior to any other care they might think of. When they decide to come to your health post, it means they will miss all the emotional care they could get just by being at home. In addition to the medical skills that you need to have to assist safe and clean delivery (remember you learned this in the *Labour and Delivery Care* Module), you should have and develop skills to provide emotional care for a labouring young woman.

To successfully provide support for young women during labour requires patience, understanding, compassion and caring. You need to create an atmosphere of inclusion involving their family and/or supporter(s). You will also increase everyone's confidence and trust in you if you offer explanations for what the woman is experiencing and for all your actions. Give plenty of reassurance and encouragement. When preparing to perform examinations and procedures, explain to the young woman and her supporter(s) what you will be doing and why; perform manoeuvres slowly and gently. If you need help or cooperation from the labouring young woman or her helper, explain what you need them to do and why. Use firm but caring speech to get the young woman's attention. Shouting is never acceptable.

11.3 Care during the postpartum period

You have learned in detail what care you should provide to the woman and her baby during the postpartum period in the *Postnatal Care* Module. We will not repeat all these things here but encourage you to refer to the *Postnatal Care* Module. In this session we will teach you briefly the points that you should give extra attention to when caring for young mothers.

11.3.1 Needs of young women during the postpartum period

- What is the **postpartum period**? (You have learned this in the *Postnatal Care* Module.)
- The period of six weeks following birth is called the postpartum period.



This period of six weeks following birth is a period of dramatic change and tremendous adjustment that affects the young mother physically and emotionally. The demands of mothering are high, and the young mother will need support from those closest to her so that she does not feel overwhelmed and tempted to give up. It is a critical time for learning and guidance, yet this must be given in a way that does not make the young mother feel incompetent. You should help and guide her to carry out such tasks as she is able within the limits of safety; praise her efforts; and offer corrections as ‘tips’ for doing something. For example, if you say: ‘Your baby is attaching to the breast well *but* her nose is obstructed so you must move her face like this’ it sounds like a correction, Whereas if you say, ‘Your baby is attaching to the breast well *and* if you move her face like this she will be able to feed even better because her nose is not obstructed’ it sounds like praise followed by a ‘tip’.

Young mothers now have the compound challenge of continuing to establish their own identity while they adjust to the role of being a mother. Immediately after the birth keep the mother and baby together as much as possible, particularly for the first hour. Suggest that she should touch the baby’s head, feel molding, and count the fingers and toes.

Later you should assist the mother to breastfeed successfully with correct attachment. Show her how to take the baby off the breast, how to keep the baby’s nose unobstructed and how to establish comfortable positions for feeding. Check the newborn gets the first BCG and polio vaccines.

Before you leave make sure both the mother and those who are supporting her understand how to recognise the signs of postpartum complications and when to return to the health post.

As the young mother tries to cope with the demands of infant care (e.g. sleep deprivation, physical discomfort), the psychological shift into a role of greater responsibility, and rapidly altering hormone levels, dramatic mood swings characteristic of **postpartum blues** may occur.

- What does the term postpartum blues mean? (You have learned this in the *Postnatal Care* Module.)
- Postpartum blues range from being easily upset and having mild feelings of being ‘down’ and weepy with unexplained sadness to more profound depression with frequent bouts of crying for no obvious reasons.

Postpartum blues usually occur around the third to fifth day after birth. It is normal for all women to experience a sense of loss after birth, but it may be more acute for young mothers. If she and those who support her are aware that this is normal behaviour it may help her to overcome these difficulties quickly.

11.3.2 Your role in addressing the needs of young mothers during the postpartum period

Your primary goal should be to help the young mother successfully take on the role and responsibilities of mothering. She may need close monitoring to keep her focused on the wide range and seemingly endless tasks involved in caring for a baby. The following is a checklist of actions for you to ensure that you give full support to each young mother.

- 1 The young mother should be observed for the first six hours after birth. Make sure she has someone reliable who will remain with her.
- 2 You should schedule a home visit for follow-up for one and six weeks postpartum. i.e. you should make a home visit at the 7th and 42nd day after birth.
- 3 During the first postpartum visit (made during the first week after birth), pay attention to the young mother's ability to cope with change and new responsibilities. Check whether she has experienced postpartum blues and whether she has overcome them or is still feeling 'down'. Observe the mother-baby interaction and breastfeeding (attachment, removal, positioning and style of feeding). Take a brief history focusing on progress in healing and involution; inspect her breasts, abdomen and perineum.
- 4 During the sixth week visit take a complete history and make a thorough physical examination. Now is a good time to discuss future contraceptive needs with the young mother. Explore with her how she is coping with mothering and any physical, emotional and/or baby problems. Make sure the newborn gets its vaccination.
- 5 You should be able to help her solve the common physical discomforts of postpartum recuperation and adjustment, such as increased perspiration, perineal pain, breast engorgement, constipation and haemorrhoids. Assure her that these are common problems and taking a soft diet will help; give her painkillers if she has pain.
- 6 Make sure she is continuing her nutritional supplements, especially if breastfeeding.
- 7 Give genuine praise for any and all accomplishments in caring for her baby.
- 8 Encourage experienced caretakers (mother, grandmother, aunt) to work with the young mother, but they should *not* take over the direct care of the baby. Encourage supporters to remind the mother to drink fluids—something often forgotten by the new mother in her distraction and fatigue.

- 9 Keep the lines of communication open and be available to the young mother as situations arise for which she will need your support or the support of other young mothers whom she may have met during her antenatal period.

11.4 Parenting and infant feeding

11.4.1 What young parents feel and need

For a young couple, childrearing presents many difficulties.

There is a high risk of infant morbidity and mortality which may be due to biological factors or to poor parental care.

The young couple may feel inadequate in caring for an infant and anxious about the baby's health.

They may feel resentment or depression over their loss of leisure and the great increase in responsibility.

The infant care needed may prevent the parents from improving their economic and/or educational situation.

Isolation from peers, crowded living conditions and dependence on others, with consequent resentment, are additional hazards.

In Box 11.1 there is a summary of the needs of young mothers and fathers. Understanding helps you to improve your response to their needs through counselling and providing postnatal care services. It is good to engage the young father when visiting the young parents at home.



Box 11.1 What young parents need

Fathers	Mothers
Acceptance and integration into pre- and postnatal services.	Postnatal support and healthcare for themselves and their infants.
Counselling about the benefits of sound sexual/reproductive health practices, including condom use.	Information about the importance of breastfeeding, immunization, nutrition and growth monitoring.
Encouragement to learn effective parenting skills, such as feeding, bathing, changing, playing, positive social interactions and participating in healthcare decisions.	Encouragement to learn effective parenting skills, such as feeding, bathing, changing, playing, positive social interactions, and making healthcare decisions.
Continued access to economic and educational opportunity.	Counselling about contraceptives to delay the next pregnancy.
	A confidential, private, affordable and welcoming service environment.
	Continued access to economic and educational opportunity.

11.4.2 Supporting young mothers to choose breastfeeding and succeed

There are many benefits of breastfeeding so it is worthwhile taking some time to counsel young mothers on breastfeeding.

- What are the benefits of breastmilk?
- Breastmilk is the perfect milk for a baby. The benefits of breastmilk are:
 - It has all of the nutrients the baby needs.
 - It is easy for the baby to digest.
 - It gives the baby important protection from infections.
 - It is always fresh, clean and ready to drink.
 - It slows the mother's bleeding after birth.
 - It helps prevent the mother from getting pregnant again too soon.
 - It does not cost money.



Breastfeeding is a particular challenge for young mothers, who often consider breastfeeding to be too confining of their movements and too demanding of their time. So it is your task to help maintain a realistic perspective that supports the young mother in making a decision that she is comfortable with and can successfully carry out. Help her achieve her identity and minimise role confusion as she negotiates between her personal development needs and her role as a mother. One way you can do this is by emphasising that she is the only one who can 'mother' her baby when she breastfeeds. Offer her a different perspective; rather than seeing breastfeeding as keeping her 'tied down', explain that she is doing something important that no one else can take over. Emphasise that breastfeeding is convenient and is rewarding to the mother. Provide breastfeeding guidance from the moment of delivery by giving practical suggestions to maximise the mother's success and confidence. In addition, it is good that you do the following:

- Help her set realistic short-term goals, e.g. breastfeeding until she returns to school is better than not breastfeeding at all.
- Connect her with a peer breastfeeding support group. Mother-to-mother support relationships have been vital in helping the young mother successfully sustain optimal breastfeeding practices.
- Focus on body image in a positive way, e.g., breastfeeding can help her return to her pre-pregnant shape.

Summary of Study Session 11

In this session, you have learned that:

- 1 Pregnancy for adolescents, especially under the age of 16, has many risks including obstructed and prolonged labour.
- 2 You should educate and counsel pregnant adolescents on protecting themselves from malaria (sleeping under ITN), getting balanced and nutritious food, prevention of mother-to-child transmission of HIV (PMTCT), personal hygiene, taking adequate rest, breastfeeding, HTPs and danger symptoms during pregnancy
- 3 You should use the FANC chart to provide an antenatal care service for young women.
- 4 You should encourage young women to deliver at a health facility and help them to work with a supporter to develop a birth preparedness and complication readiness plan.

- 5 While offering support to young women in labour you should be patient, understanding, compassionate and caring. You should ensure that they understand what is happening and what you are doing.
- 6 Young mothers have the compound challenge of continuing to establish their own identity while they adjust to the role of being a mother.
- 7 You should help the young mother successfully take on the role and responsibilities of mothering.

Notes for Activity 11.1

You should have used the principles of FANC to help you complete this table.

Table 11.2 Focused Antenatal Care (FANC) for Health Post. (Adapted from the FMOH)

First visit (when pregnancy is confirmed)	Second visit (4–6 months)	Third visit (8 months)	Fourth visit (9 months)
1 Take a proper history	1 Ask for and note any changes since last visit	1 Ask for and note any changes since last visit	1 Ask for and note any changes since last visit
2 Counsel on danger signs and on: PMTCT breastfeeding hygiene nutrition sleeping under ITN HTP	2 Counsel on danger signs and other issues as before and also on family planning	2 Counsel as before	2 Counsel as before
3 Explain the need for 3 additional ANC visits	3 Explain the need for 2 additional ANC visits	3 Explain the need for 1 additional ANC visit	3 Review birth plan
4 Assist woman and family to develop a birth plan	4 Review the birth plan	4 Review the birth plan	4 Check BP and examine woman to confirm fetal lie and presentation
5 Check BP, weight and give physical examination	5 Check BP and give a general and abdominal physical examination	5 Check BP and give physical examination as before	5 Treat malaria(if necessary)
6 Give first dose of tetanus toxoid (TT) vaccine unless the mother's TT is up to date	6 Give second dose of TT vaccine	6 Treat malaria (if necessary)	6 Refer for further evaluation if BP is high, fetal movement is not felt or there is abnormal lie and presentation, there is suspicion of multiple pregnancy or if any sign of emergency is detected
7 Provide iron supplement for 3 months	7 Provide iron supplement for 3 months	7 Refer for further evaluation if BP is high, fetal movement is not felt, there is suspicion of multiple pregnancy or any sign of emergency is detected	7 Refer for any other services and management as appropriate

8 Treat malaria (if necessary)	8 Treat malaria (if necessary)	8 Refer for any other services and management as appropriate	8 Register the mother on ANC registry
9 Refer for lab tests	9 Refer for further evaluation if fetal movement is not felt or if any sign of emergency is detected	9 Give schedule for fourth visit	
10 Refer for any other services and management as appropriate	10 Refer for any other services and management as appropriate	10 Register the mother on ANC registry	
11 Give schedule for second visit	11 Give schedule for third visit		
12 Register the mother on ANC registry	12 Register the mother on ANC registry		

Self-Assessment Questions (SAQs) for Study Session 11

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering the questions below. Write your answers in your Study Diary and discuss them with your Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

First read Case Study 11.1 and then answer the questions that follow it.

Case Study 11.1 Tsega's pregnancy

Tsega is a newly married 18-year-old girl who has found that she is pregnant. She had wanted to continue her education so was unhappy about her pregnancy. However, the families are very happy for the young couple and Tsega has been in good health. You have made the four FANC visits and Tsega has a plan to deliver at your health post. A week after your fourth visit she developed labour pains and was brought to your health post, which is just a half-hour walk from Tsega's home. Some people from her village brought her but her mother, who was her supporter, was not able to come with them. Tsega is now alone and is weeping.

SAQ 11.1 (tests Learning Outcomes 11.1 and 11.2)

Does Tsega have a high risk of obstructed labour? What evidence is there for your answer?

SAQ 11.2 (tests Learning Outcomes 11.2 and 11.3)

What particular emotional needs might Tsega have during pregnancy and childbirth?

SAQ 11.3 (tests Learning Outcomes 11.2 and 11.3)

- (a) You were not at the health post when Tsega was brought in but you arrived just before she gave birth to a healthy boy. After birth, for how long will you observe her at your facility and what will you advise her on before you send her home?
- (b) When will you make home visits to see how she is doing and what will you do during each visit?

Study Session 12 Promoting Adolescent and Youth Reproductive Health

Introduction

Successful implementation of adolescent and youth reproductive health services and programmes requires the full support of young people, parents, community leaders and other influential community members in your *kebele*. To get the support of the community including young people, you need to promote adolescent and youth reproductive health (AYRH) using a variety of promotion methods. The same health promotion principles that you learned in the *Health Education, Advocacy and Community Mobilisation* and other Modules apply in promoting adolescent and youth reproductive health. In this session you will learn the best methods to use to promote adolescent and youth reproductive health.

Learning Outcomes for Study Session 12

When you have studied this session, you should be able to:

- 12.1 Define and use correctly all of the key words printed in **bold**. (SAQ 12.1)
- 12.2 Explain the importance of promoting adolescent and youth reproductive health. (SAQ 12.1)
- 12.3 Describe the different methods of promoting adolescent and youth reproductive health including community conversation, youth clubs/group discussion, peer education and age appropriate family life education. (SAQ 12.2)
- 12.4 Identify the health promotion strategies and actions appropriate for different age groups of young people. (SAQ 12.2)

12.1 Promoting adolescent and youth reproductive health

In Study Sessions 1 and 2 you learned that young people are especially at risk of multiple health and social problems, mainly arising from their risky behaviours. Young people can be influenced to have positive healthy behaviour provided they get sufficient support from their families, health workers and communities. Studies conducted in the years 2005 to 2006 showed that only 15% of young people living in rural areas were enrolled in secondary school and that youth reproductive health programmes in Ethiopia tend to only reach older, unmarried, urban boys who are in school. So the most vulnerable members of the population, namely rural youth (86%), married girls and out-of-school adolescents were missed by these programme efforts. So in this Module emphasis will be given to the importance of targeting vulnerable groups of young people to get the best results from your limited resources.

Health Promotion is the process of enabling people to increase control over and to improve their health, which includes sexual and reproductive health. Young people need interventions to decrease and to alleviate their vulnerability. These include information and skills, a safe and supportive environment and appropriate and accessible health and counselling services.

Health promotion could be conducted in various settings such as schools and in the community and at health posts. In all situations, it is important to keep in mind that different groups of young people need different approaches and messages depending on their age, living and family arrangements, and school status. In the following paragraphs you will understand the specific issues that you need to address, separately, for young people aged 10–14, 15–19 and 20–24 years, orphans and other vulnerable children.

12.2 Health promotion in schools

An effective school health programme is one of the strategic means used to address important health risks among young people and to engage the education sector in efforts to change the educational, social and economic conditions that put adolescents at risk.

As the number of young adolescents being enrolled in schools is increasing all the time, school-based sexual and reproductive health (SRH) education is becoming one of the most important ways to help adolescents recognise and prevent risks and improve their reproductive health (Figure 12.1).

Studies show that school-based reproductive health education is linked with better health and reproductive health outcomes, including delayed sexual initiation, a lower frequency of sexual intercourse, fewer sexual partners and increased contraceptive use. Many programmes have had positive effects on the factors that determine risky sexual behaviours, by increasing awareness of risk and knowledge about STIs and pregnancy, values and attitudes toward sexual topics, self-efficacy (negotiating condom use or refusing unwanted sex) and intentions to abstain or restrict the number of sexual partners (Figure 12.2).



Figure 12.1 Students listening at school through their mini-media.



Figure 12.2 Through knowledge couples decrease risky sexual behaviour. (Photo: Basiro Davey)

Box 12.1 elaborates the main objectives of skills-based education in schools.

Box 12.1 Objectives of skills-based health education in schools

- Prevent/reduce the number of unwanted, high-risk pregnancies
- Prevent/reduce risky behaviours and improve knowledge, attitudes and skills for prevention of STIs including HIV
- Prevent sexual harassment, gender-based violence and aggressive behaviour
- Reduce drop-out rates in girls' education due to pregnancy
- Promote girls' right to education.

12.3 Peer education programme

Peer education is the process whereby well-trained and motivated young people undertake informal or organised educational activities with their peers (those similar to themselves in age, background, or interests). A **peer** is a person who belongs to the same social group as another person or group. The social group may be based on age, sex, occupation, socio-economic or health status, and other factors.

Peer education is an effective way of learning different skills to improve young people's reproductive and sexual health outcomes by providing knowledge, skills, and beliefs required to lead healthy lives. Peer education works as long as it is participatory and involves young people in discussions and activities to educate and share information and experiences with each other. (Figure 12.3) It creates a relaxed environment for young people to ask questions on taboo subjects without the fear of being judged and/or teased.

- What is a taboo subject?
 - Taboo refers to strong social prohibition (or ban) relating to human activity or social custom based on moral judgement and religious beliefs. In most of our communities openly talking about sex is considered unacceptable.

The major goal of peer education is to equip young people with basic but comprehensive sexual and reproductive health information and skills vital to engage in healthy behaviours.

Several areas of adolescent and youth reproductive health such as STIs (including HIV and its progress to full-blown AIDS), life skills, gender, vulnerabilities and peer counselling could be addressed in peer education. Although peer education is mainly aimed at achieving change at the individual level by attempting to modify the young person's knowledge, attitudes, beliefs or behaviours, it can also effect change at a group or social level by modifying existing norms and stimulating collective action.



Figure 12.3 Adolescents like to discuss issues that matter to them with their peers in a relaxed atmosphere.

Box 12.2 Advantages of peer education for young people

- Peer education helps the young person to obtain clear information about sensitive issues such as sexual behaviour, reproductive health, STIs including HIV
- It breaks cultural norms and taboos
- It is combined with training that is user friendly and offers opportunities to discuss concerns between equals in a relaxed environment
- Peer education training is participatory and rich in activities that are entertaining while providing reliable information
- Training in peer education offers the opportunity to ask any questions on taboo subjects and discuss them without fear of being judged and labelled
- Peer education as a youth-adult partnership: peer education, when done well, is an excellent example of a youth-adult partnership. Increased youth participation can help lead to outcomes such as improved knowledge, attitudes, skills and behaviours.

Peer education can take place in small groups or through individual contact and in a variety of settings: schools, clubs, churches, mosques, workplaces, street settings, shelters, or wherever young people gather. You will know from your own experience that young people get a great deal of information from their peers on issues that are especially sensitive or culturally taboo. Often this information is inaccurate and can have a negative effect. Peer education makes use of peer influence in a positive way.

As a health worker closely working with the community, you might be asked to give training on peer education to young people. However, before you are asked to train peer educators, you are likely to receive short-term training on how to train young people to be effective peer educators. Therefore, in this study session you will study only some basic tips that will help you in training adolescents to be peer educators. Firstly, young people, like adults, have a tendency to mask how much they don't know about a subject. Hence, you should not assume the topic is understood because there are no questions; ask questions of the participants when they do not offer their own. Secondly, young people and adults learn better if they are neither criticised nor judged by the facilitator. It is important to keep a positive attitude. Young people will learn better in an atmosphere of support, trust and understanding.

These basic tips will also be useful to the young people who you have trained to be peer educators. They will also want to know whether they should organise some activities or just be available to talk to peers, e.g. at school, work or in a bar.

After taking the training, a good peer educator should have the following qualities.

- Ability to help young people identify their concerns and seek solutions through mutual sharing of information and experience.
- Ability to inspire young people to adopt health seeking behaviours by sharing common experiences, weaknesses, and strengths.

- Become a role model; a peer educator should demonstrate behaviours that promote risk reduction within the community in addition to informing about risk reduction practices.
- Understand and relate to the emotions, feelings, thoughts and “language” of young people.

Examples of youth peer education activities include organised sessions with students in a secondary school, where peer educators might use interactive techniques such as role plays or stories, and a theatre play in a youth club, followed by group discussions. Theatre play in this sense doesn't mean that peer educators should be properly trained artists. It only refers to short dramas which are based on real-life experiences that young people are likely to face in their day-to-day life. Peer educators are also expected to use informal conversations with friends, where they might talk about different types of behaviour that could put their health at risk and where they can find more information and practical help.

12.4 Family life education

Family life education is defined by the International Planned Parenthood Federation (IPPF) as ‘an educational process designed to assist young people in their physical, emotional and moral development as they prepare for adulthood, marriage, parenthood, and ageing, as well as their social relationships in the socio-cultural context of the family and society’. An effective family life education helps young people to finish their education and reach adulthood without early pregnancy by delaying initiation of sexual activity until they are physically, socially and emotionally mature and know how to avoid risking infection by HIV and other STIs.

Educating adolescents in schools can lay the groundwork for a lifetime of healthy habits; since it is often more difficult to change established habits than it is to create good habits initially.

Important family life education content includes understanding oneself and others; building self-esteem; forming, maintaining, and ending relationships; taking responsibility for one's actions; understanding family roles and responsibilities; and improving communication skills.

Note from the above descriptions that family life education has many things in common with life skills (see Study Session 2 of this Module).

Traditionally adolescents get very limited information on reproductive health topics such as physiology, reproduction cycle, and life skills. Currently in Ethiopia, Family Life Education (FLE) is being taught to adolescents in primary school (from grade 7 onwards) integrated in the natural and social sciences, with reproductive health issues mainly incorporated in biology.

12.5 Community Conversation

Community conversation is a process whereby members of the different communities come together, hold discussions on their concerns and by using their own values and capacity reach shared resolutions for change and then implement them (Figure 12.4).



Figure 12.4 A health worker facilitating a community conversation.

As you learned in the Study Sessions on HIV/AIDS in the *Communicable Diseases* Module and in the *Health Education, Advocacy and Community Mobilisation* Modules, the day-to-day activities of community conversation are handled by you working closely with the *kebele* health committee. It is important to use the opportunity of meeting the community in the quarterly meetings for HIV/AIDS and other diseases so that you can raise the community's awareness about adolescent and youth reproductive health issues.

In the following sections you will learn the specific health promotion activities that you need to undertake for young people of different age groups.

12.6 Girls and boys aged 10–14 years living with their parents

Young people in **early adolescence** (aged 10–14 years) who live with their parents are often forced into early marriage, and suffer its consequences including early pregnancy leading to child birth complications such as fistula. They could also suffer sexual violence including female genital mutilation (FGM), abduction, polygamy and rape which predisposes them to STIs/HIV/AIDS. Because of lack of economic resources and unequal power relations with spouses girls are often unable to negotiate condom use with older spouses.

The fact that they have poor health seeking behaviour with limited access to antenatal or postnatal care and skilled delivery contributes to the high maternal mortality in this age group.

Boys are particularly at risk of dropping out of school to work. Those who migrate to urban areas are likely to live on the street.

Box 12.3 shows the main activities that you are expected to undertake on behalf of young people in early adolescence (aged 10–14 years).

Box 12.3 Key actions for young people aged 10–14 years who are living with their parents

- Sensitise community leaders, religious leaders, *kebele* officials and parliamentarians on SRH so that they will advocate on behalf of 10–14 year olds having access to appropriate information and services
- Select and train mentors and educators from the community
- Train peer educators from this age group (equal number of boys and girls) on SRH to disseminate advice on SRH and provide non-prescriptive contraceptives in clubs and other venues
- Provide age appropriate family life education in clubs and other venues where this group gather
- Awareness creation/sensitisation on the new family law which sets the minimum age of marriage at 18 years for both males and females
- Monitor and follow up implementation of SRH at the community level
- Provide training on gender and its effects on the reproductive health of young people
- Provide technical and material support to parent and teachers associations (PTAs).

- Provide technical and material support to create “safe spaces” for child brides
- Provide SRH training and family life education, negotiation and assertiveness skills for girls aged 10–14 years who are about to be married or who have already married
- Provide trained community volunteers to seek out child brides and persuade them to come to health facilities for antenatal, postnatal and delivery care.

You can use the following strategies to accomplish the activities indicated in Box 12.3:

- Create parent-teacher associations (PTAs) in schools and within the *kebele* committee as advocates and to follow up on enrollment and retention rates of female and male students.
- Advocate against early marriage, gender based violence and other HTPs.
- Create safe places (church, mosque, *kebele*) where groups meet, support each other, exchange information and receive sexual and reproductive health information and services.
- Promote antenatal, postnatal and skilled delivery services to this age group.
- Encourage and provide incentives to bring married girls and boys who have dropped out of school back to school.
- Encourage making schools gender sensitive (i.e. separate toilets for girls and boys, reduce harassment of girls on the road to schools).
- Organise Reproductive health/HIV/AIDS clubs in-school and out-of-school. (Figure 12.5)

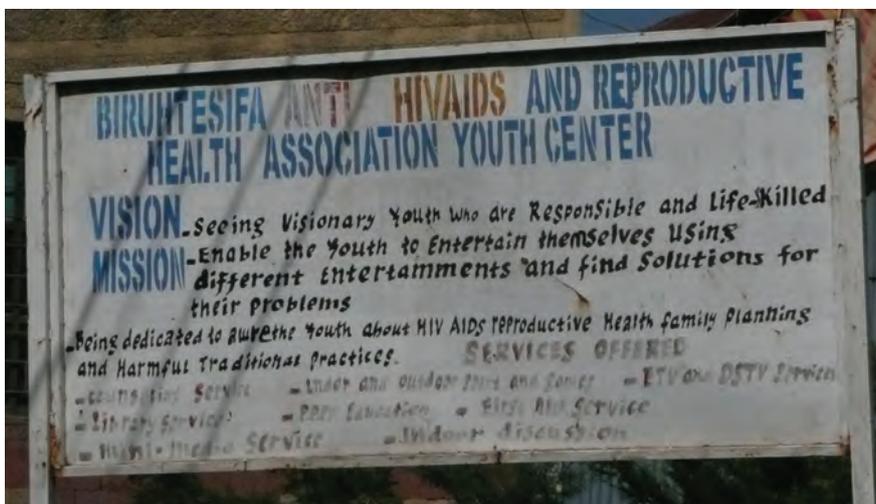


Figure 12.5 Sign advertising SRH club for young people. (Photo: Pam Furniss)

12.7 Girls and boys aged 15–19 years

Many in this group will be married or in a sexual relationship (remember average age at first marriage is 16 years for Ethiopian women even though marriage under 18 years is illegal). The reproductive health risks that girls in this age range are likely to encounter include sexual harassment, rape, abduction, FGM and polygamy. They are also at risk of dropping out of school because of poor performance due to work load and lack of support.

This group of late adolescents are more likely than the early adolescents to be married and to experience unwanted pregnancy, unsafe abortion, STI/HIV/AIDS. They may migrate to urban areas hoping for a better life but ending up as prostitutes (girls) and/or living on the streets (mostly boys but also girls).

- What are key actions that you should undertake for this 15–19 years age group?
- The key actions used for adolescents aged 10–14 years also apply to this group (see Box 12.3). In addition you need to provide youth friendly services that these adolescents can access for themselves at community level and at your health post (Figure 12.6). It may also be necessary to provide parents with communication skills and to sensitise them on the sexual and reproductive health of adolescents.

You should continue to advocate for the minimisation and eradication of sexual violence and harmful traditional practices using community conversations and dialogues; create referral linkages between schools and health facilities and outreach services, organise youth (in school and out of school) RH/HIV/AIDS clubs, gender clubs, and provide contraceptives in places where young people gather.

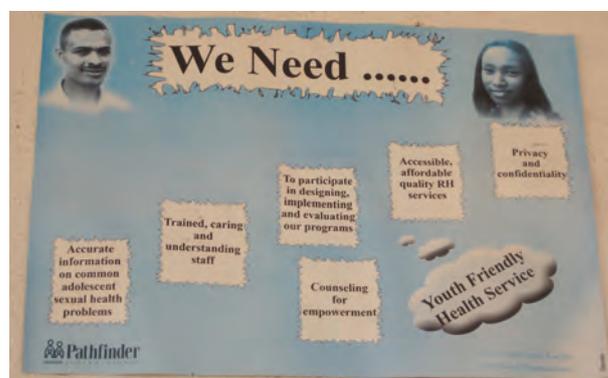


Figure 12.6 Sign at a health post advertising youth friendly services. (Photo: Heather McLannahan)

12.8 Young people aged 20–24 years

Important reproductive health concerns among these young people include; gender based violence, (rape, abduction), unwanted pregnancy, abortion, and sex in exchange for money or gifts. Because of this they are at risk of STIs including HIV, and of developing AIDS. Unemployment is also another significant issue that worries young people in this age group.

The key actions outlined in Box 12.3 also apply to this group. Particularly, you need to focus on training peer educators and sensitising community members to the needs for SRH services to young people whether they are married or not.

In general most strategies listed above apply to all age groups; the following are issues where you need to give greater emphasis for this older age group:

- Provide youth friendly services in vocational training schools and workplaces, and where these group congregate, ensuring you can provide an adequate supply of contraceptives
- Peer education on SRH
- Strengthen referral networks among health providers and young people.

12.9 Orphans and other vulnerable adolescents aged 10–19 years

- Which groups of young people are especially vulnerable to having reproductive health problems?
- As you have learned in Study Session 1, orphans, young married girls in rural areas, and youths who are abused, trafficked, physically or mentally impaired or migrate to urban areas are most vulnerable to negative reproductive health outcomes. More often they lack parental support and the financial resources to sustain themselves which predisposes them to engaging in prostitution (Figure 12.7), living on the streets and to acquiring STIs including HIV which eventually causes the development of AIDS.



Figure 12.7 Some girls end up as prostitutes.
(Photo of a street poster in Dire Dawa: Heather McLannahan)

It is important to keep in mind that the key actions listed above apply to these groups as well. Most of the strategies to implement the activities are also similar. Of particular importance is the need to create a safe place where they can meet to support each other and obtain RH information and services. You need to select and train individuals from the group to serve as peer educators and train community volunteers to seek out and provide them with information and services, and create a network of referrals.

Summary of the Study Session 12

In Study Session 12, you have learned that:

- 1 Adolescent and youth reproductive health promotion needs to receive proper attention in order to protect young people from adopting risky behaviours that could negatively affect their health.
- 2 There are a variety of ways to conduct health promotion for adolescents including school education, peer education, community conversation, and family life education. You can do promotion activities in schools, the community and at your health post.
- 3 The kind of health promotion messages appropriate for adolescents depend on their age, living arrangements and whether they are in school or out-of school.
- 4 Peer education is one of the effective strategies used to improve young people's reproductive and sexual health outcomes by providing the knowledge, skills and beliefs necessary to lead healthy lives.
- 5 Adolescent family life education is an effective adolescent health promotion strategy. It provides knowledge on physical, mental, social, moral, behavioural and mood changes and developments during puberty.
- 6 Community conversation is also one the key strategies that should be used to raise the community's awareness and to bring about positive behaviours among adolescents and young people.
- 7 Young adolescents (10–14) who live with their parents may have reproductive health problems such as early marriage and pregnancy leading to difficult child birth with later complications such as obstetric fistula. They may also experience sexual violence (including FGM, abduction, polygamy and rape).
- 8 Adolescents in the age group 15–19 years face similar reproductive health risks such as sexual harassment, rape, abduction, FGM and polygamy. They are more likely to be married but if they have unwanted pregnancies they may resort to unsafe abortion. They are also more likely to acquire STIs such as HIV and to develop AIDS.
- 9 Major issues among young people aged 20–24 years include; unemployment, gender-based violence, (rape, abduction), unwanted pregnancy/abortion, and sex in exchange for money or gifts. Because of this they have the greatest risk of STIs including HIV/AIDS.
- 10 To effect positive behaviour change, you need to be active in training or sensitising community leaders, religious leaders, *kebele* officials, and parliamentarians on SRH so that they too can advocate on access to information and services.

Self-Assessment Questions (SAQs) for Study Session 12

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering these questions. Write your answers in your Study Diary and discuss them with your Distance Learning Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 12.1 (tests Learning Outcomes 12.1 and 12.2)

In the rural village where you are working you are informed by the *kebele* leaders that the adolescents are having significant problems. Some identified problems are violence against adolescent girls on their way to school or to social activities such as markets, and fetching water, boys engaging in risky behaviours including drinking alcohol, chewing khat, and going to prostitutes especially when they get the chance to go to the towns. There are two primary and one secondary school serving the neighbouring communities.

- (a) What strategies would you use to approach the adolescents?
- (b) Which groups of individuals in the community need to be involved to implement your activities aimed at changing the behaviour of the adolescents?

SAQ 12.2 (tests Learning Outcomes 12.1, 2.3 and 12.4)

In the same village where you are working (SAQ 12.1), you note that the adolescents aged 15–19 are a particularly vulnerable group who need your special attention.

- (a) What are the common challenges that you expect adolescent girls aged 15–19 years to experience?
- (b) What specific actions are necessary to address your concerns for this group?

Study Session 13 Adolescent and Youth Reproductive Health Programme Management

Introduction

In Study Session 1 you learned that young people aged 10–24 years old make up about one third of the Ethiopian population and are faced with many reproductive health problems such as unwanted pregnancy, abortions, sexually transmitted infections (STIs) including HIV which progresses to AIDS. In the preceding sessions you have learned what should be done to help young people have good sexual and reproductive health. You have also learned that the Government of Ethiopia is committed to addressing the reproductive health problems of young people in Ethiopia. It is a reflection of the government's commitment to AYRH that this Module is included in your study. The reproductive health (RH) problems of young people are mainly addressed through AYRH programmes that are implemented at community level. In this session you will learn how to plan, implement and monitor AYRH services and programmes in your community.

Learning Outcomes for Study Session 13

When you have studied this session, you should be able to:

- 13.1 Define and use correctly all of the key words printed in **bold**. (SAQs 13.1, 13.2 and 13.3)
- 13.2 Calculate the size of the target group for and coverage of AYRH services. (SAQ 13.1)
- 13.3 Describe the steps in organising AYRH services. (SAQs 13.1 and 13.2)
- 13.4 Explain how to organise AYRH programmes at schools and in the community. (SAQ 13.2 and 13.3)
- 13.5 Know how to monitor and evaluate an AYRH programme. (SAQ 13.3)

13.1 Planning an AYRH programme for your community

13.1.1 Calculating the size of your target group

AYRH services could be delivered through various outlets such as the health post, household, community, schools, and other social institutions such as religious institutions, as well as areas frequented by young people. Before you provide services it is important that you know the size of your target group and what specific services they need and through which outlets you could provide the services.

- How would you find out the size of your target group?
- You learned how to conduct a survey of your community in the *Health Education, Advocacy and Community Mobilisation* Module. This is one of the first things that you do when you enter a community before starting to provide any service. From that survey, you know the number of persons by age and sex for each household and for the whole community or *kebele*. From the survey you can find out the number of young people aged 10–24 years old (Figure 13.1).



Figure 13.1 In general two thirds of the population is under the age of 25 but your target group is aged 10-14 years of age.

It is helpful to make a table (see Table 13.1) categorising the young people by age and sex group. This will help you to plan and tailor your AYRH programmes.

For example, suppose you found that the total population of your *kebele* was 5,000 and the total number of young people in the age group 10-24 years was 1,500 you should assume that half of these are females and each age group is one third of the total. This is shown in Box 13.1.

- What is the percentage of young people in your community?
- The percentage of young people in your *kebele* = $(1,500 \div 5,000) \times 100 = 30\%$

Table 13.1 Young people in the *kebele* by age and sex.

Age	Sex		Total
	Female	Male	
10–14	250	250	500
15–19	250	250	500
20–24	250	250	500
Total	750	750	1,500

Calculating the number of young people in the *kebele* by age and sex is important for:

- planning tailor-made RH information and services
- calculating the utilisation of services by age and sex
- monitoring progress and evaluating achievements.

13.1.2 Calculating AYRH service coverage

It is important to understand the common indicators for calculating service coverage; these are shown in Box 13.1.

Box 13.1 AYRH indicators

- Proportion of young people using condoms (for age groups 15–19 and 20–24 years)
- Contraceptive prevalence rate among sexually active young people for age groups 15–19 and 20–24 years (contraceptive prevalence = proportion of adolescents using contraceptives)
- Prevalence of STIs among female and male young people in age groups 15–19 and 20–24 years (prevalence of STIs = proportion of young people with STIs)
- Proportion of pregnant women aged 15–19 and 20–24 years old seeking antenatal care (ANC)
- Proportion of young women aged 15–19 and 20–24 years old delivered at the health post
- Proportion of young women who delivered with the assistance of a trained health service provider
- Proportion of young people referred for HIV counselling and testing
- Proportion of young women referred for abortion-related services
- Proportion of young women counselled on sexual abuse.

If we want to calculate ANC coverage among young pregnant women aged 15–19 years we divide the total number of young pregnant women aged 15–19 years who use ANC by the total number of young pregnant women aged 15–19 years in the *kebele* and multiply by 100.

ANC coverage among young women 15–19 =

$$\frac{\text{number of young pregnant women 15–19 who use ANC}}{\text{number of young pregnant women 15–19 in the kebele}} \times 100$$

The same can be done for the other indicators.

- How would you calculate ANC coverage among women aged 20–24 years?
- ANC coverage among young women 20–24 =

$$\frac{\text{number of young pregnant women 20–24 who use ANC}}{\text{number of young pregnant women 20–24 in the kebele}} \times 100$$

13.1.3 Organising adolescent and youth friendly RH services

Stop reading for a moment and think of your past experience. How did you organise and start providing adolescent- and youth-friendly reproductive health (AYFRH) services at your health post?

In order to organise AYFRH services it is important to start with a needs assessment of the adolescent and youth reproductive services at the health post. In Box 13.2 you see the five steps that you can follow to organise AYFRH services at your level.

Box 13.3 Steps in organising AYFRH services

- 1 Conduct a needs assessment of adolescent and youth services provided at the health facility
- 2 Assess whether the health workers are trained to provide AYFRH services and find out what materials are available in the health facility
- 3 Identify existing problems in providing RH service for young people
- 4 Develop proposals to solve the problems identified
- 5 Present an action plan to implement the proposals.

We will now show you how you go about each of the above five steps.

Step 1: Conducting a needs assessment of existing services at the health post

Figure 13.2 on the next page, is a needs assessment tool. You use it to collect the required information on the services already provided. It will help you identify existing problems and the people and materials available to provide RH services for young people. In addition, the needs assessment tool will help you collect information on how the health post keeps track of data on AYFRH services provided. Overall, the tool will help you determine whether the facility has youth-friendly characteristics.

- What are the characteristics of AYFRH services? (If you do not remember, reread Section 10.1.1. in this Module.)
- The major characteristics of AYFRH services include:
 - Convenient hours
 - Convenient location
 - Adequate space and sufficient privacy
 - Availability of peer education and a counselling programme
 - Affordable fees for the service
 - Involves young people in the provision of information and services (Figure 13.3)
 - Informs the community about services for AYFRH
 - Availability of health workers trained in AYFRH services
 - Materials available for AYFRH service provision



Figure 13.3 Discussing with young people helps to identify their needs.

As you see in Figure 13.2 there are about 11 questions related to AYFRH service categorised under the following main headings:

- Materials/supplies and services
- Training of health workers
- Involvement of the young people and the community
- Convenience of the location and service hours

Now look at Figure 13.2.

AYFRH service needs		
General Information:		
Name of <i>Woreda</i> _____	Name of <i>Kebele</i> _____	Name of health facility _____
About Materials/supplies and services		
1	Does the health facility meet the “Standards on Youth Friendly Reproductive Health Services” when providing services to young people?	Yes No
2	Are Health Education materials on the different components of AYRH services currently available at the health facility?	
	○ Sexually transmitted infection	Yes No
	○ HIV/ AIDS	Yes No
	○ Unwanted/unplanned pregnancy and contraceptive use/family planning	Yes No
	○ Maternal health care (antenatal care, delivery care postnatal care)	Yes No
3	Does the health facility have referral forms for young people? (could be the same for all clients/patients, but need to verify that it is appropriate for young people)	
	○ Referral (one way only)	Yes No
	○ Referral and Feedback (back referral)	Yes No
4	Does the health facility have case management guidelines for the following services?	
	○ STIs	Yes No
	○ HIV/AIDS	Yes No
	○ Sexual abuse	Yes No
	○ Contraception/family planning	Yes No
	○ Antenatal, delivery, postnatal	Yes No
5	Does the facility have the following supplies and services?	
	○ Contraceptives	Yes No
	○ Emergency contraceptives	Yes No
	○ Pregnancy test	Yes No
	○ Syndromic management of STIs	Yes No
	○ HIV testing	Yes No
Training of health workers		
6	Are any of the health workers in the facility trained in the case management guidelines?	Yes No
7	Are any of the health workers in the health facility trained on AYFRH services?	Yes No
Involvement of young people and the community		
8	Are young people involved in providing information and services to their peers in the community?	Yes No
9	Does the facility inform the community about their AYFRH services available?	Yes No
Convenience of the location and service hours		
10	Are the service hours of the facility convenient for young people?	Yes No
11	Do the consultation rooms for young people ensure?	
	○ Privacy (visual and auditory)	Yes No
	○ Confidentiality? (records locked and not accessible to other people)	Yes No

Figure 13.2 An AYFRH needs assessment tool for use in a health facility

Step 2: Assess whether the health workers are trained to provide AYFRH services and find out what materials are available in the health facility

- How will you carry out step 2?
- The information that you want has been gathered using the needs assessment tool (Figure 13.2).

Step 3: Identifying problems related to AYFRH

Activity 13.1

Figure 13.2 is called an assessment tool because it is used like any other tool to enable you to carry out a task (e.g. a spoon is a tool that can be used to stir food in a cooking pot). Use this assessment tool (i.e. Figure 31.2) to collect information about the services that are available at your health post. If you have worked for sometime in the health post, you will be familiar with the facilities and you can be the source of information for the assessment. If you are a newcomer to the facility and there are other health workers or practitioners you should talk to them and collect the information jointly.

Based on the information you collect, use Table 13.2 to categorise the problems you found. Copy the table into your study diary and show this to your Tutor.

Table 13.2 Problems identified.

Materials and services	Training of health workers	Involvement of the young people and the community	Convenience of the location and service hours

Steps 4: Developing a proposal

Now you should develop a proposal to show how you are going to solve the problems you identified in your assessment. You may not be able to respond to all of the problems you have identified. Therefore you should prioritise the problems based on the importance of the problem and the resources you have or you could acquire. If you can't address the problems at your level, the proposal would help you request support from the health centre or *woreda* health office. The proposal should have the problems identified (it is good if you have prioritised the problems and put only two or three priority problems in your proposal). You need to include in your proposal what you want to achieve by addressing the identified problem—we usually call this the **objective**. You may have different ways of achieving your objectives — we call these ways **strategies** — and it is good also to indicate your strategies in your proposal.

You may need to do one or more activities for each of your prioritised problems. You should put the major activity for each problem in your proposal. Addressing some of your identified problems may require resources; if you think you need resources for your priority problems, indicate in your proposal what resources you need. Finally, you should include the time within which you would like to accomplish your proposed activities. Table 3.3 is a form that is suitable for developing a proposal. It has been completed to show you how you can use it. For example, let us say that when you conducted your needs assessment you saw that the health post had no health education materials on contraceptives. You decided to prioritise this as a major problem and used a form (see Table 13.3) to develop your proposal.

Table 13.3 Form for developing a proposal

	Problem: Materials and services No health education materials on contraception available at the health post
Objective	Make health education materials on contraceptives available at the health post
Strategy	Mobilise support from the <i>woreda</i> health office, health centre and NGOs working in the <i>kebele</i>
Activity	Collect available health education materials
Resource	Transport and per diem cost to travel to the <i>woreda</i> health office and health centre
Time	One month

Step 5: Developing an action plan

With the proposal it is useful to develop an action plan for each problem that you have identified. The action plan is a very simple tool which will help you organise yourself to respond to the problems to AYFRH service provision at your health post. In the action plan you put very specific actions. The activities you have put in the proposal may be more general activities. Table 13.4 shows a form that you can use to help you develop an action plan. You need to indicate in your action plan by whom and when the specific action will be carried out. Just as for the proposal Table 13.4 has been completed for the problem identified in the needs assessment.

Table 13.4 Action plan

Problem	Action Required	Person responsible	Date to be carried out
Lack of health education materials on contraceptives at the health post	Collecting health education materials Request both orally and through formal letter that (i) the <i>woreda</i> health office Or (ii) the NGO working in the <i>kebele</i> (if any) Or (iii) the health centre provides you with health education materials on contraceptives	Health Extension Practitioner	September 1st 2005 (E.C.)

13.2 Organising school based AYRH programmes



Figure 13.4 Talking to teachers.

For successful school-based activities, it is important that you work with the teachers and students themselves in each particular school (Figure 13.4). Initial discussion with some of the teachers and the students could give you ideas on the topics you need to focus on and the best strategies to employ. Remember that you need to tailor the information that you provide to students according to their age. You can use the various promotional strategies that you learned in the *Health Education, Advocacy and Community Mobilisation* Module and in Study Session 12 of this Module to reach young people who are still in school.

- Name some suitable strategies for reaching young people in school.
- Most schools have clubs organised to respond to selected thematic areas or topics like an environmental health club and anti-AIDS clubs. A suitable strategy would be to visit the anti-AIDS club and work with young people there.

If the schools have already established clubs, it is a good opportunity for you to reach the students in the schools through the existing clubs. The anti-AIDS club is appropriate for dealing with AYRH issues. If the schools do not have clubs, you can help them establish a club that can work on AYRH in the school.

- How would you help the school establish a club if it doesn't have one?
- You can do this by holding an initial discussion with the school officials, biology teachers, and student representatives from each grade. They can mobilise the students to be members of the club. Your role will be to educate the club members and they will work on most of the promotional activities.



Figure 13.5 School club leaders discussing their club activities

It is good to assess on a regular basis the changes that have been brought about by your school-based interventions. You can do this assessment by asking questions in the same way that you did when you held your initial discussions with the teachers and the students. Asking the club leaders how frequently they meet, how many of the members are girls, how many are boys, what specific promotional activities they have been doing, what challenges they have faced and what type of support they need from you will help you to gain a better understanding of the value of your school-based interventions (Figure 13.5). It is a good idea to assess the activities every three months because this will give you important information to help you to plan your next activities.

13.3 Organising household and community level AYRH Programmes

It is at household and community level that you can reach young people who do not go to school including those who are married. From the survey that you conducted, you already have the number of young people in your community. In addition to categorising them by age (10–14, 15–19, 20–24), it is now advisable to categorise them by marital status in order to tailor your messages to the specific groups. Therefore it is important that you have specific household and community level interventions for this group of young people. At household level, when you plan a household visit for other health

activities it is a good idea to integrate reproductive health-related activities and address them in each household where there are young people.

Once you have the different categories of young people by age and sex, you can form peer groups in each sub-*kebele* (*gotts*). First you must train the peer educators (see the previous study session in this Module). The groups meet for regular sessions: maybe every two weeks or every month depending on how often they wish to discuss issues of concern to them. You will be the resource person when needed. As each peer group is likely to require your assistance at some point, it is good idea if you develop a plan for peer education related activities.

To be able to plan support activities and assess their effectiveness you need the following information:

- 1 The number of peer education groups in the *kebele*
- 2 The number of peer members in each group
- 3 The number of sessions each group conducted during the quarter
- 4 The topics they covered in the peer education sessions.

Try to ensure that the peer groups do have similar characteristics, like married girls in one group; unmarried in another group.

If you follow the five steps when setting up AYFRH services at your health post you will be able to improve the sexual and reproductive health of the young people in your community with the help of all you have learned in this Module.

Summary of Study Session 13

In this session you have learned that:

- 1 AYRH services could be delivered through various outlets and these include: health post, household, community and schools.
- 2 You should know the size of the target group for AYRH programme in your *kebele*. You can get this number from the household survey that you initially conducted. Categorising the target group by age and sex (10-14, 15-19, 20-24) is important for:
 - planning tailor-made RH information and services
 - calculating the utilisation of services by age and sex
 - monitoring progress and evaluating achievements.
- 3 AYRH service coverage is calculated by dividing the total number of young people utilising the particular service by the total number of young people in the *kebele*.
- 4 The steps in organising AYFRH services at your health post include:
 - Conducting a needs assessment of AYRH services provided at the health facility
 - Identifying human resources and materials available at the health post
 - Identifying existing problems in providing RH services for young people
 - Developing proposals to solve the identified problems
 - Presenting an action plan to implement the proposals.
- 5 School based AYRH programmes should be tailored to the age of the group and could be implemented through clubs.

-
- 6 Community based AYRH programmes should also be tailored to the age and marital status of the young people and could be implemented through clubs and involve different activities including peer education sessions and community conversations.
 - 7 Collecting, analysing and reporting data on the indicators of AYRH service coverage should be used for monitoring and evaluating AYRH services.

Self -Assessment Questions (SAQs) for Study Session 13

Now that you have completed this study session, you can assess how well you have achieved its Learning Outcomes by answering the questions below. Write your answers in your Study Diary and discuss them with your Distance Learning Tutor at the next Study Support Meeting. You can check your answers with the Notes on the Self-Assessment Questions at the end of this Module.

SAQ 13.1 (tests Learning Outcomes 13.1 and 13.2)

In 2003 E.C. the total number of young people aged 10-24 years in a *kebele* whose total population is 6,000 was about one third of the total population. Females constitute half of the young people of age 10-24 years. From the same year, you have data showing that the total number of young people aged 10-24 years in the *kebele* who were treated for STIs was 200 out of which 50 were female.

- (a) What is the prevalence of STIs among young people aged 10-24 years in this *kebele*?
- (b) What is the prevalence of STIs among young females aged 10-24 years in this *kebele*?
- (c) What is the prevalence of STIs among young males aged 10-24 years in this *kebele*?

SAQ 13.2 (tests Learning Outcomes 13.1 and 13.3)

You are assigned to work in a *kebele* called Selamdar. One of your assignments is to provide adolescent and youth friendly reproductive health (AYFRH) services in the *kebele*. Discuss the steps that you will follow to organise AYFRH service in this *kebele*.

SAQ 13.3 (tests Learning Outcomes 13.1, 13.4 and 13.5)

Discuss what approaches you will use to organise AYRH services at community and school level.

Notes on the Self-Assessment Questions (SAQs) for Adolescent and Youth Reproductive Health

Study Session 1

SAQ 1.1

Abebe is 17 years old so he is in the late adolescence period.

SAQ 1.2

The change in his voice is a physical change. His interest in girls is a psychosocial change.

SAQ 1.3

Abebe is spending more time with his friends and staying out late without parental permission. It seems he might succumb to peer pressure to experiment with substances and indulge in other reckless behaviour as his behaviour is already worrying his parents.

SAQ 1.4

Abebe should learn about the dangers of unprotected sex. He should know how STIs including HIV are acquired and how to protect himself by using a condom.

SAQ 1.5

In general girls have their first sexual experience earlier than boys (at 16 years old) so the concerns of a girl of the same age may centre on unwanted pregnancy. However, she should also be aware of the risks of STIs and needs to be encouraged to obtain dual protection (from pregnancy and from STIs).

Study Session 2

SAQ 2.1

- (a) Hawa was too young to get married legally and have a child. Adolescence is a period of rapid physical growth so the fetus would have been competing for nutrients with Hawa. This resulted in poor growth, reflected by its low birth-weight. At 15 Hawa may be emotionally unprepared to take adult roles and may not be able to give proper care to her child. The fact that she lost her parents and had no income compromised her options in life so marriage seemed a way out but she thereby lost the opportunity to have a good education and find employment.
- (b) Hawa could have negotiated on at least two issues even after she got married: first she could have delayed the first birth using contraceptives; and second, she could have asked to continue her education. However, since she doesn't equal her husband in terms of age, income, and social status it was difficult for her to decide freely about these important issues in her life. Besides, it is difficult to make a mature and rational decision when only 15 years old.

SAQ 2.2

- (a) Kebede's risky behaviours included having contact with a prostitute, chewing khat, drinking alcohol and smoking.
- (b) His sexual behaviour put him at risk of acquiring sexually transmitted infections, including HIV/AIDS. Cigarette smoking and alcohol consumption increase his risk of acquiring many chronic diseases. Further, as he is engaged in behaviours, such as alcohol drinking and khat chewing, that can become addictive, he could have social, psychological or mental health problems in the future (e.g. being isolated and stigmatised).
- (c) Kebede applied two important interrelated life skills – decision-making skills and critical thinking skills. He reflected on his own behaviour and tried to understand the consequences of his actions. He decided to stop his risky behaviours. In doing this he was able to analyse the influence that his peers were having on his behaviour and so he found new friends who were more supportive of what he was trying to achieve.

Study Session 3

SAQ 3.1

- (a) Since Azeb was unhappy and upset when she learned that she was pregnant, we can conclude that the pregnancy was unplanned and unwanted.
- (b) From the story, it is evident that Azeb needs appropriate information and counselling on issues related to her unwanted pregnancy. Specifically, she needs to know that she should attend for antenatal care. The medical risks, such as anaemia and hypertension, should be explained and she should be told the warning signs of complications in pregnancy and what to do if she experiences any of these. You will be aware that she may face social stigma and that there is a danger of her dropping out of school so you should provide reassuring and supportive counselling. It is unlikely that she qualifies for a legal abortion so you should warn her of the dangers of unsafe abortion while being careful to emphasise the possible positive outcomes of having a baby.

SAQ 3.2

- (a) Since Azeb tried to terminate her pregnancy, this is an example of unsafe induced abortion. Non-medically induced abortion is likely to result in many complications including bleeding (which she experienced), infections and even death.
- (b) Azeb is still in school, strongly hoping to complete her education and have a decent career. In addition, she is not getting any support from her partner (her boyfriend actually denied having a relationship with her). Assuming that the self-inflicted wound has resulted in terminating her pregnancy Azeb needs to get emotional support and be counselled about family planning services to avoid having the same problem again. She also needs to be checked to see whether she is anaemic, and you should refer her for a post-abortion check to ensure she does not have physical damage or genital tract infections.

Study Session 4

SAQ 4.1

Tessema and Meselech are young and uneducated. They did not know about dual protection or STIs. They may have contracted STIs from previous partners or Tessema might have visited a prostitute to prove his sexual powers.

SAQ 4.2

Tessema should go to a health facility that can offer treatment and counselling. Since you are not trained to provide this treatment you need to refer Tessema to seek care from the nearest health facility (health centre or hospital) where the service is available. You can advise Tessema not have intercourse before he gets treatment for his illness. You can also explain that he may have an STI and you can provide condoms and tell him about their proper use.

SAQ 4.3

Meselech seems to have one of the STIs characterised by vaginal discharge. She may also be infertile as a consequence of this and if she does not conceive she risks divorce which will affect her social status in the community.

SAQ 4.4

Meselech appears to have an STI so you need to refer her to the appropriate health facility (health centre or hospital) where she can get treatment. Both Meselech and Tessema should be advised to go for HIV testing and counselling. You need to educate them on the prevention of STIs.

Meselech should also be advised to avoid taking medications without consulting a health professional.

Study Session 5

SAQ 5.1

- (a) The Ethiopian family law protects young women's rights against forced and early marriages (less than 18 years of age).
- (b) Since marriage before the age of 18 is illegal in Ethiopia she has the right to say 'No' to such a request. As you have learned in Study Session 1 of this Module, young people have the right to expect and demand equality, full consent and mutual respect in sexual relationships.

SAQ 5.2

Emebet has faced many health consequences of early marriage including having a stillbirth and a vesico-vaginal fistula. These complications needed prolonged treatment and when she returned to her village she found her husband had remarried. As a result of being divorced and ill she developed psychosocial problems including feelings of loneliness, isolation and depression.

Study Session 6

SAQ 6.1

The types of gender-based violence Bekelu experienced were physical (she is usually beaten) and sexual (she is coerced into having sex with him against her will).

SAQ 6.2

There is an unequal power relationship (Bekelu is physically weaker than him) and alcohol use. Both these factors can contribute to GBV.

SAQ 6.3

Barrier to reporting the GBV: fear of blame by parents.

SAQ 6.4

Bekelu is worried about STIs including HIV/AIDS.

SAQ 6.5

Counsel Bekelu in a non-judgemental manner; encourage her to share her problems with her family members; contact and discuss with her parents if possible; discuss with the *kebele* officials and women's affairs head of the *kebele*.

SAQ 6.6

Activity 6.1

Sex is the biological characteristic that defines humans as female or male.

Gender refers to socially and culturally defined roles for males and females.

Gender-based violence (GBV) is any form of deliberate physical, psychological or sexual harm or threat of harm directed against a person on the basis of their gender. **Sexual harassment** is any type of unwanted sexual attention such as unpleasant sexual comments or physical gestures.

Sexual abuse is any type of unwanted sexual contact and includes all forms of sexual coercion (emotional, physical and economic) against an individual.

Rape is forced sexual intercourse that takes place against a person's will.

Date rape is committed by a boyfriend forcing his girlfriend to have sex against her will.

Acquaintance rape is committed by someone who is known to the victim.

Sexual violence includes a wide variety of undesired physical and psychological sexual acts.

Study Session 7

SAQ 7.1

Alemu consumes alcohol, khat and the illicit substance hashish; he has already developed high-risk behaviours that could make him vulnerable to HIV infection. Long-term use of alcohol may make him infertile, long-term use of khat may be addictive and reduce his desire for sex. He may not be able to have a satisfactory orgasm when he uses hashish.

SAQ 7.2

It seems that Alemu is already addicted to these substances as he knows they are bad for him but he can't quit. If he tries to quit he will suffer withdrawal symptoms.

SAQ 7.3

Help him to think critically of his experiences with these substances and how they fail to fulfill his expectations. Engage him in the community conversation sessions; this will enable him to change his behaviour.

Study Session 8

SAQ 8.1

- (a) Pregnancy before the age of 18 year has several health risks, which include obstructed or prolonged labour, pre-eclampsia (hypertension of pregnancy), unsafe abortion, and premature and stillbirth.
- (b) To prevent or delay early pregnancy a 16-year-old girl should abstain from sex. If that is not possible she should use dual protection.

SAQ 8.2

- (a) Combined oral contraceptive pills: appropriate because it has a low failure rate and also offers relief from pain during menstruation.
- (b) Depo-provera (DMPA): appropriate because she doesn't need to remember when to take oral contraceptives; it has a low failure rate.
- (c) IUCD: not appropriate because women under the age of 20 who have not given birth appear to have greater risks of expulsion and painful menses due to IUCD.
- (d) Sterilisation: not appropriate because she has not yet had a child.

SAQ 8.3

- (a) Implants: appropriate because very low failure rate, reversible and long acting.
- (b) Condom: appropriate because available without a prescription and provide protection against STIs/HIV.
- (c) Lactational amenorrhea method: not appropriate because she doesn't fulfill the three criteria for LAM.
- (d) Abstinence: not appropriate because she is married.

SAQ 8.4

LAM is appropriate for any young woman who is under six months postpartum, fully or nearly fully breastfeeding, and amenorrhoeic.

SAQ 8.5

- 1 Emergency contraceptive pills.
- 2 Take two pills immediately and the remaining two pills after 12 hours of the first dose.
- 3 If vomiting occurs within two hours of the first dose, take the extra pills
 - Come back for a regular contraceptive method
 - ECPs do not protect from STIs/HIV/AIDS, so she needs to use dual protection.

SAQ 8.6

- (a) Two pills should be taken as the first dose as soon as convenient, but not later than five days (120 hours) after unprotected intercourse.
- (b) The second two pills should follow 12 hours later.

Study Session 9

SAQ 9.1

ROLES is the acronym that you can use to remind yourself of good non-verbal techniques to be used in counselling. It is helpful in all situations when you are counselling young people and helps them to see that you are interested in helping them with whatever sexual issue they bring to you. So you would use ROLES when counselling this young man.

SAQ 9.2

- (a) No, this young girl would not be comfortable telling you about her reproductive health problems in front of older clients who might tell her parents.
- (b) The three most important characteristics to create a good counselling environment for a young person are to ensure privacy, ensure confidentiality and give respect.

SAQ 9.3

You will not have made the decision for her. She must make her own decision. Your role has been to use the other good approaches to establish trust and encourage her to identify possible options. You will then have discussed the advantages, disadvantages and consequences of these options but you will have left her to make her own decision.

Study Session 10**SAQ 10.1**

- (a) Roda Health Post is not providing AYFRH services. This is because of the following reasons:
- The health worker at the health post is not trained in adolescent and youth-friendly services and is not welcoming to and supportive of the access to RH information and services by young people.
 - The health worker and the guard do not show respect for young people.
 - The adults who were waiting for the services were not supportive. They did not seem to know that young people have the right to access health information and services.
 - The health worker did not give enough time to Fatima.
 - The service hours were not convenient for young people.
- (b) Barriers to Fatima's utilisation of RH Services

Individual/personal factors	Cultural/social factors	Institutional factors
Schooling status: she is a student who went to the health post with her school materials; the adults, the guard, and the health worker were judgemental based on their belief that a student who is 'unmarried' should not be sexually active and hence shouldn't come to the health post.	Awareness level of the communities Attitudes towards young people's sexual behaviour Attitude towards AYRH services	Judgemental health worker Space/locations: Fatima has to wait for the service with adults Timing: it was not convenient for Fatima

SAQ 10.2

- (a) An appropriate referral linkage is the required standard that is missing. The health worker at the health post should have awareness of where a VCT service is available and be able to refer young people to it.
- (b) As it is a long way for young people to go for a VCT the health centre could arrange an outreach service for Adane's *kebele* and other distant *kebeles* in the health centre's catchment areas.

SAQ 10.3

Even if she comes to the health post for health problems other than RH, you should assess her RH using the HEADS assessment. HEADS can be used to assess whether she is at risk from STIs (including HIV) or might become pregnant. You should also assess whether she abuses substances and/or is being sexually abused.

Study Session 11

SAQ 11.1

Tsega is not under 16 so her risk of obstructed labour is not especially high, although it is higher than it would be for an older woman. However, at 18 her pelvis might be immature so the birth canal could be restricted in size. On a positive note she has been in good health and both families are pleased she is pregnant so she may be well nourished.

SAQ 11.2

Tsega was not happy to be pregnant so she will have needed caring support during her pregnancy. At the health post she is weeping so she is probably missing her family and will need support through the labour from a skilled assistant. She should not be left alone to weep.

SAQ 11.3

- (a) You should observe her for six hours, explain the signs of postpartum complications to her and tell her when to return to the health care facility.
- (b) You should schedule a home visit for follow-up on the 7th and 42nd days after birth. During the first week postpartum visit, congratulate her on her labour and if possible tell family members how well she managed. Then pay attention to her ability to cope with change and new responsibilities. Observe the mother–baby interaction and breastfeeding (attachment, removal, positioning and style of feeding). Take a brief history focusing on progress in healing and involution; inspect breasts, abdomen and perineum.

During the sixth week visit take a complete history and physical examination and discuss her contraceptive needs. Explore with her how she is coping with mothering and find out whether she has any physical, emotional and/or baby problems.

Study Session 12

SAQ 12.1

- (a) There are many ways you can reach the adolescents. You may organise community conversations (in schools or in the community) to increase the community's awareness of protective behaviours. You may also use peer educators to promote age appropriate family life education.
- (b) To effect positive behaviour change, you need to be active in training or sensitising community leaders, religious leaders, *kebele* officials, and parliamentarians on adolescent and youth sexual and reproductive health issues so that they too can advocate on access to information and services for young people.

SAQ 12.2

- (a) In a rural setting these groups of girls are considered mature enough to get married and hence start sexual activity. They may nevertheless have unwanted pregnancies and this may lead them to seek unsafe abortions. Some may be in polygamous marriages or married to an older husband and they may not have been able to negotiate for safer sex using a condom thereby possibly exposing themselves to the risk of STIs such as HIV. They may also have to face other reproductive health risks including; sexual harassment, rape, abduction and FGM They are at risk of dropping out of school because they are expected to do other work.
- (b) These are some of the activities that you are able to initiate:
- Select and train mentors and educators from the community.
 - Train boys and girls as peer educators on SRH to disseminate information and provide non-prescriptive contraceptives in clubs and other venues where young people in this age group gather.
 - Provide age appropriate family life education in clubs and other venues where this group gather.
 - Create awareness of the new family law which sets the minimum age at marriage of 18 years for both males and females.
 - Train and sensitise parents, community members and faith based organisations on SRH issues such as HTP, gender based violence.

Study Session 13**SAQ 13.1**

- (a) Prevalence of STIs among young people aged 10–24 years =

$$\frac{\text{number of people aged 10 – 24 years with STIs in year 2003 E.C. in the kebele}}{\text{number of people aged 10 – 24 years with STIs in year 2003 E.C. in the kebele}} \times 100$$

the prevalence of STIs among young people aged 10–24 years is 10%

- (b) Prevalence of STI among young females aged 10–24 years =

$$\frac{\text{number of females aged 10 – 24 years with STIs in year 2003 E.C. in the kebele (50)}}{\text{number of females aged 10 – 24 years in the same year in the kebele (1000)}} \times 100$$

the prevalence of STIs among young females aged 10–24 years is 5%

Prevalence of STI among young people of age 10–24 =

$$\frac{\text{number of males of age 10 – 24 with STI in year 2003 E.C. in the kebele (150)}}{\text{number of males of age 10 – 24 year in the same year in the kebele (1000)}} \times 100$$

the prevalence of STIs among young males aged 10–24 years is 15%

SAQ 13.2

The steps in organising AYFRH services include:

- Conducting a needs assessment of adolescent and youth services provided at the health post in Selamdar.
- Identify human resources and materials available in the health post.
- Identify existing problems in providing RH service for young people.
- Develop proposals to solve the problems identified.
- Present an action plan to implement the proposals.

SAQ 13.3

When organising AYRH programmes at community and school level you should consider the following:

- Tailoring messages for different groups (segmentation by age, sex, marital status)
- Involving young people
- Involving community members and teachers
- Establishing clubs
- Conducting peer education sessions
- Building the capacity of the clubs through training
- Regular monitoring.

