MIDWIFERY

NTQF Level III

Learning Guide #22

Unit of Competence: Provide Adolescent, Youth and Reproductive Health

Module Title: Providing Adolescent, Youth and Reproductive Health

LG Code: HLT MDW3 M06 LO3-22

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LO 3: Provide AYRH service package

Instruction Sheet	Learning Guide #22

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

- AYRH Service seeking behavior
  - ✓ Venerability, risk taking behaviors and life skills
  - ✓ Unwanted pregnancy and abortion
  - ✓ Gender based violent
  - ✓ Substance use
  - ✓ Adolescent and youth friendly reproductive services
  - ✓ Harmful traditional practice
  - ✓ Advice and treatment of AYRH problems
- Diagnosis and management of sexually transmitted infections
  - ✓ Low risk conditions
  - ✓ High risk conditions
- Managing AYRH services

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 –

- Client's RH symptom of RH problem, service seeking behavior, and compliance on advice and treatment are advised based on the national adolescent and youth RH guideline
- Diagnose and manage sexual transmitted infections
- Low risk conditions are managed according to the guidelines
- High risk conditions are referred to the next higher health facility according to the standard protocol
- Follow up is undertaken according to the SRH guideline

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	AYRH Service seeking behavior

1.1 Venerability, risk taking behaviors and life skills

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 1.1). Some risk-taking behaviours lead to serious lifelong consequences.

Figure 1.1 Adolescents often take risks without being fully aware of the consequences.

- Vulnerabilities can be categorised as:
  - Physical,
  - Emotional and
  - Socioeconomic

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.

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.
- 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.

Types of risk-taking behavior and its consequences

Adolescents can make impulsive decisions resulting in dangerous situations. For instance, reckless behaviors 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 behavior. 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 behaviors 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 behavior will lead to multiple reproductive health problems. In the short term the adolescent might pick up a sexually transmitted infection such as gonorrhea (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 realize that this type of behavior is age-appropriate, and encourage adults to help them avoid serious consequences.

Psychological and behavioral 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-judgmental 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 behavior, 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 behavior. 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 judgments 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.

Life skills

One of the reasons why a high number of adolescents and young people show risky behaviors 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 behaviors 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 Life skills translate into positive behaviors that promote health, mental wellbeing and good social relationships. Among the most important life skills are assertiveness and decision-making.

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 Research shows that interventions that address these specific skill areas (such as decision-making and assertiveness skills) are effective in promoting desirable behaviors, such as sociability, improved communication, effective decision-making and conflict resolution, and preventing negative or high-risk behaviors, such as use of tobacco, chat, 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' behaviors by telling them that it is perfectly OK to say 'No' when they have to. This could be done through individual or group counseling 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 analyze 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 .

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

- 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 behaviors, 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.

Unwanted pregnancy and abortion

Unwanted pregnancy

Why do adolescents and young girls face unintended pregnancy?

An unintended pregnancy is a pregnancy that is mistimed, unplanned, or unwanted at the time of conception. It is a core concept to better understand the fertility of populations and the unmet need for contraception (birth control). Unintended pregnancy mainly results from the lack of or inconsistent or incorrect use of effective contraceptive methods.

It is associated with an increased risk of problems for the mother and the baby. If a pregnancy is not planned before conception, a woman may not be in optimal health for childbearing. For example, women with an unintended pregnancy could delay prenatal care that may affect the health of the baby.

The consequences of unwanted pregnancy

Unplanned pregnancy, and in particular unwanted pregnancy, can have negative health, social, and psychological consequences. Health problems include greater chances for illness and death for both mother and child. Abortion is the most common and frequent consequence of unintended pregnancy and, in the developing world, can result in serious, long-term negative health effects including infertility and maternal death.

In addition, such childbearing has been linked with a variety of social problems, including divorce, poverty and child abuse. One of the most obvious is, of course, abortion.

Abortion

Abortion is the termination of 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 deliberately caused by medical procedures (induced abortion).

- **Spontaneous abortion** is the loss of pregnancy before fetal viability by itself (sometimes called early pregnancy loss or miscarriage)
- **Induced abortion** is a deliberate termination of pregnancy before fetal viability; can be either safe or unsafe.

Box 1.1 Reasons for Abortion

- ***Education* - Fear of drooping from school or interruption of their studies.**
- ***Economic factors*- Fear for Financial difficulty to raise the child.**
- ***Social condemnation*- Fear to what people or parents might think or say; to avoid bringing shame and condemnation on themselves and their family.**
- ***Having no stable relationship*-common in adolescents and youth than in adults.**
- ***Failed contraception* -Contraceptive is often used inconsistently and incorrectly. Also less effective methods tend to be used by these age groups.**
- ***Coerced sex* including rape and incest.**

Abortion may be unsafe due to:

- Safe service may not be accessible, affordable, or not permitted by law. This might cause adolescents to try self-induced or have the procedure by an unskilled medical or non-medical provider.
- Cost and/or other reasons, adolescent women are also more likely to postpone abortion until after the first trimester, which makes the procedure more risky.

Legal provisions for safe abortion services in Ethiopia

A comprehensive care service provision considers woman’s individual circumstances such as woman mental and physical health needs, her personal circumstances, and her ability to access services. Considering these facts the Penal code of the Federal Democratic Republic of Ethiopian has provided legal permission for safe abortion services.

Complications from unsafe abortion

What are the complications of unsafe abortion?

Complications from unsafe abortion include bleeding, infection, injury to reproductive organs, intestinal perforation, and toxic reactions to substances or drugs used to induce abortion. These complications may result in infertility or even death. Moreover, whether there are medical complications or not, adolescent women may face negative psychological and social consequences after abortion. They may feel sorrow or guilt, or they may encounter negative reactions from peers, families, providers and society at large.

Post abortion care

Post abortion care is a comprehensive service for treating women that present to health-care facilities after abortion has occurred spontaneously or after an attempted termination. Components of post abortion care include:

- Emergency treatment of abortion and potentially life threatening complications
- Post abortion family planning counseling and services
- Link between post abortion emergency services and reproductive health care system

Your role as a Health Extension worker is to educate adolescents and young people about safer sex, the use of family planning, and the negative consequences of unwanted pregnancy and unsafe abortion so that they can prevent its occurrence. Additionally, you have to aware adolescent and youths about the legal provision of safe abortion services thereby get safe abortion services in health facilities.

1.3 Gender based violent

Gender refers to the economic, social and cultural attributes and opportunities associated with being male or female in a particular social setting at a particular point in time.

Sex refers to biological and physiological attributes that identify a person as male or female.

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.

Types of Sexual and Gender-based Violence Sexual Violence

Sexual abuse includes all forms of sexual coercion (emotional, physical, and economic) against an individual. It may or may not include rape. Any type of unwanted sexual contact is considered to be sexual abuse. Sexual abuse is often not recognized as a reproductive health issue. In some cultures, the subject of sexual abuse is often not discussed. However, as providers and counselors, it is important to recognize this

problem as a reproductive health issue. If sexual abuse is not dealt with in a professional, nonjudgmental manner, it can lead to further sexual and reproductive health problems. Providers and counselors should possess good counseling skills and adequate knowledge of sexual abuse in order to help adolescents and youth. Perpetrators may be a parent, partner, ex-partner or boyfriend.

Rape is the invasion of any part of the body of the victim with a sexual organ, or of the anal or genital opening of the victim with any object or any other part of the body by force.

Acquaintance rape—when the person who is attacked knows the attacker.

Marital rape—when one spouse forces the other to have sexual intercourse.

Stranger rape—when the person who is attacked does not know the attacker.

Gang rape—when two or more people sexually assault another person.

Incest—when his/her own family member sexually abuses a person

Sexual harassment is unwelcome sexual requests for sexual favors, and other verbal or physical conduct of a sexual nature that tends to create unfriendly or offensive environment which causes harm to the victim.

Physical Violence

It may include beating, punching, kicking, biting, burning, disfigurement or killing, with or without weapons; often in combinations with other forms of sexual and gender-based violence.

Emotional and Psychological Violence

Non-sexual verbal abuse that is insulting, degrading, forcing the victim/survivor to engage in humiliating acts, whether in public or private.

1.4 Substance Abuse

Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Illicit drugs are those drugs which are illegal and prohibited by law. Abused substances produce some form of intoxication that alters judgment, perception, attention, or physical control. 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. Psychoactive substance use can lead to **dependence syndrome** – the condition where a person becomes unable to function normally without using these substances.

1.1. Alcohol

The effect of alcohol is visible in all aspects of human life which includes physical, psychological, social and economic. Alcohol has immediate consequences which lead to intoxication (drunkenness), and long-term effects including addiction. 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. Alcohol use contributes to a wide range of diseases, health conditions and high-risk behaviours, from mental disorders and road traffic injuries, to liver diseases and unsafe sexual behaviour.

Alcohol reduces your inhibitions, slurs speech, and decreases muscle control and coordination, and may lead to alcoholism.

Table 5.1 the effect 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	

Alcohol affects youth reproductive and sexual health in that excessive alcohol intake can shrink the genitals. It kills sperm producing cells in male reproductive system and makes a man infertile. It is also a cause for female infertility. Alcohol induces miscarriage in pregnant mothers. A young mother who becomes pregnant should stop alcohol consumption as soon as she conceives. If alcohol consumption extends to the period of pregnancy, it brings brain damage and mental retardation in newborns.

1.2. Addictive Substances and Narcotics

Khat

Khat is a plant which has a stimulant effect on the brain. For its stimulant effect people do not feel tired and hungry and work for prolonged time while using it. In Ethiopia it has been widely used for many years and its consumption is increasing in young generation as a means of stimulation and pleasure.

Even though it seems harmless at the beginning, it causes increase in respiratory rate, heart rate and blood pressure which may lead to health problems in the long term like inability to sleep and mental problems like depression. It also affects appetite which causes gastric irritation and constipation. Since it affects mood and perception, this predisposes the individual to engage in unsafe sexual practices which could expose to HIV infection.

Tobacco and cigarettes

Tobacco is a plant that can be chewed or smoked which contains addictive substance called nicotine. Nicotine produces a feeling of happiness and pleasure. People cite many reasons for using tobacco, including pleasure, improved performance and vigilance, relief of depression, curbing hunger, and weight control. Some immediate health 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. It increases the risk of cancer development in different body parts including lung cancer. It also predisposes for blood pressure, heart disease, difficulty in penile erection and problem in sperm production. Smoking also makes women less fertile and reduces their chance of conceiving. Smoking causes damage to the baby; they become 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. 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.

Cannabis (marijuana or hashish)

Cannabis is a plant which grows in many parts in the world. It is the most common illicit psychoactive substance being used. Its use among young people in Ethiopia both in rural and urban areas is increasing. Cannabis can usually be smoked, but it can also be eaten. Its smoke irritates your lungs more and contains more cancer-causing chemicals than tobacco smoke. Common effects of marijuana use include pleasure, relaxation, and impaired coordination and memory. Smoking cannabis disrupts short-term memory and its long-term exposure produces long-lasting cognitive impairment. Cannabis use by men also brings inability to have a satisfactory orgasm.

1.3. 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 respective to each specific substance. Some specific consequences of substance abuse include:

- Loss of the ability to make rational decisions which may lead to unsafe sexual practices
- Poor school performances due to frequent absent from school. They become suspended from schooling due to frequent fighting and aggressive behaviors.

- Relationships with parents, friends, and teachers could be affected. They may neglect family duties and engage in frequent violence; fighting with family members or with their friends;
- They often break rules or commit crimes as a result of which they could be arrested and imprisoned.

1.4. 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.
- 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 people to educate their peers on negative consequences of substance use.
- Young people as they migrate from rural to urban settings in order to get work and employment opportunities, they are at increased risk to substance abuse. As a health extension worker you can provide counseling 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.

1.5 Adolescent and Youth Friendly RH services

Reproductive health 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.

Reproductive Health Services for Young People

Think of the services you would wish to provide for young people as part of an AYFRH 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 1.2

Box 1.2 Services intended to be provided in adolescent and youth-friendly services

- Information and counseling on sexual and reproductive health issues
- Promotion of healthy sexual behaviours through various methods including peer education
- Family planning information, counseling and methods including emergency contraceptive methods
- Condom promotion and provision
- Testing services like HIV counseling and testing (you may not perform it)
- Prevention and counseling about STIs
- Education on unsafe abortion and post-abortion care
- Antenatal care (ANC), delivery, postnatal care (PNC) and prevention of pregnant mother-to-child transmission (PMTCT) of HIV
- Appropriate referral linkage between facilities at different levels

Barriers to RH service utilization

What are the factors/problems that could affect the utilization of reproductive health service by young people in your area? **Barriers** are factors or obstacles which hinder adolescents and youth from using reproductive health services in the desired level.

- There are many factors/problems that affect the utilization of available sexual and reproductive health services by young people. We can categorize these as follows.
    1. Individual/personal factors
    2. Institutional factors
    3. Social/cultural factors

Table ??? Barriers to RH service utilization

Individual factors	Social/ cultural factors	Institutional factors
Marital status; Childbearing status	Awareness level of the communities	Judgmental health workers
Gender norms	Attitudes towards young people's sexual behavior	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
Economic status	Peer pressure	Space: if young people are not counseled and served in a private space, they will be afraid that they will be seen by adults
Residence		

Stop reading and think of your experience. How does each of the factors listed under the individual/personal and cultural/social factors 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 tackling these barriers to RH service utilization. In the next section we will suggest some specific things you could do to reduce these barriers.

Your role in tackling 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 much behaviour that negatively affect health start. As a Health Extension worker 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 utilization by young people. You can do this in a number of ways. Some of the things you can do include;

- Recognizing 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-judgmental manner.
- Providing them with appropriate information, counseling 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 centers/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.

1.6 Harmful traditional practice

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. Health related Harmful Traditional Practices affecting young people in Ethiopia are Female Genital Cutting/Mutilation, Abduction, early Marriage and polygamy.

Female Genital Cutting (FGC) is cutting away part of the external genitalia of the girl and women. **FGC (Female Genital Cutting)** is widely spread practice in Ethiopia, with more than half of girl's age 15-19 years having been circumcised.
Female genital mutilation is one of the harmful traditional practices that cause problems of adolescent reproductive health. Mutilation of female genitals causes immediate and delayed health problems in young females. The immediate health problems of the young females include pain, bleeding, unconsciousness, septicemia, problem of urination and sometimes death. Among the problems that come late are infertility, scar, fistula, delay in labour, infant and maternal mortality and HIVI/AIDS. In addition to the violation of human rights related to females, it seriously affects the happy and peaceful marriage of such victims. Furthermore, the number of deaths of mothers and infants has increased as a result of this practice.

Early-age Marriage: it is a common practice in Ethiopia. Although there are regional differences early marriage is common in many parts of Ethiopian. Early-age marriage is preferred by many families for different reasons in Ethiopia. First, families prefer to get their daughters married while alive and or before they get old. Second, the marriage is accomplished with wealthy family in order to improve the living conditions of the bride's family. Third, it is to establish better relationship and tie between two families. Fourth, to prove that the bride is virgin, a litmus test that reassures that the bride is from a decent family. Fifth, it is to ensure that the bride is married at the right and socially accepted age limit.

Box 4.1 Health Consequences of Early-age Marriage
• Miss opportunity to go to school

- Frequent pregnancy
- Unsafe/illegal/ abortion
- High maternal mortality
- Physical effect of early child bearing (obstructed labor, uterine rapture, still birth etc)
- Fistula:- a dirty injury that results in the loss of control of urine and stool which results in incontinence and body smell
- Injury by being forced to become sexually active before reaching physical maturity

Legal aspects of early marriage

In Ethiopia, many marriage arrangements are traditionally made when either of the couple is under age, and/or without their consent or approval. This is illegal act 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 health 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.

Abduction/Forced marriage: is unlawful kidnapping or carrying away of girls for marriage. It is usually practiced due to culture and tradition, lack of awareness, lack of access to legal information and inadequate legal protection for the victims. Abduction is common in certain parts of Ethiopia, especially in the SNNP and Oromiya regions.

Box 4.2. Some of health related consequences of abduction

Physical

- Since force is used, there is physical injury
- Damage to the genital organ such as tearing and injury
- Bleeding and possibly death
- Infection
- Acquisition of sexually transmitted infections including HIV/AIDS
- Unwanted pregnancy that leads to unsafe abortion
- Child birth related complications including fistula/death
- Low birth weight baby whose chance of surviving is poor
- High fertility accelerated by early pregnancy and early child bearing.

Psychological

- Devastate her moral and psychology
- Stigmatization and isolation
- Hopelessness
- Fearful
- Hatred
- Anger
- Guilty blaming herself
- Loss of confidence, depression and tendency to commit suicide

Socio – economic

- No love and care for the family
- She runs away to urban area (becomes commercial sex worker)
- Family break

Polygamy is the practice of having more than one wife. It is widely practiced in many parts of the regions in Ethiopia. Eleven percent of married women in Ethiopia are in polygamy unions, with 9 percent having only one co-wife and 2 percent having two or more co-wives (EDHS 2011). Polygamy exposes women to increased risk of contracting sexually transmitted diseases. In many of the regions, including Oromia, SNNP, Somali, Benshangul and Gambela polygamy is widely practiced. Five percent of women in teens and eight percent of women age 22-24 are married to men who have more than one wife.

1.7 Advice and treatment of AYRH problems

????????????????????

Self check -1	AYRH Service seeking behavior

MCQ

1. Health Consequences of Early-age Marriage include

    A. Frequent pregnancy

    B. Unsafe/illegal/ abortion

    C. High maternal mortality

    D. All

2. Which of the following is not Complications from unsafe abortion
    A. Bleeding
    B. Infection
    C. Injury to reproductive organs
    D. None of the above

Information Sheet -2	Diagnosis and management of sexually transmitted infections

Introduction to Sexually transmitted infections (STIs)

STI – Infections acquired through sexual intercourse (may be symptomatic or asymptomatic), STD is Symptomatic disease acquired through sexual intercourse,the term STI is most commonly used because it applies to both symptomatic and asymptomatic infections.

Prevalence and Incidence of STIs: higher among urban residents, unmarried, and young adults, it Differs between countries and regions within countries. The Differences can be caused by social, cultural, and economic factors or levels of access to care.STIs in Ethiopia have no uniformity in reporting STI cases, only surveillance system is for HIV and syphilis among pregnant women. All regions except South Nations Nationality Peoples Region reported 451,686 cases of STIs between June 1998 and June 2002, this number reflects severe underreporting.

Sexually transmitted infections (STIs) including HIV/AIDS spread fastest where there is poverty, powerlessness, and social instability. STIs are infections caused by various micro-organisms that are transmitted mainly by intimate sexual contact through fluids produced in the human reproductive tract. There are two broad categories of STIs:

Infections caused by bacteria. Common bacterial infections include gonorrhoea, trichomoniasis, chlamydia, syphilis, granuloma inguinale (donovanosis), chancroid, and lymphogranuloma venereum. These infections are usually easily treated with the correct type and course of antibiotics. Left untreated, these infections can cause long-term harm, including infertility, chronic pelvic pain, and damage to the central nervous system, infection of the lymph nodes, cardiovascular disease, and even death.

Infections caused by viruses. Common viral infections include human papillomavirus (HPV), genital herpes, hepatitis B and C, genital warts, and HIV. There is no cure for these infections, but some symptoms may be relieved with medications. Clients with these infections often need ongoing support and care from health care providers. Left untreated, viral infections can lead to cervical cancer, liver damage, and even death. One major infection caused by viruses is HIV. HIV is the virus that causes Acquired Immune Deficiency Syndrome (AIDS). HIV slowly damages the body's immune system, reducing its ability to fight other diseases. People living with HIV—after years of infection without any signs or symptoms—develop AIDS. When they have AIDS, they may get sick more easily with certain illnesses (skin rashes, chronic diarrhoea, wasting, pneumonia, oral thrush, or tuberculosis). Without treatment, most people with AIDS will eventually die from illnesses their bodies can no longer fight.

Transmission

The bacteria and viruses that cause STIs, including HIV, are carried in body fluids including semen, vaginal fluid, mucus membrane secretions (fluids released from the skin that lines the anus, vagina, mouth), and blood. Infections are spread by actions that transfer body fluids, such as: Vaginal intercourse; Anal intercourse (with a man or a woman); Oral intercourse (risk is with the person using their mouth); other sexual activities that allow body fluids to enter the mouth, anus, or vagina or to touch an open cut or sore; Skin-to-skin contact of the genitals (spreads human papilloma virus (HPV), herpes and primary syphilis).

Infections in the blood (Hepatitis B, Hepatitis C, and HIV) are also spread by sharing needles with an infected person (for example, among injecting drug users), transfusions of infected blood or blood products, tattooing, body piercing, or being cut with needles, razors, or other sharp objects that are contaminated with HIV, or infected blood touching an open cut or sore. HIV and some STIs also can be passed by pregnancy, childbirth, or breastfeeding

All members of a community are not at equal risk for acquiring and transmitting STIs.Relatively small groups of individuals, who have high rates of partner change, increase the rate of spread of STIs. These groups are termed **"core groups."**

"Bridging groups" are the members of which have sexes both with core groups and the general population, thus spreading infections into the general population.

Defining the Content of STI Interventions

A comprehensive RTI intervention strategy requires three levels of action:

Primary prevention—preventing the acquisition of infection: prevention of sexually transmitted infections, prevention of endogenous infections, and prevention of iatrogenic infections;

Tecondary prevention—identifying and treating established infection: management of symptomatic infections, screening for asymptomatic infections, and mass treatment approaches; and

Tertiary prevention—minimizing the adverse consequences of such infection.

I. Primary Prevention of Sexually Transmitted Infections

Various behaviors determine a person's risk of acquiring a sexually transmitted infection, thereby providing several opportunities for intervention. Primary prevention interventions stress either reducing an individual's risk of sexual contact with an infected person or decreasing the per-exposure probability of acquiring an infection. Secondary prevention efforts (discussed below) seek to decrease the duration of infectiousness for those STDs (primarily bacterial) that are amenable to treatment.

Three factors in combination—the likelihood of contact with an infected person, the efficacy of per-exposure transmission, and the duration of infectiousness—are the principal determinants of the spread of sexually transmitted infection within a population.

Strategies to reduce exposure to infections include encouraging a delay in the initiation of sexual activity, a reduction in the number of concurrent sexual partners, a reduction in the rate of sexual partner change, more careful selection of sexual partners, and efforts to reduce the incidence of nonconsensual sex. Strategies to reduce the per-exposure risk of infection include avoiding certain sexual practices, treatment of other RTIs, and the promotion of condoms and other vaginal barrier methods

Delay of Initiation of Sexual Activity Delaying the initiation of sexual activity is especially important because of the enhanced biological susceptibility of adolescents to sexually transmitted infections and their consequences. Behavioral research findings also suggest that early coital debut is associated with a subsequent higher prevalence of high-risk sexual practices. Recognition of the difficulties adolescents often face in obtaining reproductive health services is another reason to encourage this approach.

The essential elements of success of several programs seem to be peer intervention approaches that stress autonomy and healthy decision making, and the provision of

accurate information concerning sexuality, the consequences of unprotected sexual activity, and the available options for avoiding infection and unwanted pregnancy. Providing accurate information on sexuality to adolescents has not been shown to increase early sexual activity; indeed, when an effect has been documented, these interventions have been associated with a significant delay in the initiation of sexual activity.

Reduction of Number of Partners Encouraging a reduction in the number of sexual partners is an important means of reducing the spread of STDs.

As some people, particularly young and unmarried individuals, may have only one partner at a time but high rates of partner change ("serial monogamy"), reducing the rate of new partner acquisition is also important. It should be emphasized, however, that many currently monogamous individuals may still be at some risk of sexually transmitted infection—either through the multiple sexual partnerships of their sole sexual partner or as a consequence of infections acquired prior to a committed, mutually monogamous, relationship. This risk exists particularly for chronic viral infections, such as HPV, hepatitis B, and HIV infection, but also to those pathogens that may have long periods of asymptomatic carriage (e.g., trichomonas or chlamydia).

The risk that any particular sex partner has an STD is determined by a complex set of factors, including the overall prevalence of infection in the community, the variance in the rates of sexual partner change within that community, and characteristics of the particular sexual networks from which partners are selected (Caldwell, Orubuloye, and Caldwell, 1991; Anderson, 1989). Many of the macroenvironmental determinants discussed above serve to highly structure both the local epidemiology of infection as well as the social interactions that comprise any particular individual's network of sexual contacts. As a consequence, the same sexual behaviors can have different consequences depending on where and with whom they are practiced.

Awareness and Education Large investments have been made in mass communication efforts aimed at encouraging AIDS awareness, providing accurate information regarding the routes of HIV transmission and the available means of STD/HIV prevention, and minimizing discriminatory responses against those with HIV or perceived to be at risk of infection. In general, the more successful campaigns have used a range of media, have been designed with appropriate attention to local cultural norms, and have employed audience segmentation and professional production and pretesting. Efforts to evaluate these approaches have focused primarily on their ability to improve knowledge and influence attitudes and, in this regard, have been fairly successful.

Indeed, a number of studies show a relatively poor correlation between improved knowledge and reduced risk behaviors. Yet public awareness and knowledge of AIDS and other infectious diseases are necessary conditions for control of diseases, even if they are not sufficient by themselves. Continued provision of information is useful even while work continues on ways to affect behavior. Within family planning programs,

HIV/AIDS information and prevention messages have been successfully incorporated into existing information, education, and communication efforts.

A broad variety of peer interventions have also been developed as primary prevention programs. These typically focus on both promoting condom use and reducing the number of partners. Even more than other types of primary prevention efforts, peer interventions require further exploration, documentation, and description of the tenets for success.

Change in the Dynamics of Partner Selection Changing the dynamics of partner selection, while addressing a potentially important determinant of infection risk, is difficult. First, sexual behaviors are private. Second, the probability that a potential partner has an active infection cannot be readily discerned. Indeed, attempts to do so based on socio-demographic characteristics often invite stigmatization, with its attendant social discrimination.

Consequently, opportunities for intervention in this area are somewhat limited. One approach is to encourage men to refrain from the purchase of commercial sexual services. Another approach is to encourage more open communication between all sex partners concerning the risk of sexually transmitted infection and the available means of protection. This latter approach may be most important in facilitating condom or other barrier method use among intimate partners, but it may also discourage partnership with individuals unwilling to discuss and negotiate these issues. Intervention in this area will require an emphasis on skills building, not just didactic information.

Other structural approaches that promote women's economic independence (e.g., changing wife inheritance laws) or aim to change harmful cultural practices (e.g., those forms of ritual cleansing that involve sexual intercourse) may also be an important means for changing the dynamics of partner selection.

Reduction of Nonconsensual Sexual Exposure Program efforts to reduce the incidence of nonconsensual sex are an important—and often overlooked— means of reducing the risk of exposure to sexually transmitted infections. In these situations, by definition, sexual partners are not selected, but some structural attempts can be made to reduce exposure to those settings where unwanted sexual activity may be encountered.

Efforts to encourage more responsible sexuality among men are the most important in this regard. For example, a number of approaches— mostly involving peer interventions and the reduction of substance use—have recently been described as means for reducing the occurrence of "date rape".

Encouragement of Safer Sexual Practices Information concerning the higher relative risk of infection associated with certain specific sexual practices— such as receptive anal intercourse—can be included in health promotion messages, along with accurate information concerning the effectiveness of barrier methods of contraception. Some programs have also encouraged alternatives to penetrative sexual intercourse,

sometimes referred to as “outer course.” These messages encourage couples to explore alternative expressions of sexual intimacy that do not carry a risk of sexually transmitted infection. The messages, as well as attempts to eroticize safer sex, have been effective at changing behavior on a short-term basis in peer interventions among gay men. Few intervention efforts have singled out specific sexual practices, however; consequently, it is not possible to discern the relative contribution of safer sexual practices and increased use of barrier methods of contraception to the observed outcomes.

Condom Promotion When properly and consistently used, latex condoms are highly effective in reducing the spread of sexually transmitted infections. Efforts to promote the consistent use of good quality latex condoms, like reducing the number of partners, have been one of the principal AIDS prevention strategies for the past decade. Not surprisingly, condom promotion efforts have used many of the same approaches—and have most often been combined with—efforts to encourage partner reduction. The biggest challenge for condom promotion is encouraging use with steady partners. In many settings where men have become willing to use condoms with casual, commercial, or new partners, there is still little use within steady relationships. Similarly, even among commercial sex workers who routinely use condoms with clients, there is a much lower rate of condom use with boyfriends.

Condom promotion efforts have included mass communication, peer interventions, and a number of innovative approaches, such as the use of street theater and commercial social marketing (see below). Condom promotion poses an additional challenge when compared with partner reduction strategies, however: not only must programs achieve the goals of accurate information provision and motivation for behavioral change, but they must also ensure that condom commodities of sufficient quality are readily available to those motivated to use them. Periodic failures in condom procurement, distribution logistics, and supply have sometimes been a major impediment to the successful implementation of condom promotion efforts.

One of the most successful strategies has been condom social marketing. Using the full range of techniques of commercial marketing, condom social marketing programs have used a wide range of print and broadcast media, widespread outlet distribution, and point-of-purchase advertising to greatly increase the volume of condom sales (which can plausibly be taken as an indicator of use), even in some of the world’s poorest countries.

Successful condom promotion among vulnerable groups of women, such as sex workers, has posed a number of challenges and spawned a number of innovative community approaches.

Voluntary Counseling and Testing Another tactic for primary prevention has been voluntary counseling and testing for HIV antibodies. This approach has been a cornerstone of the HIV prevention effort in the United States since the mid-1980s.

Promotion of the Use of Other Barrier Methods information concerning the use of chemical barrier methods — such as spermicides containing nonoxynol-9 for primary prevention of STDs.

II. Secondary Prevention

Secondary prevention—the identification and treatment of established infections of the reproductive tract—is also an important element of a comprehensive intervention strategy. Appropriate treatment relieves symptomatic morbidity, prevents the more serious complications of infection that result in additional morbidity and occasional mortality, and serves to limit the duration of infectiousness—a critical determinant in the sustained spread of sexually transmitted infection.

Unfortunately, a large proportion of RTIs are asymptomatic, especially in women. This characteristic of RTIs limits the utility of approaches that only treat symptomatic infection. Thus, while clinical management of symptomatic infections is essential, it is not adequate in itself. There are two general strategies for addressing asymptomatic RTIs: case finding or screening, an effective approach although limited by the cost of diagnosis, follow-up, and treatment; and selective mass treatment. In the latter approach, there is no attempt to identify specific infections; rather, all members of a target population believed to be at risk are empirically treated with effective therapy. This approach has had limited application to date, but some interesting studies are under way.

Management of Symptomatic Infections

While a sizable proportion of RTIs are asymptomatic, many infections are symptomatic. Symptomatic men and women with RTIs can be classified with a number of clinical syndromes, including urethral discharge, vaginal discharge, genital ulcer, lower abdominal pain, and inguinal swelling. The World Health Organization (1991, 1994) has developed a set of standardized flowcharts or algorithms to help guide the clinical management of these syndromes in a variety of service settings, including those with and without microscopy facilities. Appendix A reproduces the most recent revision of WHO guidelines for the management of STD-associated syndromes.

WHO flowcharts have included a number of screening questions regarding sexual behavior (World Health Organization, 1991). Risk assessment is positive only if patient answers yes to: Does your sexual partner have a discharge from his penis or open sores anywhere in his genital area? Or if she answers yes to two or more of the following: Are you younger than 21 years? Are you unmarried or not in union? Have you been with your husband or sexual partner for less than 3 months? Have you had more than one sexual partner in the last 4 weeks?

In addition to using standardized case management to choose therapeutic interventions, efforts are also needed to improve treatment adherence (compliance) and encourage sexual abstinence for the duration of therapy among those diagnosed with STDs.

Clinics also have to allow sufficient time for providers to conduct appropriate counseling regarding the primary prevention of RTIs, condom use, and the importance of partner notification and treatment.

Screening for Asymptomatic Infections

Interventions aimed at screening for asymptomatic infections (case finding) have historically been an important strategy for STD control. For example, serologic screening for syphilis infection is a standard component of routine antenatal care in many settings. Providing prompt treatment for mothers has proven to be an extremely cost-effective strategy for preventing congenital syphilis, even in extremely resource poor settings. Syphilis screening requires minimal diagnostic facility, is relatively inexpensive, requires therapy with antibiotics that could be readily available and affordable in most settings, and requires a modest level of client follow-up and treatment adherence. Therefore, the widespread implementation of screening for asymptomatic syphilis infections in antenatal clinics can be seen as a "sentinel" intervention. Yet although the necessary steps to ensure antenatal syphilis screening, maternal follow-up and appropriate treatment are all relatively simple, they are rarely successfully coordinated in most developing country settings (Temmerman, Mohamedali, and Fransen, 1993).

In considering screening for other asymptomatic infections, cervical infections in women (primarily caused by gonorrhea and chlamydia) are an important priority, given the high costs associated with PID and its complications. Diagnostic screening for these infections with currently available technology is neither simple nor inexpensive, however, so such screening must be rationed. Selective screening is most cost-effective when prevalence is generally low (i.e., 2-3%); in high prevalence settings (> 5%), universal screening is the more cost-effective approach, if affordable (Marrazzo et al., 1997). Hence, in selecting those for screening, sub-populations known to have a higher prevalence of infection are sought (Over and Piot, 1993; Aral and Peterman, 1993). Again, the relative cost-effectiveness of this screening may improve as simpler and less expensive diagnostic tests become available.

Another potentially important method for identifying people with asymptomatic sexually transmitted infections is through partner notification and referral efforts (formerly known as contact tracing). Identification and treatment of infected partners could also help lower the risk of reinfection for women who have been treated for STDs. Partner notification may be either passive—infected people are expected to personally notify their partners concerning the possibility of infection and the need for treatment ("patient referral")—or active—clinic staff solicit names of sexual contacts and attempt to contact them ("provider referral").

Mass Treatment Approaches

Treatment of an entire group of individuals at risk of infection (without diagnosing individual infections in the population) requires that the therapy administered be safe,

highly effective, inexpensive, and associated with minimal side effects. A mass treatment approach requires that the intervention be acceptable to the community concerned and that the number of infections prevented be sufficient to justify the expense and any possible risks (World Health Organization, 1986). For many years, putting silver nitrate or antibacterial eye drops in the eyes of newborn infants as a prophylaxis against ophthalmia neonatorum caused by gonorrhea has met these criteria. This intervention ranks among the most cost-effective in terms of preventing serious morbidity (preventable blindness) at exceptionally low cost.

Another mass treatment strategy involves the treatment of populations with high STD prevalence with antibiotics known to be effective against pathogens prevalent in those communities. To be effective at the population level, mass treatment interventions require high treatment compliance and coverage and need to take into account local migration patterns and sexual networks. After considering these factors, STD mass treatment interventions have generally focused on treating either specific subpopulations known to have high STD rates (such as sex workers and migrant laborers) or entire communities with high STD rates. A “selective mass treatment” program among female sex workers (introduced as an addition to a long-established screening program) in the Philippines had a strong initial effect on the prevalence of gonorrhea, but this effect dissipated after a few months because of high rates of reinfection.

In practice, a mass treatment approach may be best used as an initial, one-time intervention to lower overall STD prevalence, in conjunction with the establishment of adequate STD diagnostic and treatment services to sustain the reduction in STD prevalence over time.

Self-check -2	AYRH Service seeking behavior

MCQ

1. _____________ Is identifying and treating established infection
   A. **Primary prevention**
   B. **Secondary prevention**
   C. **Tertiary prevention**
   D. **None**
2. Which of the following is **not** viral infection?
   A. Human papillomavirus (HPV)
   B. Genital herpes
   C. Genital warts
   D. Trichomoniasis

True or false

3. Sexual transmission, Blood transfusion, or exposure to infected blood products and MTCT are the primary modes of transmission of HIV.
4. Counseling and behavior approach offer primary prevention against STI.

Short answer

5. Discuss the difference between STI and STDs?

5.

Information sheet -3	Managing AYRH services

Syndromic case management

(a) Identifying the syndromes

A number of different organisms that cause STIs give rise to only a limited number of syndromes. A syndrome is simply a group of the symptoms a patient complains about and the clinical signs you observe during examination. The aim of syndromic management is to identify one of these syndromes and manage it accordingly.

This table explains the signs and symptoms for the main STI syndromes and their causes.

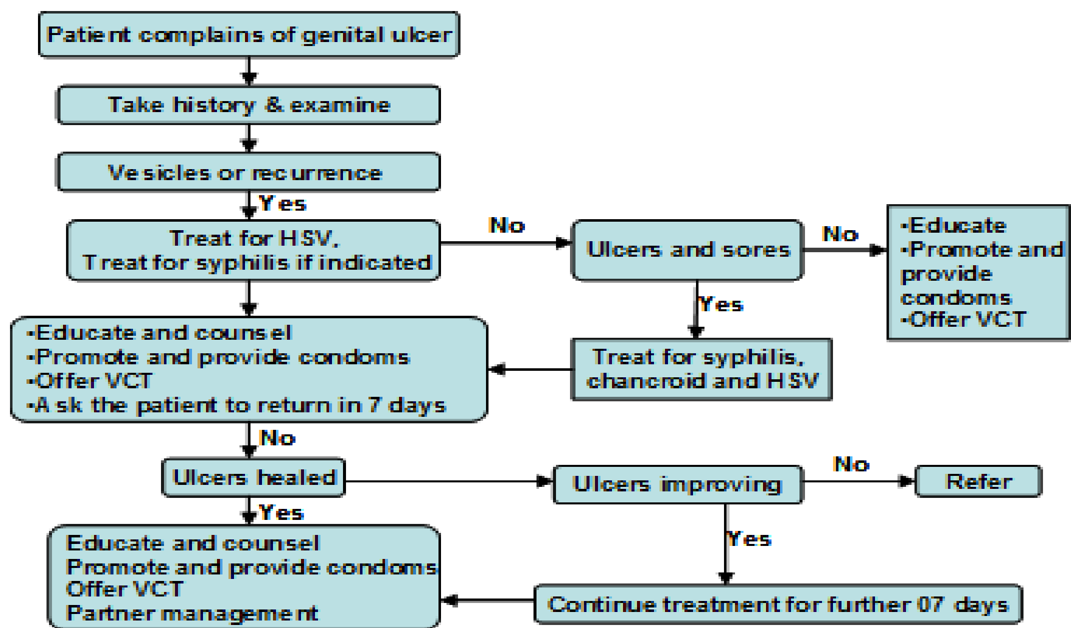
Syndrome	Symptoms	Signs	Most common Causes
Vaginal Discharge	Unusual vaginal discharge Vaginal itching Dysuria (pain on urination) Dyspareunia (pain during sexual intercourse)	Abnormal vaginal discharge	VAGINITIS: – Trichomoniasis – Candidiasis CERVICITIS: – Gonorrhoea – Chlamydia
Urethral Discharge	Urethral discharge Dysuria Frequent urination	Urethral discharge (if necessary ask patient to milk urethra)	Gonorrhoea Chlamydia
Genital ulcer	Genital sore	Genital ulcer	Syphilis Chancroid Genital herpes
Lower abdominal pain	Lower abdominal pain Dyspareunia	Vaginal discharge Lower abdominal tenderness on palpation Temperature >38°	Gonorrhoea Chlamydia Mixed anaerobes
Scrotal Swelling	Scrotal pain and Swelling	Scrotal swelling	Gonorrhoea Chlamydia
Inguinal bubo	Painful enlarged Inguinal lymph	Enlarged inguinal lymph	LGV Chancroid

	nodes	nodes Fluctuation Abscesses or fistulae	

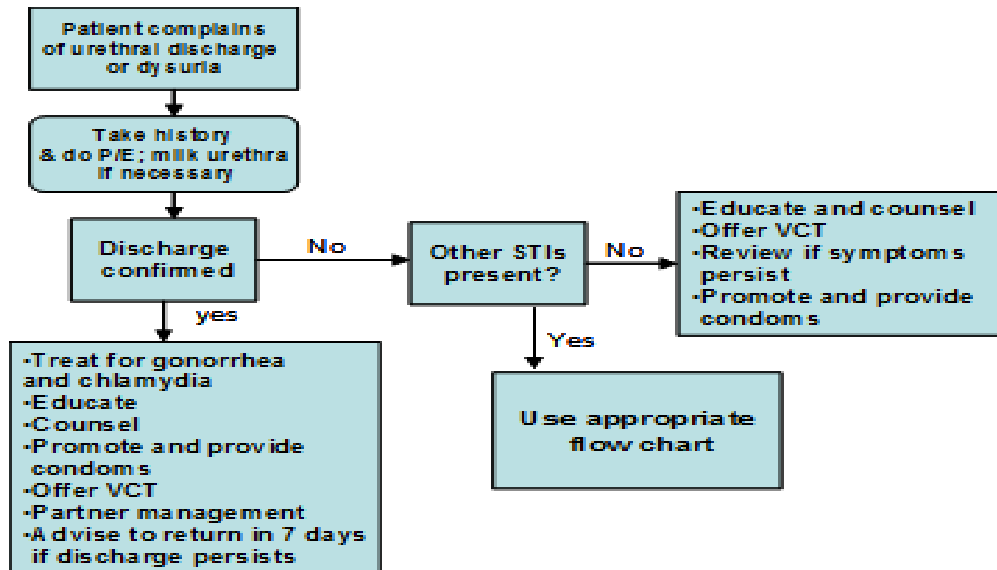
(b) General guidelines on use of the flowcharts

A flowchart is a diagrammatic map that guides you through a series of three sorts of steps for decisions and actions you need to make. The **patient's symptom**: the clinical problem – the patient's presenting symptom at the top; which is the entry point to each of the flowcharts referring to an STI-related symptom. **Action boxes**: these ask you to do something or what you need to do (different boxes suggest Take history and examine treatment, education and condom promotion, etc., and patient referral if necessary. **Decision boxes**: These ask you to make a decision, usually by answering "yes" or "no" to a question. Each decision or action is enclosed in a box, with one or two routes leading out of it to another box, with another decision or action.

Flow charts in use that manage the most common STD syndromes include the following: Urethral discharge syndrome in man: epidymitis: a complication of untreated urethral syndrome: lower genital tract syndrome: pelvic inflammatory diseases: Genital ulcer syndrome. Once a syndrome has been identified, treatment can be provided against the majority of the organisms responsible for the syndrome.



Urethral Discharge Syndrome



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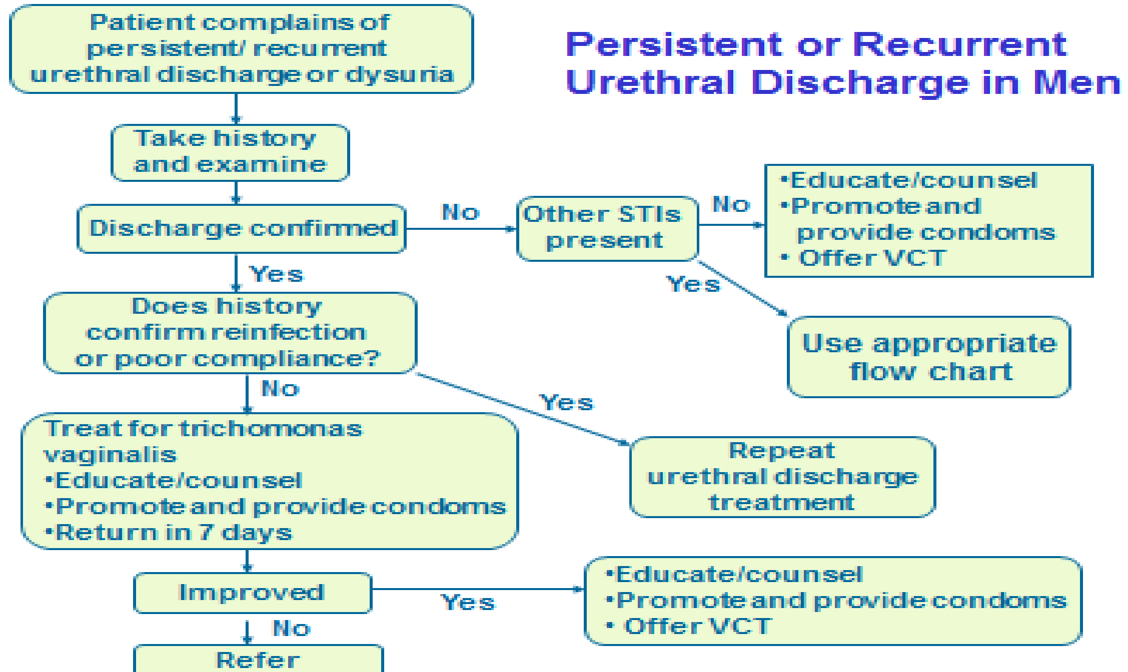
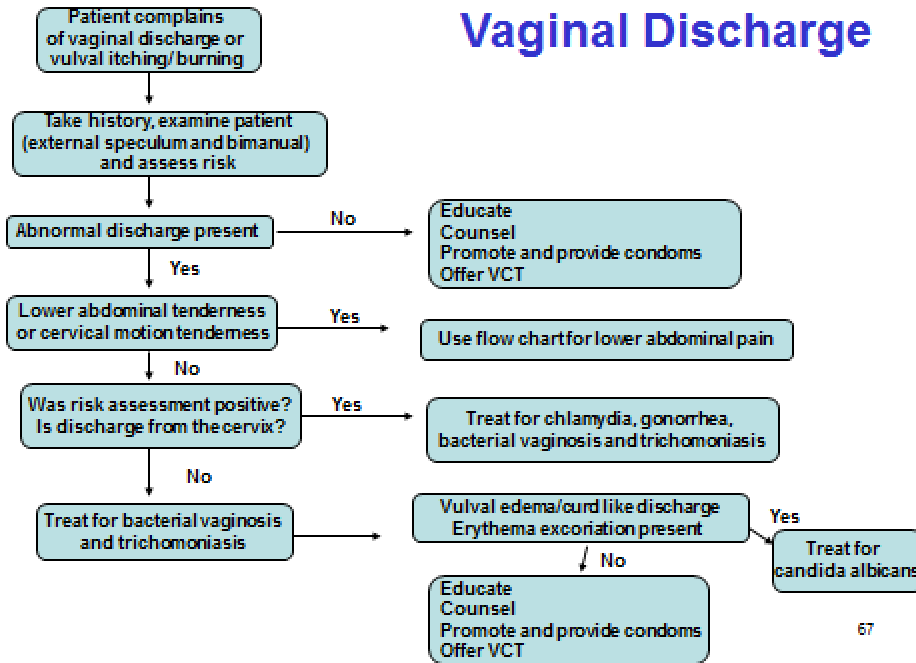
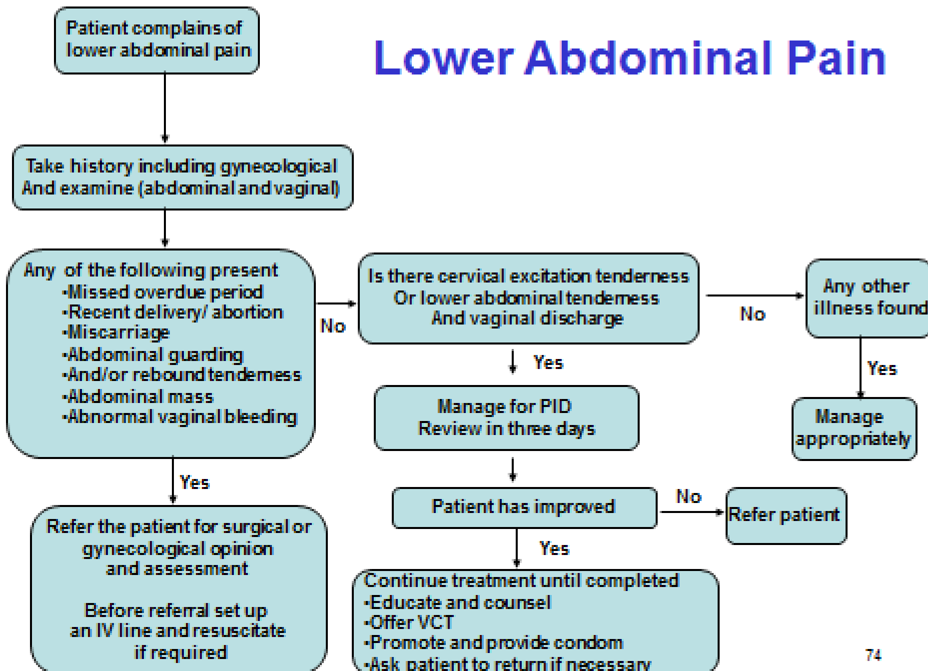
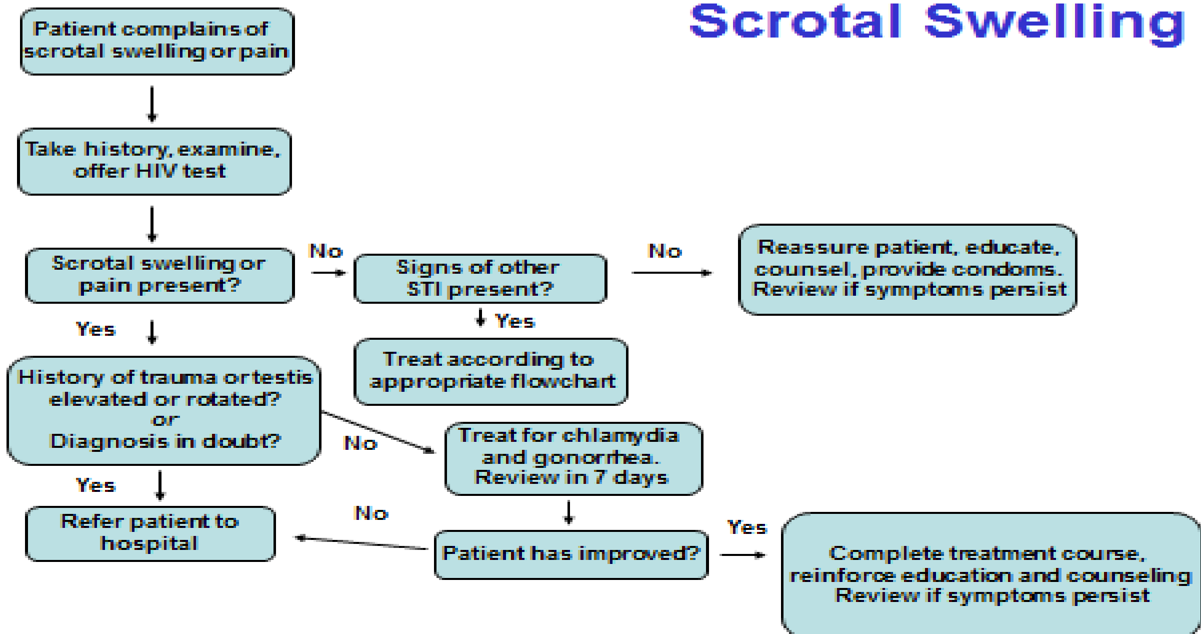
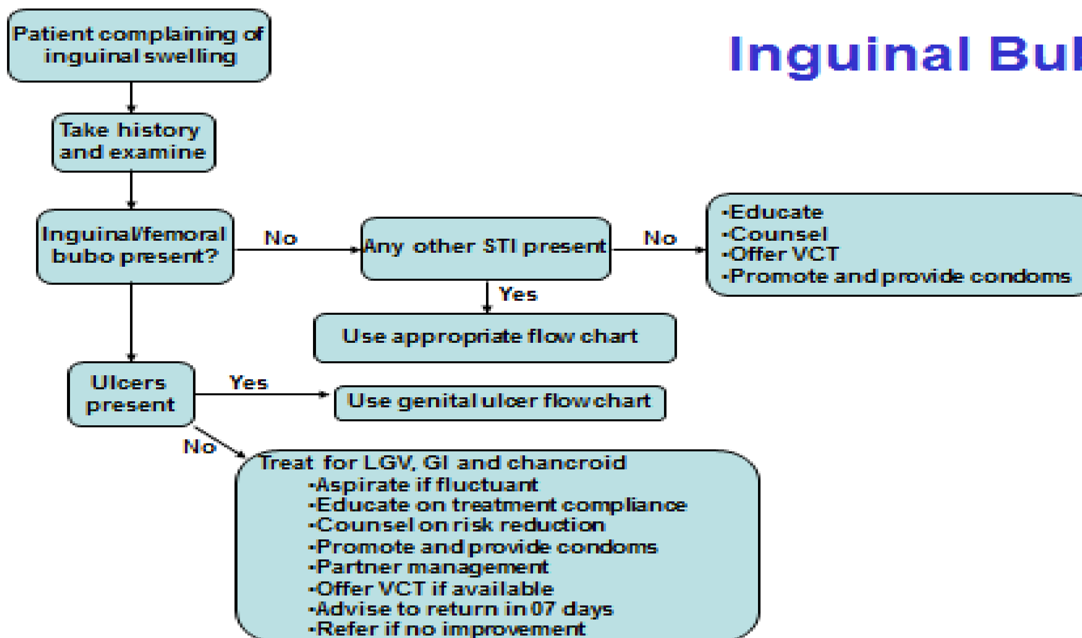


Federal TVET Agency


Vaginal Discharge
Patient complains of vaginal discharge or vulval itching/burning
Take history, examine patient (external speculum and bimanual) and assess risk
Abnormal discharge present
No
Educate
Counsel
Promote and provide condoms
Offer VCT
Yes
Lower abdominal tenderness or cervical motion tenderness
Yes
Use flow chart for lower abdominal pain
No
Was risk assessment positive? Is discharge from the cervix?
Yes
Treat for chlamydia, gonorrhea, bacterial vaginosis and trichomoniasis
No
Treat for bacterial vaginosis and trichomoniasis
Vulval edema/curd like discharge Erythema excoriation present
Yes
Treat for candida albicans
No
Educate
Counsel
Promote and provide condoms
Offer VCT
67


Lower Abdominal Pain
Patient complains of lower abdominal pain
Take history including gynecological And examine (abdominal and vaginal)
Any of the following present
•Missed overdue period
•Recent delivery/ abortion
•Miscarriage
•Abdominal guarding
•And/or rebound tenderness
•Abdominal mass
•Abnormal vaginal bleeding
No
Is there cervical excitation tenderness Or lower abdominal tenderness And vaginal discharge
No
Any other illness found
Yes
Manage appropriately
Yes
Manage for PID Review in three days
Patient has improved
No
Refer patient
Yes
Continue treatment until completed
•Educate and counsel
•Offer VCT
•Promote and provide condom
•Ask patient to return if necessary
Yes
Refer the patient for surgical or gynecological opinion and assessment
Before referral set up an IV line and resuscitate if required
74





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III. Tertiary Prevention

The third set of interventions is tertiary prevention, minimizing the impact of complications of infection. The main components of tertiary prevention are clinical management of septic abortion, alarm and transport for ectopic pregnancies, the management of infertility, and cervical cancer screening. As noted above, these complications are a major source of reproductive morbidity and mortality. For many of these conditions, the associated disability costs are fairly high, but so are the perceived costs of intervention. Consequently, the threshold to intervene is often quite high and a vicious cycle has developed. Because interventions have rarely been attempted, proven models for successful program development in resource-poor settings are lacking, and inexperience fuels programmatic complacency.

HIV/AIDS

AIDS (acquired immune deficiency syndrome) is a human tragedy. Since the epidemic began in the early1980s, AIDS has caused more than 30 million deaths and orphaned more than 14 million children worldwide. With no cure in sight, the AIDS-causing virus, human immunodeficiency virus (HIV), continues to spread around the world, causing more than 13,000 new infections each day.

By the end of 2007, 33.2 million people were living with HIV, including 2.5 million children under 15 years old. Over 95 percent of these HIV cases occurred in the developing countries of sub-Saharan. The consequences of HIV/AIDS extend beyond its immediate victims, also affecting surviving family members, communities, and societies.

In developing countries, AIDS orphans face extreme economic uncertainty and are at higher risk of malnutrition, illness, abuse and sexual exploitation than children orphaned by other causes. In addition, these surviving children face the stigma and discrimination that accompany HIV/AIDS, leaving them socially isolated and often deprived of basic social services such as education.

The primary modes of transmission of HIV are: sexual transmission, transfusion, or exposure to, infected blood products, or exposure to contaminated needles and other equipment; and MTCT. The greatest risk of transmission of HIV infection follows an HIV-contaminated blood transfusion. Ninety percent of individuals who receive a transfusion of HIV-contaminated blood acquire infection

Several large studies have confirmed that there is no risk of transmission through casual contacts with household members, such as sharing meals, sleeping together (without sexual contact), handshaking, hugging, or holding a baby

Self-check -3	AYRH Service seeking behavior

Multiple choice question

Instruction: Read the question statements and choose the correct answer by encircling from the given alternative. Each question has only one correct answer and one mark.

1. Which of the following are most common causes of genital ulcer or sore?
   A. Syphilis, Chancroid and Genital herpes
   B. Gonorrhoea and Chlamydia
   C. Trichomoniasis and Candidiasis
   D. LGV and Gonorrhoea

Multiple choice questions

1. ________________________D
2. _________________________A

True or false

3. __________________________T
4. __________________________T

Short answer

5. ____
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____________________________STI is an Infection acquired through sexual intercourse which is applied to both symptomatic and asymptomatic infections, STD is Symptomatic disease acquired through sexual intercourse.

Prepared By							
No	**Name**	**Educational Back grand**	**LEVEL**	**Region**	**College**	**Email**	**Phone Number**
1	Masresha Leta	Midwifery	A	Harari	Harar HSC	masreshaleta3@gmail.com	0911947787
2	Gosaye T/haymanot Zewde	Midwifery	A	Harari	Harar HSC	Zewegosa@yahoo.com	0913227450
3	Amare Kiros	Midwifery	A	BGRS	Pawi HSC	amarekiros9@gmail.com	0920843010
4	Jalele Mosisa	Midwifery	B	oromia	Nekemte HSC	jalemosis2018@gmail.com	0939316415
5	Serkalem Fetene	Midwifery	A	oromia	Mettu HSC	serkefetene@gmail.com	0912022476
6	Balela Kadir	Midwifery	B	oromia	Nagelle HSC	balela.kedirbedu@gmail.com	0916633542
7	Sadeya Mohamed	Midwifery	A	Somali	Jigjiga HSC	yanaan261@gamil.com	0915076012

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