MIDWIFERY

NTQF Level II

Learning Guide #21

Unit of Competence: Provide Adolescent, Youth and Reproductive Health

Module Title: Providing Adolescent, Youth and Reproductive Health

LG Code: HLT MDW3 M06 LO2-21

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LO 2: Promote adolescent and youth RH services

Instruction Sheet	Learning Guide #21

This learning guide is developed to provide you the necessary information regarding the following content coverage and topics –

- Consulting community representatives
- Promotion of AYRH services
  - ✓ Health Education
  - ✓ Using Inter-sectoral approach
- Self-care approach in AYRH problems

This guide will also assist you to attain the learning outcome stated in the cover page. Specifically, upon completion of this Learning Guide, you will be able to –

- Influential community representatives and volunteers are identified and consulted
- RH service promotion and education are organized and promoted in partnership with the community and relevant organizations on the basis of inter-sectoral approach
- RH service promotion and education are provided and sustained to meet community and organizational requirements on the basis of duty and responsibilities of all stakeholders
- RH problem are supported to take self-care approach in line with individual needs for changing unhealthy behavior on the basis of healthy promotion and strategic behavioral change approach of FMOH

Learning Instructions:

1. Read the specific objectives of this Learning Guide.
2. Follow the instructions described in number 3 to 14.
3. Read the information written in the "Information Sheets 1". Try to understand what are being discussed. Ask you teacher for assistance if you have hard time understanding them.
4. Accomplish the "Self-check 1" in page --------------------.
5. Ask from your teacher the key to correction (key answers) or you can request your teacher to correct your work. (You are to get the key answer only after you finished answering the Self-check 1).
6. If you earned a satisfactory evaluation proceed to "Information Sheet 2". However, if your rating is unsatisfactory, see your teacher for further instructions or go back to Learning Activity #1.
7. Submit your accomplished Self-check. This will form part of your training portfolio.
8. Read the information written in the "Information Sheet 2". Try to understand what are being discussed. Ask you teacher for assistance if you have hard time understanding them.
9. Accomplish the "Self-check 2" in page --------------.

10. Ask from your teacher the key to correction (key answers) or you can request your teacher to correct your work. (You are to get the key answer only after you finished answering the Self-check 2).
11. Read the information written in the “Information Sheets 3 . Try to understand what are being discussed. Ask you teacher for assistance if you have hard time understanding them.
12. Accomplish the “Self-check 3” in page -----------.
13. Ask from your teacher the key to correction (key answers) or you can request your teacher to correct your work. (You are to get the key answer only after you finished answering the Self-check 3).
14. Do the “LAP test” in page --------------------

Information Sheet -1	Consulting community representatives

1.1 Consulting community representatives

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.

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.

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Self check -1	Consulting community representatives	Pr

Information Sheet -2	Promotion of AYRH services

Promoting adolescent and youth reproductive health

Young people can be influenced to have positive healthy behavior 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 counseling 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.

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 behaviors, 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

Objectives of skills-based health education in schools

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

Peer education programme

Peer education is the process whereby well-trained and motivated young people undertake informal or organized 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 judgment 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 behaviors.

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 counseling 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 behaviors, it can also effect change at a group or social level by modifying existing norms and stimulating collective action.

Advantages of peer education for young people

- Peer education helps the young person to obtain clear information about sensitive issues such as sexual behavior, 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 labeled
- 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 behaviors.

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 criticized 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 organize 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 behaviors by sharing common experiences, weaknesses, and strengths.
- Become a role model; a peer educator should demonstrate behaviors 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 organized 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 behavior that could put their health at risk and where they can find more information and practical help.

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.

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 behavior 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 (aged10–14 years).

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

- Sensitize community leaders, religious leaders, keeled 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 no prescriptive contraceptives in clubs and other venues
- Provide age appropriate family life education in clubs and other venues where this group gather
- Awareness creation/sensitization 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.

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 sensitize them on the sexual and reproductive health of adolescents. You should continue to advocate for the minimization 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, organize youth (in school and out of school) RH/HIV/AIDS clubs, gender clubs, and provide contraceptives in places where young people gather.

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 sensitizing 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.

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.

Self check -2	Promotion of AYRH services

MCQ

1. Objectives of skills-based health education in schools
    A. Prevent/reduce the number of unwanted, high-risk pregnancies
    B. Prevent sexual harassment, gender-based violence and aggressive behavior
    C. Reduce drop-out rates in girls' education due to pregnancy
    D. Promote girls' right to education
    E. All of the above
2. Advantages of peer education for young people
    A. Peer education helps the young person to obtain clear information about sensitive issues such as sexual behavior, reproductive health, STIs including HIV
    B. It breaks cultural norms and taboos
    C. It is combined with training that is user friendly and offers opportunities to discuss concerns between equals in a relaxed environment

D. All
E. None

Information sheet -3	Self-care approach in AYRH problems

What is self care intervention?

Explaining what **self**-**care** means, the organisation says that it is the “the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a health-**care** provider”

Who Self Care definition?

The World Health Organization defines **self care** as the ability of individuals, families and communities to promote, maintain health, prevent disease and to cope with illness with or without the support of a health **care** provider.

Ensure patients, **service** users and carers are able to make informed choices to manage their **self-care** needs. Communicate effectively to enable people to assess their needs, and **develop** and gain confidence to **self-care**. **Support** and enable people to access appropriate information to manage their **self-care** needs.

Self check -3	Self-care approach in AYRH problems

MCQ

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