

MIDWIFERY

Level- III

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Acronyms

AYRH- Adolescent Youth Reproductive Health

RH – Reproductive health

STD- Sexual transmitted diseases

STIs-sexual transmitted infections

WHO- World health organization

Introduction to Adolescent, Youth and Reproductive Health

Reproductive health (RH) is a crucial part of general health and a central feature of human development. Reflection of health during childhood, adolescence and adulthood, sets the stage for health beyond the reproductive years for both women and men. Lack of access to comprehensive reproductive care is the main reason that so many women suffer and die. Most illnesses and deaths from reproductive causes could be prevented or treated with strategies and technologies well within reach of even the poorest countries. Men also suffer from reproductive health problems, most notably from Sexually Transmitted Infections (STIs). But the number and scope of risks is far greater for women for a number of reasons.

This module is a component of learning resource package prepared, in the context of the National TVET-Qualification Framework (NTQF), for use in pre-service training for trainees enrolled in Midwifery level III training program. There are four units in the module and each describes the learning objectives, information sheet, learning outcomes, learning materials, self check operation sheet and LAP test.

Therefore, it is designed to provide you with the basic knowledge, skills and attitude required by enrolled midwife in consultation /collaboration with other members of the health care team, to provide midwifery interventions for clients with sexual and reproductive health care needs.

Module units

- Plan adolescent and youth RH services
- Promote adolescent and youth RH services
- Provide RH service package
- Register and document RH records

Learning objectives of the Module

At the end of this session, the students will able to:

- Define terms
- Verify history and concept of RH
- Identify Sexual and Reproductive Right
- List components of RH
- Identify eligible and target groups for RH
- Describe reproductive health indicators
- Conduct resource mapping
- Develop action plan

Unit one: Plan adolescent and youth RH services

This learning unit is developed to provide the trainees the necessary information regarding the following content coverage and topics:

- Introduction to adolescent and RH
- Identifying eligible and target groups for RH
- Reproductive health indicators
- Resource mapping
- Developing action plan

This unit will also assist you to attain the learning outcomes stated in the cover page. Specifically, upon completion of this learning guide, you will be able to:

- Define terms
- Verify history and concept of RH
- Identify sexual and reproductive rights
- List components of RH
- Identify eligible and target groups for RH
- Describe reproductive health indicators
- Conduct resource mapping
- Develop action plan

1.1. Introduction to Adolescent and Reproductive Health (RH)

1.1.1. Definition of terms

Health: is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (World Health Organization, 1948.)

Reproductive Health: WHO defines reproductive health as "...a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

"Reproductive health addresses the human sexuality and reproductive processes, functions and system at all stages of life and implies that people are able to have "a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so."

Men and women have the right to be informed and have access to safe, effective, affordable and acceptable methods of their choice for the regulation of fertility which are not against the law, and the right of access to appropriate health care services for safe pregnancy and childbirth and provide couples with the best chance of having a healthy infant. Reproductive health is life-long, beginning even before women and men attain sexual maturity and continuing beyond a woman's child-bearing years.

Sexual health: Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

Sexuality: is a central aspect of being human throughout life; it encompasses sex, gender identities and roles; sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors.

Adolescence: Adolescence has been defined as the period when: the individual progresses from the point of initial appearance of secondary sex characteristics to sexual maturity; Psychological processes and patterns of identification to those of an adult develops; Transition from the state of total socio – economic dependence to relative independence attained; rapid physiological

changes and vulnerability to physical, psychological and environmental influences; physical, biological, psychological and social maturity from childhood to adulthood appeared.

World health organization defines adolescents as individuals between 10 and 19 years of age. The broader terms "youth" and "young" encompass the 15 to 24 year-old and 10 to 24 year-old age groups, respectively. The National Youth Policy of Ethiopia classifies youth as those between the ages of 15-29 years. Ethiopia has a rapidly growing population of adolescents and youth 33.8% of the estimated total population of 90 million (CSA, 2015).

Adolescent health has been afforded international prominence because: young people constitute a large and growing segment of the population; certain health problems (like STIs and HIV) are more prevalent in this age group; behaviors starting in adolescence frequently lead to health problems, which may emerge in later life, at immense cost to the individual and their society; while young people face many new problems, there are also new opportunities which if combined with the energy and creativity of young people can bring tremendous dividends and can help them play vital role in their family and to the society as a whole; future economic development depends on having increasing proportion of reasonably well educated, healthy and economically productive population

1.1.1. History and Concepts of Reproductive Health

A. History of RH

In ancient times till the latter part 19th century and the early 20th century that providing services for mothers and children was not public responsibility. During that time services were provided on a basic health services in clinics and health centers basis and very much depended on where one happened to live, whom one knew, and the class and the race to which one belonged. Parallel developments in three areas are considered to be the main factors which facilitated the organisation of maternal and child health (MCH) services: increasing social action for welfare of children, advances in medicine, and the developments of local and state health departments.

A wide interest in child care developed in the 19th century in Europe and North America marked by the establishment of "Milk Stations" at work places, Infant Welfare centers, and School of mothers followed by the "Sheppard Towner Act, 1921" which provided grants to the states to enable them to provide health care to mothers and children.

At establishment World Health Organization (WHO) set four priorities; Tuberculosis, Malaria, MCH and Venereal Diseases. During the 1960s, United Nations population fund (UNFPA) established with a mandate to raise awareness about population “problems” and to assist developing countries in reproductive health addressing Concern about population growth particularly in the developing world and among the poor coincided with the rapid increase in availability of technologies for reducing fertility - the contraceptive pill became available during the 1960s along with the Intra uterine device (IUD) and long acting hormonal methods.

Population policies became widespread in developing countries during the 1970s and 1980s and were supported by UN agencies and a variety of non-governmental organizations (NGOs) of which international planned parenthood federation (IPPF) arguing that rapid population growth would not only hinder development, but was itself the cause of poverty and underdevelopment. In 1972, WHO established the Special Program of Research, Development and Research Training in Human Reproduction (HRP), whose mandate was focused on research into the development of new and improved methods of fertility regulation and issues of safety and efficacy of existing methods? Almost without exception, population policies focused on the need to restrain growth; very little was said about other aspects of population, such as changes in structure or in patterns of migration.

Child survival was introduced as concept in the early 80s by Unite Nations International Children’s Emergency Fund (UNICEF) and United states Agency for International Development (USAID) but the maternal component of MCH was largely ignored this time. The significance of MCH was restated at Almata in 1978, when MCH was identified as one of the “essential components of primary health care (PHC)". The safe motherhood conference of 1987 in Nairobi and the initiative was an attempt to correct this inequity, with its major aim being to reduce the neglected tragedy of maternal mortality and morbidity world-wide.

The idea of MCH spread to the developing world, but until the end of World War II, it was carried out primarily by charitable organizations. The governments were more concerned with the provision of curative care to urban populations and control of epidemics. At the end of the war, newly independent countries began to take upon themselves the responsibility for the health

of their populations, and in some countries (e.g. Burma, Mongolia and Korea) the importance of the health of the mother was entrenched in the constitution itself.

The concept of reproductive health arose in the 1980s with a growing movement away from population control and demographic targets towards a more holistic approach to women's health². It was not until the international conference on population and development (ICPD) in 1994 and the Fourth World Conference on Women (FWCW) in 1995 that the concept gained international acceptance and was heralded as a turning point for women's health. The ICDP brought to international recognition two important guiding principles of RSH that empowering women and improving their status are important ends in themselves and essential for achieving sustainable development; and reproductive rights are inextricable from basic human rights, rather than something belonging to the realm of family planning. The FWCW reaffirmed and strengthened the consensus that had emerged at the ICPD.

The ICPD conference was instrumental in formalizing the paradigmatic shift in how women's health was conceptualized and how services were delivered. The way in which reproductive health was viewed began to change: the focus became the promotion of healthy reproductive lives, rather than the prevention of sexual morbidity. Not only were there changes in the kinds of programs that were delivered, but also in the intended recipients and manner of delivery of programs. For example, men were recognized as having an important role to play; child survival was emphasized; the integration of reproductive and sexual health RSH services into primary health care rather than their being offered as a separate service in separate facilities was advocated; and the need for reproductive health services specifically designed for refugees and internally displaced persons (IDPs) was recognized. Overall, it called for a fundamental rethink of health service provision.

In Ethiopia MCH coordinating office was established at the Ministry of Health in 1979. MCH coordinators were assigned to the then regions. At present the MCH/RH activities are coordinated by the Family Health Department, which is one of the main departments of the Ministry of Health. In the regions and zones family health teams and experts, respectively are responsible for managing and coordinating MCH/RH services.

B. Concepts of RH

The term “Reproductive Health “is most often equated with one aspect of women’s lives; motherhood. Complications associated with various maternal issues are indeed major contributors to poor reproductive health among millions of women worldwide.

Half of the world’s women are now 15 – 49 years of age. Without proper health care services, this group is highly vulnerable to problems related to sexual intercourse, pregnancy, contraceptive side effects, etc. Death and illnesses from reproductive causes are the highest among poor women everywhere. In societies where women are disproportionately poor, illiterate, and politically powerless, high rates of reproductive illnesses and deaths are the norm. Ethiopia is not an exception in this case. Ethiopia has one of the highest maternal mortality in the world; it is estimated to be 412 deaths per 100,000 live births Ethiopian demographic health survey (EDHS) for 2016 and according to WHO on world health statistics for 2018 maternal mortality in Ethiopia has been reduced to 353. In Ethiopia, contraception use in women is 41% according to the mini EDHS 2019.

A woman’s status is often described in terms of her income, employment, education, health and fertility as well as the role she plays within the family, the community and society. It also involves society’s’ perception of these roles and the value it places upon them. The status of women implies a comparison with the status of men and is therefore a significant reflection of the level of social justice in a society.

Typically, where rates of maternal death are high the social status of women is low; their needs have been ignored altogether or have taken second place to those of men since childhood. The link is not coincidental, yet discrimination as a contributory factor to maternal mortality has been largely ignored. The stereotype of the woman with low status is the woman with a child at the breast, another on the way and several more children playing round her skirts. It is the woman for whom marriage and motherhood have been her only destiny from birth; not to have achieved them would have carried a stigma. It is the woman who looks old beyond her age who is in poor health from the constant demands of pregnancy, motherhood and domestic work. She is often responsible for growing the family’s food as well as preparing it, or working for wages outside the home just to make ends meet. Typically such a woman will have very little if any education neither title, nor prospect of inheriting the family land on which she works, nor the house in

which she lives. The problems are very many and interwoven. Some of the major ones which may greatly contribute to mortality and morbidity are:

Unregulated fertility (“The four Toos” – Too many children, too early, too late, too closely spaced): In many patriarchal societies a woman’s only path to social status and personal achievement is through motherhood. In such societies girls marry at an early age, start to produce children in an early age, will have many children, the children are born in short intervals and childbearing continues to the maximum age possible. The risks involved in repeated childbearing are many. The second and the third births are the most trouble free, while the risk of serious complications, such as hemorrhage, rupture of the uterus and infection rises steadily from the third birth onwards. Repeated short interval pregnancy, childbirth and breastfeeding deplete the woman from the necessary nutrient reserves and her body does not recover from the effects of previous pregnancies resulting in malnutrition, anemia and accompanying health problems.

Because their bodies are not fully prepared for demands of childbirth, teenagers run an excess risk of death. Studies have indicated as high as 7 times risk of death compared to women aged 20 – 24. According to a study in a developing country, the risk of death was fivefold for women 40 years old compared to women 20 – 24 years. Of course the degree of risk is enormously affected by socio economic circumstances, her general state of health, and access to good quality professional health care. Thus a 42 year old Swedish woman faces a far less hazardous prospect in giving birth than a 20 year old woman in a remote village in Ethiopia.

Education: As one moves along the spectrum from most developed to least developed countries, the ratio of literate male adults to literate female adults increases, in addition to the generally poor literacy status of the populations of the developing countries. Though poverty and underdevelopment mean that a large number of boys and girls never see the inside of a class room, the greater disadvantage of females in education is universal in developing countries. Even in areas of developing countries where a relatively similar proportion of girls and boys start to go to school, often the number of females attending higher levels of education sharply decreases.

Education has been described as “medication against fatalism”. Illiterate women have little understanding of the physiology of reproduction or how it can be altered and to accept pregnancy as divinely ordained. Studies have shown that as a general rule the number of children a woman

bears declines as her level of education rises. An uneducated woman is more likely to be exposed to harmful traditional practices and less likely to seek professional health care and her deliveries are too often not attended by trained health workers. Education is often a passport to employment. The chance of finding employment outside the home and the poorly paid insecure casual work is improved by education, and gets better the higher up the education ladder a woman climbs.

Health: the low status of women is reflected in conditions that directly or indirectly affect their health and hence increase maternal mortality and morbidity. Many health problems that affect women have their roots in childhood. Son preference is sometimes reflected by giving less food to females. Such phenomenon may be observed in societies where son preference is not visibly acknowledged. Studies have also shown that women are affected by food taboos, many of which are related to pregnancy. Evidence from some studies shows that in many developing countries less care and attention is given to females compared to males with similar health problems. In addition, poor women who are attached to long hours of work, child care and housekeeping find it hard to take time off to visit a clinic. Some societies attach a stigma to being ill. It has overtones of not being able to cope as well as others. Women tend to ignore health problems until they can no longer keep going. In some parts of the world a woman cannot visit a clinic or a hospital without the permission of her husband.

Type of Work and Income: Gender inequalities arise from the different values placed on women's and men's work. Men's work is judged to be productive and markets are seen as a way to judge the value of that work. Barriers to this sphere of work often exist for women who have difficulties gaining title to land, access to credit, and access to other assets. Traditionally, women have had the main responsibility for seeing to the needs of families in their homes. Responsibilities in this reproductive arena limit women from participating in so-called 'productive' work. Although child care, care of the elderly, obtaining fuel, preparing meals, and maintaining the home are demanding tasks, deemed to be important to households and recognized as essential for society, they are usually unpaid. Another major reason for undervaluing women's work is that households are usually viewed as sites of consumption rather than producers of goods and services.

In many circumstances women bear a double burden. While they are working to support their families with work outside their homes, they are at the same time carrying full responsibility for housekeeping and childcare. However, the double burden of women often goes unnoticed as most of the work is “unpaid”.

Thus, without measures to improve the social conditions of women the tragically high number of maternal deaths and sufferings will not be improved. However, such measures must never be considered as an alternative to professional maternity care but rather as complementing it.

1.1.2. Sexual and Reproductive Rights

Reproductive rights embrace certain human rights recognized in national and international legal and human rights documents, includes:

1. The Right to Life: No woman's life should be put at risk by reason of pregnancy.
2. The Right to Liberty and Security of the Person: No person should be subjected to female genital mutilation, forced pregnancy, sterilization or abortion.
3. The Right to Equality and to be Free from all Forms of Discrimination: Equality and freedom from discrimination in one's sexual and reproductive life.
4. The Right to Privacy: All sexual and reproductive health-care services should be confidential and all women have the right to autonomous reproductive choices.
5. The Right to Freedom of Thought: Includes freedom from the restrictive interpretation of religious texts, beliefs, philosophies and customs as tools to curtail freedom of thought on sexual- and reproductive-health care and other issues.
6. The Right to Information and Education: Relating to sexual and reproductive health for all, including access to full information on the benefits, risks and effectiveness of all methods of fertility regulation, in order that all decisions taken are made on the basis of full, free and informed consent.
7. The Right to Choose Whether or Not to Marry and to Found and Plan a Family: Recognizes that all persons have the right to protection against a requirement to marry without that person's full, free and informed consent.
8. The Right to Decide Whether or When to Have Children: Recognizes that all persons have the right to decide freely and responsibly the number and spacing of their children and to have access to the information, education and means to enable them to exercise

this right and further recognizes that special protection should be accorded to women during a reasonable period before and after childbirth.

9. The Right to Health Care and Health Protection: Includes the right of health-care clients to the highest possible quality of health care, and the right to be free from traditional practices which are harmful to health.
10. The Right to the Benefits of Scientific Progress: Includes the right of sexual and reproductive health-service clients to new reproductive-health technologies that are safe, effective and acceptable.
11. The Right to Freedom of Assembly and Political Participation: Includes the right of all persons to seek to influence communities and governments to prioritize sexual and reproductive health and rights.
12. The Right to be Free from Torture and Ill-Treatment: Including the rights of all women, men and young people to protection from violence, sexual exploitation and abuse.

1.1.3. Components of RH

The Components of reproductive health care include the following:

- Quality family planning counselling, information, education, communication and services;
 - Prenatal, safe delivery and post natal care, including breast feeding;
 - Prevention and treatment of infertility;
 - Prevention and management of complications of unsafe abortion;
 - Safe abortion services, where not against the law;
 - Treatment of reproductive tract infections, sexually transmitted diseases and other conditions of the reproductive system;
 - Information and counselling on human sexuality, responsible parenthood and sexual and reproductive health;
 - Active discouragement of harmful practices, such as female genital mutilation;
 - Referral for additional services related to family planning, pregnancy, delivery and abortion complications, infertility, reproductive tract infections, sexually transmitted diseases and HIV/AIDS, and cancers of the reproductive system, including breast cancer.
- Wherever possible, reproductive health and family planning programs should include

facilities for the diagnosis and treatment of STIs, recognizing that they often increase the risk of HIV transmission.

1.2. Eligible and target groups for RH

The target population of a service includes for whom the service is primarily or solely intended. These people may be of a certain age or sex or may have other common characteristics.

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

- Women alone are at risk of complications from pregnancy and childbirth
- Women face high risks in preventing unwanted pregnancy; they bear the burden of using and suffering potential side effects from most contraceptive methods, and they suffer from the consequences of unsafe abortion.
- Women are more vulnerable to contracting and suffering complications of many sexually transmitted infections including HIV/AIDS.
- From the equity point of view, this population group constitutes about 24% of the population; which is a significant proportion.
- Deaths and illnesses from reproductive causes are highest among poor women everywhere.

II. Adolescents (Both sexes)

- Adolescents lack reliable reproductive health information, and thus the basic knowledge to make responsible choice regarding their reproductive behavior.
- In many countries around the world, leaders, community members, and parents are reluctant to provide education on sexuality to young men and women for fear of promiscuity.
- Many adolescents are already sexually active, often at a very young age.
- The reproductive health status of young people, in terms of sexual activity, contraceptive use, child bearing, and STIs lays the foundation for the country's demographic feature.
- During adolescence normal physical development may be adversely affected by inadequate diet, excessive physical stress, or pregnancy before physiological maturity is attained.

- Adolescents are at high risk to acquire infertility associated with STIs and unsafe abortion
- Conditions of work are designed for adults rather than adolescents and put them at greater risk of accidental injury and death.
- Current health services are generally not organized to fulfill the reproductive need and demands of adolescents.

III. Under Five Children

- Children's health is a base for healthy adolescence and childbearing ages.
- Proper health service for children serves to increase the opportunities of women to have contact with the health institution.
- The health of children and women is inseparable
- The morbidity and mortality of children in Ethiopia is one of the highest in the world.
- Bearing high number of children has adverse consequences on health of the mother, the general income distribution and health status of the family.

1.3. Reproductive Health Indicators

Following on a number of international conferences in the 1990s, in particular the 1994 ICPD, many countries have endorsed a number of goals and targets in the broad area of reproductive health. Most of these goals and targets have been formulated with quantifiable and time-bound objectives.

A health indicator is usually a numerical measure which provides information about a complex situation or event. When you want to know about a situation or event and cannot study each of the many factors that contribute to it, you use an indicator that best summarizes the situation. For example, to understand the general health status of infants in a country, the key indicators are infant mortality rates and the proportion of infants of low birth weight. Maternal health care quality, availability and accessibility can be measured using maternal mortality.

Reproductive health indicators summarize data which have been collected to answer questions that are relevant to the planning and management of RH programs. The indicators provide a useful tool to assess needs, and monitor and evaluate program implementation and impact.

Indicators are expressed in terms of rates, proportions, averages, categorical variables or absolute numbers.

1.3.1. Criteria for selecting indicators

Indicator selection raises technical questions about the implications of data collection as well as other operational issues. A good indicator has a number of important attributes, and those recommended by the World Health Organization (WHO, 1997c) are outlined below.

1. To be **useful**, an indicator must be able to act as a “marker of progress” towards improved reproductive health status, either as a direct or proxy measure of impact or as a measure of progress towards specified process goals.
2. To be **scientifically robust**, an indicator must be a valid, specific, sensitive and reliable reflection of that which it purports to measure. A *valid* indicator must actually measure the issue or factor it is supposed to measure. A *specific* indicator must only reflect changes in the issue or factor under consideration. The *sensitivity* of an indicator depends on its ability to reveal important changes in the factor of interest. A *reliable* indicator is one which would give the same value if its measurement was repeated in the same way on the same population and at almost the same time.
3. To be **representative**, an indicator must adequately encompass all the issues or population groups it is expected to cover.
4. To be **understandable**, an indicator must be simple to define and its value must be easy to interpret in terms of reproductive health status.
5. To be **accessible** the data required for an indicator should be available or relatively easy to acquire by feasible data collection methods that have been validated in field trials.
6. To be **ethical**, an indicator requires data which are ethical to collect process and present in terms of the rights of the individual to confidentiality, freedom of choice in supplying data, and informed consent regarding the nature and implications of the data required.

These indicators can be input, process, out-put and impact indicators.

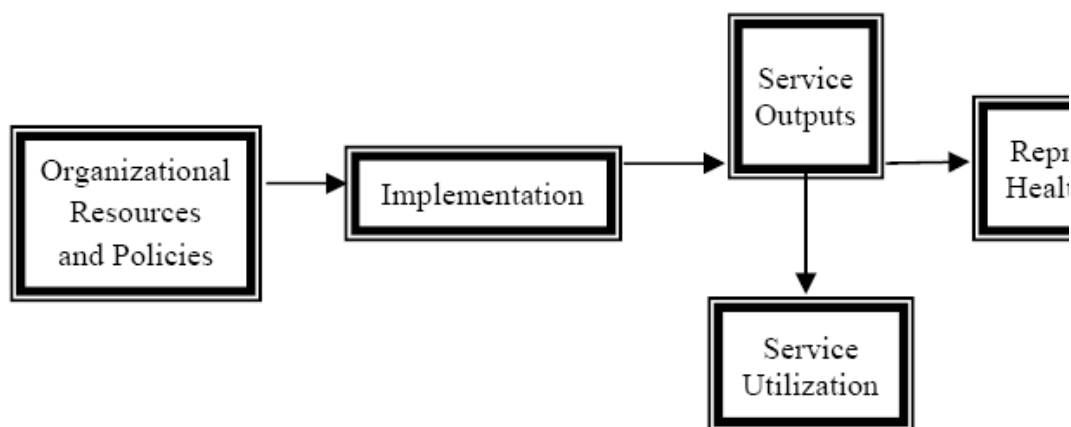


Figure 1.1. A Conceptual Framework for Monitoring and Evaluating Reproductive Health Programme Components

1.3.2. Sources of data

Routine service statistics: summaries of health service records can give information and it is very cheap, but may be incomplete or sometimes may not give enough information. It gives input and process indicators.

Population Census: The data collected at population censuses such as population by age and sex, marital status, and urban and rural residence provide the denominator for the construction of process, output and impact indicators.

Vital statistics reports: The vital registration system collects data on births, deaths and marriages. These data are available by age, sex and residence. These data provide the numerator for the construction of process, output and impact indicators.

Special studies: collection and summarization of information for a particular purpose.

Sample surveys: For Example Demographic and Health survey

1.3.3. Reproductive Health Indicators for Global Monitoring

- There are seventeen reproductive health indicators developed by the United Nation Population Fund (UNFPA). The list and description of these indicators are given below.

1. Total fertility rate: Total number of children a woman would have by the end of her reproductive period. TFR is one of the most widely used fertility measures to assess the impact of family planning programmers.

2. **Contraceptive prevalence (any method):** Percentage of women of reproductive age who are using (or whose partner is using) a contraceptive method at a particular point in time.
3. **Maternal mortality ratio:** The number of maternal deaths per 100 000 live births from causes associated with pregnancy and child birth.
4. **Antenatal care coverage:** Percentage of women attended, at least once during pregnancy, by skilled health personnel for reasons relating to pregnancy.
5. **Births attended by skilled health personnel:** Percentage of births attended by skilled health personnel. This doesn't include births attended by traditional birth attendants.
6. **Availability of basic essential obstetric care:** Number of facilities with functioning basic essential obstetric care per 500 000 populations. **Essential obstetric care** includes, Parenteral antibiotics, Parenteral oxytocic drugs, Parenteral sedatives for eclampsia, Manual removal of placenta, Manual removal of retained products, Assisted vaginal delivery. These services can be given at a health center level.
7. **Availability of comprehensive essential obstetric care:** Number of facilities with functioning comprehensive essential obstetric care per 500 000 populations. It incorporates obstetric surgery, anesthesia and blood transfusion facilities.
8. **Perinatal mortality rate:** Number of perinatal deaths (deaths occurring during late pregnancy, during childbirth and up to seven completed days of life) per 1000 total births. Deaths which occur starting from the stage of viability till completion of the first week after birth (22 weeks of gestation up to end of first week after birth, WHO). Total birth means live birth plus IUFD born after fetus reached stage of viability.
9. **Low birth weight prevalence:** Percentage live births that weigh less than 2500 g.
10. **Positive syphilis serology prevalence in pregnant women:** Percentage of pregnant women (15–24) attending antenatal clinics, whose blood has been screened for syphilis, with positive serology for syphilis.
11. **Prevalence of anaemia in women:** Percentage of women of reproductive age (15–49) screened for haemoglobin levels with levels below 110 g/l for pregnant women and below 120 g/l for nonpregnant women.

12. Percentage of obstetric and gynaecological admissions owing to abortion:

Percentage of all cases admitted to service delivery points providing in-patient obstetric and gynaecological services, which are due to abortion (spontaneous and induced, but excluding planned termination of pregnancy)

13. Reported prevalence of women with female genital mutilation (FGM):

Percentage of women interviewed in a community survey, reporting to have undergone FGM.

14. Prevalence of infertility in women: Percentage of women of reproductive age (15–49) at risk of pregnancy (not pregnant, sexually active, non-contraception and non-lactating) who report trying for a pregnancy for two years or more.

15. Reported incidence of urethritis in men: Percentage of men (15–49) interviewed in a community survey, reporting at least one episode of urethritis in the last 12 months.

16. HIV prevalence in pregnant women: Percentage of pregnant women (15–24) attending antenatal clinics, whose blood has been screened for HIV, who are sero-positive for HIV.

17. Knowledge of HIV-related prevention practices: The percentage of all respondents who correctly identify all three major ways of preventing the sexual transmission of HIV and who reject three major misconceptions about HIV transmission or prevention.

1.4. Resource Mapping

- Resource mapping is a method of showing information regarding the occurrence, distribution, access to and use of resources; topography; human settlements; and activities of a community from the perspective of community members.
- Resource mapping is used to:
 - ✓ Identifying and examining relationships between a community's resources, topography, settlements, and activities
 - ✓ Enabling people to picture resources and features and to show graphically the significance attached to them
 - ✓ Identifying problems, possibilities, and opportunities
- Resource mapping tell you:

- ✓ How people within a community view their environment
- ✓ Community members' analysis of the natural resources found in their community and how they are used
- Key elements of resource mapping are local perceptions of resources and territories.
- To make resource mapping it takes 1.5 to 2 hours and no need supporting software
- A community resource map is usually spatially limited to the social, cultural, and economic domains of the local analysts who produce it so for larger geographical areas (such as a protected area or national park) and areas with several different administrations, producing a sufficient number of community specific sketch maps might be politically unrealistic.

1.4.1. Community Resource Mapping

Two to three hours should be allowed to produce and analyze a community resource map and to ensure that a full discussion occurs with local analysts. Markers and large sheets of paper are required. Notebooks/paper and pens are needed to make a copy of the diagram and for the note-taker to record the discussion generated during the diagram development.

The map can be drawn on the ground; if this is the case, then a large area will be needed as well as various objects such as sticks, stones, leaves, seeds, colored powder, and so on, which the analysts can use to represent features on the map.

The discussion group will include a facilitator, observer/note-taker and selected local analysts. The facilitator and observer/note-taker should be experienced in the principles behind the use of participatory tools and methods as well as in their practical use. Knowledge of the social structure of the community is required by the facilitator because community members might consider resource distribution, use, and access to be sensitive issues.

1.4.2. Possible Approach

The following approach is a general example that can be adapted to suit the local context, views of local analysts, and the research objectives.

Step 1: Select Local Analysts. Identify the groups of people to talk to about their perceptions of their local resources. These decisions will be based on the objectives and depth of information required for the **AYRH**. For example, separate groups of men and women might be useful

because women and men might use different resources: women will map the resources they

think are important (such as water sources, firewood sources, and so on) and men will map the resources they think are important (such as grazing land, infrastructure, and so on). However, it might be necessary to break down the population into further categories (such as ethnicity, wellbeing category, or caste). Groups of five to ten local analysts should reflect any relevant and important social divisions.

Step 2: Provide Introductions and Explanations. When working with each group, the facilitator and observer/note-taker should begin by introducing themselves and explaining carefully and clearly the objectives of the discussion. Check that the local analysts understand and feel comfortable with what will be discussed.

Step 3: Produce a Community Resource Map. First decide what type of area the map will show or any limitations, such as a village, an indigenous ancestral domain, a watershed, and so on. (Social maps, which show households, begin as physical maps of the residential area, but are treated separately in another section.) With the help of local analysts, select a suitable place and medium such as on the ground using objects such as stones, seeds, sticks, and colored powder; on the floor using chalk; or directly on a large sheet of paper, using pencils and pens. Ask the local analysts to start by preparing the outline or boundary of the map. It might be helpful for them start by placing a rock or leaf to represent a central and Important landmark. Although it might take some time to get going, the process should not be rushed.

Ask the analysts to draw other landmarks on the map that are important to them. It is not necessary to develop an absolutely accurate map; the goal should be to get useful information about local perceptions of resources. Local analysts should develop the content of the map according to what is important to them, which might include infrastructure and services (such as roads, houses, bridges, schools, health clinics); water sites and sources; agricultural lands (such as crop varieties and locations), forest lands, and grazing areas; soils, slopes, and elevations; shops and markets; churches; and special places (such as sacred sites, cemeteries, and bus stops).

Once the map is underway, sit back and watch; only interrupt when absolutely necessary or if the analysts stop drawing. Alternatively, it might be helpful to go away for a time and come back

later. If the map is being drawn on the ground, ask the local analysts to start making a copy on to paper (indicating which direction is north) once the broad outline has been established. This process is important because extra information and corrections can often arise as a result. Also ensure that a copy or permanent record of the map is available if they want it. Once the local analysts stop, ask whether anything else of importance should be added. When the map is completed, facilitators should ask the analysts to describe it. Ask questions about anything that is unclear.

A further stage that might be useful involves transposing the information from the community resource map onto a conventional topographic map (see http://www.iapad.org/two_stage_resource_mapping.htm for details). This process creates two outputs by local analysts: a community resource map rich in local people's perceptions regarding their resource base and a more detailed topographic map that adds precision in the location of the information.

Step 4: Analyze a Community Resource Map. Once the map has been completed, use it as a basis for conducting semi-structured interviews on topics of interest (such as how land use patterns have changed and why) or for collecting more statistical data (such as how crop yields vary from one area to another) and for enabling local analysts to conduct their own discussions and analysis. These discussions should be noted or recorded. It might be useful to have a list of key questions to guide a discussion about community resources. Key questions might include the following examples:

- What resources are abundant or scarce?
- Which resources have the most problems?
- How does access to land (or another specified resource) vary between households or social groups?
- Who makes decisions about land (or another specified resource) allocation?
- Where do people obtain water and firewood?
- Who collects water and firewood?
- Where do people take livestock to graze?

If local analysts have sufficient time, it might be useful to ask them to draw a series of maps to

illustrate changes over time. If there are several different groups, ask each group to present its map to the others for their reactions and comments. Are there serious disagreements? If so, note these and whether a consensus is reached.

Step 5: Conclude the Activity. Check again that the analysts know how the information will be used. Ask the analysts to reflect on the advantages, disadvantages, and the analytical potential of the tool. Thank the local analysts for their time and effort.

Points to Remember

Good facilitation skills are key. The approach outlined above is a general guide; be flexible and adapt the tool and approach to local contexts and needs. During community mapping a map is drawn of selected physical features on a flat surface. The selected features for a village could be:

- ✓ The natural resources.
- ✓ The poverty pattern(s).
- ✓ The territory of the village.
- ✓ The housing pattern(s).
- ✓ The cropping pattern(s).
- ✓ The space and the area the village occupies

Prior to the mapping, do the following:

- ✓ Choose a place where most of the community members can participate.
- ✓ Involve the community to collect materials like ash or sand to sketch the map.
- ✓ Go round the localities on foot, or do a walk to see the key areas like the
- ✓ Site of the health center, the kebele office, the church, the main road, the river, etc. Ask the community members to sketch the map, and put signs for those key areas using ash or sand.

1.5. Developing action plan

Steps in organizing adolescent youth friendly reproductive health (AYFRH) services

1. Conduct a needs assessment of adolescent and youth services provided at the health facility

2. Assess whether the health workers are trained to provide AYFRH services and find out what materials are available in the health facility
3. Identify existing problems in providing RH service for young people
4. Develop proposals to solve the problems identified
5. Present an action plan to implement the proposals.

Step 1: Conducting a needs assessment of existing services at facility

- It will help you identify existing problems and the people and materials available to provide
- RH services for young people.
- In addition, the needs assessment tool will help you collect information on how the health facility keep track of data on AYRH services provided.
- Overall, the tool will help you determine whether the facility has youth-friendly characteristics.

AYFRH service needs

General Information:

Name of *Woreda* _____ Name of *Kebele* _____ Name of health facility _____

About Materials/supplies and services

- 1 Does the health facility meet the "Standards on Youth Friendly Reproductive Health Services" providing services to young people? Yes
- 2 Are Health Education materials on the different components of AYRH services currently available at the health facility?
 - Sexually transmitted infection Yes
 - HIV/ AIDS Yes
 - Unwanted/unplanned pregnancy and contraceptive use/family planning Yes
 - Maternal health care (antenatal care, delivery care postnatal care) Yes
- 3 Does the health facility have referral forms for young people? (could be the same for all clients but need to verify that it is appropriate for young people)
 - Referral (one way only) Yes
 - Referral and Feedback (back referral) Yes
- 4 Does the health facility have case management guidelines for the following services?
 - STIs Yes
 - HIV/AIDS Yes
 - Sexual abuse Yes
 - Contraception/family planning Yes
 - Antenatal, delivery, postnatal Yes
- 5 Does the facility have the following supplies and services?
 - Contraceptives Yes
 - Emergency contraceptives Yes
 - Pregnancy test Yes
 - Syndromic management of STIs Yes
 - HIV testing Yes

Training of health workers

- 6 Are any of the health workers in the facility trained in the case management guidelines? Yes
- 7 Are any of the health workers in the health facility trained on AYFRH services? Yes

Involvement of young people and the community

- 8 Are young people involved in providing information and services to their peers in the community? Yes
- 9 Does the facility inform the community about their AYFRH services available? Yes

Convenience of the location and service hours

- 10 Are the service hours of the facility convenient for young people? Yes
- 11 Do the consultation rooms for young people ensure?
 - Privacy (visual and auditory) Yes
 - Confidentiality? (records locked and not accessible to other people) Yes

Figure 1.2. Need assessment tool for problem identifying?

Step 2: Assess whether the health workers are trained to provide AYFRH services and find out what materials are available in the health facility.

Step 3: Identifying problems related to AYFRH.

Table 1. Shows summary of the information gathered in steps 1,2 and 3

Materials and services	Training of health workers	Involvement of the young people and the Community, Convenience of the location and service hours Steps	Convenience of the location and service hours

Steps 4: Developing a proposal

- Now you should develop a proposal to show how you are going to solve the problems you identified in your assessment.
- You may not be able to respond to all of the problems you have identified.
- Therefore you should prioritize the problems based on the importance of the problem and the resources you have or you could acquire.
- The proposal should have the problems identified.
- The proposal should also have what you want to achieve by addressing the identified problem. This is called **Objective**.
- The proposal should also have the different methods you use to tackle the problems. This is called **Strategy**.
- The following table will help you in how to write a proposal.

Table 2.3. Form for developing a proposal

	Problem: <u>Materials and services</u> No health education materials on contraception available at the health post
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Objective	Make health education materials on contraceptives available at the health post
Strategy	Mobilize support from the woreda health office, health center and NGOs working in the Kebele
Activity	Collect available health education materials
Resource	Transport and per diem cost to travel to the woreda health office and health center.
Time	One month

Step – 5: - Prepare Action Plan

Table 2.4. Table shows how to prepare action plan

Problem	Action required	Responsible person	Time bound
Lack of health education materials on contraceptives at the health facility	Collecting health education Materials Request both orally and through formal letter that (i) the woreda health office Or (ii) the NGO working in the kebele (if any Or (iii) the health centre provides you with health education materials on contraceptives	Health care professional	January 2023 (E.C.)

Self-check-1: written test

Directions: Answer all the questions listed below

Test-1 Say True or False

1. Men and women have the right to be informed and have access to safe, effective, affordable and acceptable methods of their choice for the regulation of fertility
2. To make resource mapping it takes 1.5 to 2 hours and no need supporting software

Test 2: choose the correct answer among the alternatives for the following multiple chose questions

1. Which is NOT target group of reproductive health
 - A. Women of child-bearing age
 - B. Adolescents of both sex
 - C. Elders of both sex
 - D. Under five children
2. A reproductive health indicator must be a valid, specific, sensitive and reliable reflection of that which it purports to measure. This indicator is ____
 - A. To be useful
 - B. To be scientifically
 - C. To be representative
 - D. To be understandable
3. Perinatal mortality rate is measured per ____ total births
 - A. 100
 - B. 1000
 - C. 10,000
 - D. 100,000

Test 3: write correct and short answer for the following essay item questions

1. List the components of reproductive health
2. Discuss the steps in organizing adolescent youth friendly reproductive health (AYFRH) services.

Unit Two: Promote adolescent and youth RH services

This learning unit is developed to provide the trainees the necessary information regarding the following content coverage and topics:

- Identifying and consulting community representatives and volunteers
- Organizing education and promotion of RH services on the basis of inter- sectorial approach
- Providing and sustaining RH service
- Supporting RH problems in line with individual needs for changing unhealthy behavior

This unit will also assist you to attain the learning outcomes 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

Identifying and consulting community representatives and volunteers

Promoting adolescent and youth reproductive health

- ◆ Adolescence is a period of transition from childhood to adulthood during which adolescents develop biologically and psychologically and move towards independence.
- ◆ Although we may think of adolescents as a healthy group, many die prematurely and unnecessarily through accidents, suicide, violence and pregnancy-related complications. Some of the serious conditions of adulthood (for example, sexually transmitted infections (STIs), like HIV; and tobacco use) have their roots in adolescent behaviour.
- ◆ More than a quarter of the world's population is between the ages of 10 and 24, with 86% living in less developed countries. These young people are tomorrow's parents. The reproductive and sexual health decisions they make today will affect the health and wellbeing of their communities and of their countries for decades to come.
- ◆ In particular, two issues have a profound impact on young people's sexual health and reproductive lives: family planning and HIV/AIDS. Teenage girls are more likely to die from pregnancy-related health complications than older women in their 20s. Statistics indicate that one-half of all new HIV infections worldwide occur among young people aged 15 to 24.
- ◆ Studies show that young people are not affected equally by reproductive health problems. Orphans, young girls in rural areas, young people who are physically or mentally impaired, abused or have been abused as children and those migrating to urban areas or being trafficked are more likely to have problems.
- ◆ Despite their numbers, adolescents have not traditionally been considered a health priority in many countries, including Ethiopia. While the country has been implementing major interventions to reduce child mortality and morbidity, interventions addressing the health needs of young people have been limited.
- ◆ Young people often have less access to information, services and resources than those who are older. Health services are rarely designed specifically to meet their needs and health workers only occasionally receive specialist training in issues pertinent to adolescent sexual health. It is perhaps not surprising therefore that there are particularly low levels of health-seeking behavior among young people. Similarly, young people in a variety of contexts have reported that access to contraception and condoms is difficult.

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

2.2. Organizing education and promotion of RH services on the basis of inter- sectorial approach

- ⊙ **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 recognize and prevent risks and improve their reproductive health.
- ⊙ Scores of 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.

- ⊙ Since many programs 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

2.3 Providing and sustaining RH service

Peer education Programme

- ▶ 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 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).
- ▶ 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. It creates a relaxed environment for young people to ask questions on *taboo* subjects without the fear of being judged and/or teased.
- ▶ **ATaboo** 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.
 - ▶ Usually 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.
 - ▶ Firstly, young people, like adults, have a tendency to mask how much they don't know about a subject. Hence, one should not assume the topic is understood because there are no

questions; because asking 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.

2.4 Supporting RH problems in line with individual needs for changing unhealthy behavior

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.
- ✚ 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 population 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.

⇒ 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.
- ⇒ Strategies to accomplish the activities
- 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).
- Organize 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).
- ☞ In addition one need to provide youth friendly services that these adolescents can access for themselves at community level and at your health post. It may also be necessary to provide parents with communication skills and to sensitize them on the sexual and reproductive health of adolescents. One 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. Particularly, one 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

- ❖ 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, living on the streets and to acquiring STIs including HIV which eventually causes the development of AIDS.

Self-check-2

Self-check -2	Promotion of AYRH services
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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

UNIT THREE: PROVIDE REPRODUCTIVE HEALTH SERVICE PACKAGE

This learning unit is developed to provide the trainees the necessary information regarding the following

content coverage and topics:

- 3.1. Counseling Client's on symptom of RH problem, service seeking behavior and treatment compliance
- 3.2. Diagnosing and managing sexual transmitted infections (STIs)
- 3.3. Managing Low risk conditions and referring high risk conditions to higher health facility
- 3.4. Undertaking Follow up

This unit will also assist you to attain the learning outcomes stated in the cover page. Specifically, upon completion of this learning guide, you will be able to:

- Counsel Client's on symptom of RH problem, service seeking behavior and treatment compliance
- Diagnose and manage sexual transmitted infections (STIs)
- Manage Low risk conditions and refer high risk conditions to higher health facility
- Undertake AYRH Follow up

3.1. Counseling Client's on symptom of RH problem, service seeking behavior and treatment compliance

3.1.1 Vulnerability, 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 3.1). Some risk-taking behaviors lead to serious lifelong consequences.



Figure 2: Adolescents often take risks without being fully aware of the consequences.

- ❖ Vulnerabilities can be categorized 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 under-nutrition 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 laborers, 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 this 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.

What period does early adolescence cover?

- ☞ Early adolescence (10-13 years) 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.

✎ **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'.i.e
 - 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.

✎ **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 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.

Reasons for Abortion

- Education - Fear of dropping 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 Ethiopia has provided legal permission for safe abortion services if there is:

- When the pregnancy puts the woman's life at risk
- Fetal impairment or deformity
- When pregnancy follows Rape or incest (based on the woman's complaint only)
- When pregnancy occurs in minors (stated maternal age <18 years)
- The woman is physically and mentally unable to care for the would-be born child

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 care provider 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.

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 an 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

3.1.2. 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 behavior changes. Psychoactive substance use can lead to **dependence syndrome** – the condition where a person becomes unable to function normally without using these substances.

▪ **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 behavior. Alcohol use contributes to a wide range of diseases, health conditions and high-risk behaviors, from mental disorders and road traffic injuries, to liver diseases and unsafe sexual behavior.

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

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.

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 (nonsmokers 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.

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.

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.

3.1.3. 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:

- Information and counseling on sexual and reproductive health issues
- Promotion of healthy sexual behaviors 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 level

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

Table2: 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

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 behavior 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 behaviors and modify unsafe ones (i.e. those that put them at risk of negative health outcomes).
- Identifying and managing health problems and unsafe behaviors

- 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.

3.1.4. 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. 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 HIV/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.

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 rupture, 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 Oromia regions.

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.

3.2. Diagnosing and managing sexual transmitted infections (STIs)

Definition: Sexually transmitted infections (STIs) are infectious diseases transmitted by sexual activity and, sometimes, by blood transfusion and from mother to child.

Table1: Classification of STI Based on mode of transmission.

Mode of Transmission	Where they came from	How they spread	Common examples
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Endogenous Infections	Organisms normally found in vagina	Usually not transmitted from person to person, But immuno compromising factors can cause overgrowth which lead to symptoms	Yeast infection Bacterial vaginosis
Sexually transmitted infections	Sexual partners with STI (s)	Unprotected sexual contact with infected partner(s)	<ul style="list-style-type: none"> • Gonorrhoea • Chlamydia • Syphilis • Chancroid, • Trichomoniasis • Genital herpes • Genital warts • HIV infection • Scabies • Pubic lice
Iatrogenic Infections	Inside or outside the body: <ul style="list-style-type: none"> • Endogenous (vagina) • STI (cervix or vagina) • Contamination from outside 	<ul style="list-style-type: none"> • By medical procedures or following examination or intervention During pregnancy, childbirth, postpartum period or in family planning (IUCD insertion) and gynecology settings. Infection may be pushed through the cervix into upper genital tract. • Contaminated needles or other instruments, e.g. uterine sounds, may introduce infection if infection control is poor. 	Pelvic inflammatory disease (PID) following abortion or other trans cervical procedure. Also due to complications and infections occurring during pregnancy and postpartum period.
Vertical Transmission	Mother to Child	<ul style="list-style-type: none"> • During pregnancy • During delivery • During breast feeding 	<ul style="list-style-type: none"> • Congenital syphilis • Ophthalmic neonatorum • Herpes genitalis • HIV infection
Through blood transfusion and or its products	Organisms found in blood or blood Products	<ul style="list-style-type: none"> • Contact with infected blood or blood products. • Transfused with infected blood. 	<ul style="list-style-type: none"> • HIV Infection • Syphilis • Hepatitis B • Hepatitis C

Table 2: Typical signs of STI and their causative agents

STD	Main Clinical Features	Causative agent	IncubationPeriod
Gonorrhoea	Pus discharge from the urethra or the cervix, dysuria, frequency.	Neisseria gonorrhoea	2 - 6 days
Genital candidiasis	White curd like discharge coating the walls of the vagina that is itchy. Soreness, excoriation and cuts.	Candida albicans	May be endogenous and recurrent
Trichomoniasis	Greenish itchy discharge from the	Trichomonas vaginalis	Variable

	vagina with offensive smell		
Chancroid	Dirty painful ulcer, Usually one that is undermining	Haemophilus ducreyi	1 - 3 weeks
Herpes genitalis	Recurrent small multiple painful ulcers which begin as vesicles	Herpes simplex virus	2 -7 days(initial infection)
Lymphogranulo maverium (LGV)	Swollen painful inguinal glands (buboes) occasionally with an ulcer and may occasionally be bilateral	Chlamydia organism - LGV strains	3 - 30 days
Granuloma inguinale	Heaped up (beefy) ulcer, usually painless which may be associated with inguinal lymph node swellings	Calymatobacteria granulomatis	1 - 10 weeks
Syphilis	Primary chancre is a painless, well demarcated ulcer. Other features depend on the clinical stage.	Treponema pallidum	2 - 4 weeks
Non gonococcal urethritis / cervicitis	Thin non itchy discharge from the cervix or urethra	Chlamydia, Mycoplasma hominis and others	7 - 14 days
Bacterial vaginosis	Thin discharge with a fishy smell from the vagina	Over growths of Gardenerella vaginalis	May be Endogenous
Hepatitis B virus infection (HBV)	Jaundice with inflammation of the Liver	Hepatitis B Virus	
HIV / AIDS	According to WHO clinical criteria for the case definition for AIDS	Human Immuno deficiency Virus	Months – 10 years or more
Venereal warts	Finger like growths on the genitals	Human papilloma virus	weeks – months

3.2.1. There are three diagnostic approaches.

- **Etiologic diagnosis:** -This is done using lab to identify the causative agent and giving treatment targeted to the pathogen identified.
- **Clinical approaches:**—using clinical experience to identify symptoms which are typical for specific STI and giving treatment targeted to the suspected pathogens.
- **Syndromic approach:** Syndromic approach;-identification of clinical syndrome and giving treatment targeting all the locally known pathogens which can cause the syndrome

Why Syndromic Approach?

- ☞ STI sign and symptoms are rarely specific to a particular causative agent.

- ✎ Laboratories are either non-existent or non-functional due to lack of resources.
- ✎ Dual infections are quite common and both clinician and laboratory may miss one of them.
- ✎ To reduce Waiting time for lab.

3.2.2. STD Syndromic Treatment Flow Charts (Algorithms)

Definition: STD syndromes refer to a group of consistent symptoms and/or easily recognizable signs caused by two or more STD agents and the provision of treatment that deals with the majority or most serious organisms responsible for producing the syndrome, rather than for Specific STDs.

Table 3: STI Syndromes and their etiologic Agents

No	STD Syndromes	Causative Agents
1	Urethral Discharge (Urethritis)	
	i) Gonococcal	Neisseria gonorrhoeae –common
	ii) Non gonococcal	Chlamydia trachomatis – common Trichomonas vaginalis –uncommon Ureaplasma urealyticum – common Herpes simplex – uncommon
2	Vaginal Discharge	
	i) Vaginitis / vaginosis <ul style="list-style-type: none"> • Trichomoniasis • Candidiasis • Bacterial vaginosis 	Trichomonas vaginalis Candida albicans Gardnerella vaginalis
	ii) Cervicitis <ul style="list-style-type: none"> • Gonococcal • Non gonococcal 	N. gonorrhoeae Chlamydia trachomatis
3	Genital Ulcer Disease (GUD)	
	<ul style="list-style-type: none"> • Syphilis • Chancroid • Genital herpes • Granuloma inguinale • Lympho granuloma venerium 	Treponema pallidum Heamophilus ducreyi Herpes simplex Calymato bacteria granulomatis Chlamydia LGV strain
4	Lower Abdominal Pain (Pelvic Inflammatory Disease)	N. gonorrhoeae C. trachomatis Mycoplasma hominis Anaerobic bacteria

		Other miscellaneous bacteria
5	Inguinal Adenopathy(Bubo)	
	<ul style="list-style-type: none"> • Lymphogranuloma venerium • Chancroid • Syphilis 	Chlamydia LGV Strains Heamophilus ducreyi Treponema pallidum
6	Painful Scrotal Swelling (Epididymorchitis)	N. gonorrhoeae C. trachomatis Other miscellaneous bacteria
7	Bartholin Abscess	N. gonorrhoeae C. trachomatis
8	Conjunctivitis With Pus In The New Born (Ophthalmia Neonatorum)	
	<ul style="list-style-type: none"> • Gonococcal • Non gonococcal 	N. gonorrhoeae C. trachomatis
9	Genital Growths (Warts)	
	<ul style="list-style-type: none"> • Syphilitic (condylomata lata) • Viral (condylomata acuminata) • Molluscum contagiosum 	T. pallidum Human papilloma virus Molluscum contagiosum virus
10	Balanitis	Candida albicans Chlamydia trachomatis

3.2.3. Components of Syndromic STI case management:

Case management of STIs refers to the care of a person with an STI syndrome or with a positive laboratory test result for one or more STIs. The goal of STI case management is not only to cure the client, but also to break the chain of transmission and avoid complications. For this reason, the STI case management package that goes beyond diagnosis and prescription, to include patient education and partner treatment as well as provision of condoms.

Components of STD case management:

1. Clinical assessment based on appropriate history taking and physical examination (to be seen shortly)
2. Syndromic diagnosis as previously discussed
3. Specific antimicrobial therapy for STD syndromes as will be seen under each syndrome.
4. Education / counseling on: Treatment compliance for patients to take all the prescribed medication even when the symptoms resolve before completing medication, nature of infection, mode of transmission of infection, risk reduction, proper use of condoms and other safer sex methods and early STD care seeking behavior.

5. Provision of condoms: All STI patients should receive from the attending clinician, advice on condom use in the future. In addition, clinicians must demonstrate condom use to all STI clients using a penis model or other material. Lastly, health workers must provide condoms to all STIs patients as part of their prescription.
6. Partner notification: All recent sexual contacts of STI patients should be treated for the syndrome corresponding to that of the index patient. Index patients should be encouraged to contact their recent sexual partners and notify them about the need for treatment. Partner notification cards may be used whenever available and where appropriate. All recent sexual partners should be treated irrespective of whether they have symptoms or not. However, when the index patient has a diagnosis of an endogenous reproductive tract infection, health workers should exercise caution in notifying partners.
7. Counsel and provision or referral for HIV Voluntary counseling and testing. STI patients should be counseled about their increased risk of HIV and encouraged to seek HIV VCT services if their HIV status is not already known.
8. Follow up examination - only if such a visit will be convenient for the patient.
9. The patient should be advised to avoid sexual contact (abstinence) until
 - ✕ He / she has completed taking all prescribed medication
 - ✕ The STD symptoms have completely resolved
 - ✕ All the sexual partners have been properly treated
 - ✕ If possible, he/she has been re-evaluated by the clinician.

3.2.4.Syndromic Flow Charts:A flow chart is a diagram (map) representing steps to be taken through a process of decision making. It can be used at any health facility.Each flow chart is made up of three steps.

- ✕ The clinical problem (patient's presenting symptom) or Problem box
- ✕ A decision to make usually by answering yes or no questions or Decision box
- ✕ An action to take (what you need to do) or Action box

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

3.2.5. Specific STI syndromes

Urethral Discharge

Urethral discharge is one of the commonest STI syndromes among men, and is associated with serious complications. It is characterized by purulent urethral discharge with or without dysuria. The amount of discharge varies depending on the causative pathogens as well as prior antibiotic treatment. Patients with this syndrome often complain of a discharge from the urethra. They may have symptoms of burning sensation while passing urine and frequency of micturition. Examination might reveal a purulent discharge from the urethra. If the discharge is not readily apparent, it may be necessary to milk the penis and massage it forwards before the discharge becomes apparent.

Case definition: Urethral discharge in men with or without dysuria

Etiology: This syndrome is commonly caused by *Neisseria gonorrhoea* and *Chlamydia trachomatis* in over 98% of cases. Other infectious agents associated with urethral discharge include *Trichomonas vaginalis*, *Ureaplasma urealyticum* and *Mycoplasma* spp.

Mixed infections especially of *Neisseria gonorrhoeae* and *Chlamydia trachomatis* occur.



Figure1. Urethral discharge

Management of Urethral Discharge: All male patients with urethral discharge should be managed according to the Syndromic chart on the next page. Treatment should be provided to cover the commonest causes. The drugs of first choice are ciprofloxacin for *N.gonorrhoeae* and Doxycycline for chlamydia. In the absence of these, cotrimoxazole may be given to cover gonorrhoea while tetracycline could be used to cover chlamydial infections. However, increased resistance to cotrimoxazole has been reported in the region.

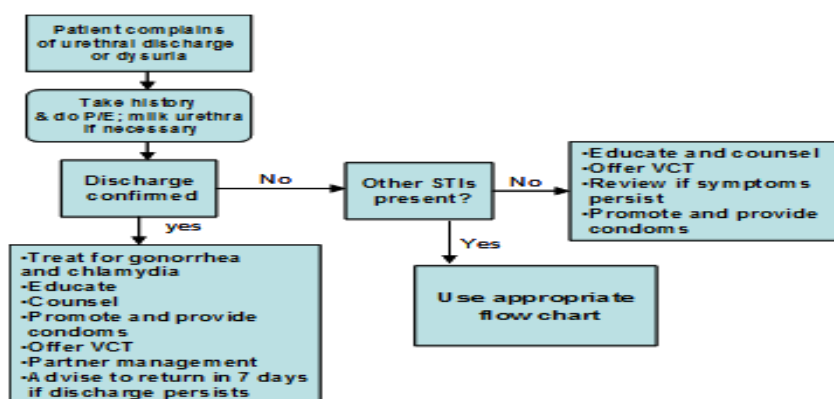
Besides antibiotic treatment, all the other components of STD case management package should be provided to patients presenting with this syndrome. They include:

- ✓ Education on treatment compliance
- ✓ Promotion and provision of condoms and demonstrating their use,
- ✓ Partner notification and offering treatment
- ✓ Offering or referring for HIV VCT services if necessary Partners should be treated irrespective of whether they are symptomatic or not. Persistent or recurrent urethritis may be due to drug resistance, poor compliance or re-infection. There is increasing evidence of high prevalence of *Trichomonas vaginalis* among men in Sub Saharan Africa, for which patients with recurrent urethritis should be treated.

Recommended treatment for urethral discharge

Ciprofloxacin 500 mg po stat or Spectinomycin 2 grams IM stat plus(+) Doxycycline 100 mg po bid for 7 days or Tetracycline 500 mg qid for 7 days Or Erythromycin 500mg qid for 7 days if the patient has contraindications for tetracycline (children, pregnancy).

Urethral Discharge Syndrome



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Genital Ulcer Syndrome

Genital ulcer disease is one of the commonest syndromes that affect men and women. The etiology of the syndrome varies in different geographical areas and can change over time. Single or multiple ulcers can present. In addition, the clinical manifestations are quite variable and can be altered by HIV infection. Furthermore, mixed infections are common. Genital ulcers have an epidemiologically synergistic relationship with HIV. There are reports that HIV alters the natural history of syphilis as well as increasing treatment failure with single dose therapies. For chancroid, the natural history is also altered where more aggressive lesions may manifest as well as treatment failure especially with single dose therapies.

Genital herpes can also be affected by HIV resulting in more persistent lesions. On the other hand, the evidence of enhanced HIV transmission in presence of STIs is more conclusive for ulcerative STIs. In Men, genital ulcer disease occurring under the prepuce may present as a discharge, similarly, GUD in women may also present as a discharge underlying the importance of clinical examination. Uncircumcised Male patients with a genital discharge should have the prepuce retracted and examined for ulcer lesions, while female patients should have the labia separated and inspected. Speculum examination may be necessary. Genital herpes, syphilis, and chancroid are the most prevalent cause of ulcerative lesions. The diagnosis is difficult to make by physical examination alone. Thus, the work-up for all genital ulcers should include serologic screening for syphilis, culture/antigen testing for HSV-1 and HSV-2, and culture for *Haemophilus ducreyi*. More than one infectious etiology may be present in a single lesion.

Herpes Simplex

Vulvovaginal infections with HSV have assumed a primary role in STDs. HSV (types 1 and 2) is a highly prevalent, incurable, recurrent viral disease. Type 2 HSV is recovered almost exclusively from the genital tract & is usually transmitted by sexual contact. Patient education and clinical skills are mandatory in obstetrics in order to prevent vertical transmission to the fetus or newborn. Systemic antiviral agents are commonly used during the first clinical episode to reduce symptoms, shorten duration of the lesion, and decrease the number of cesarean deliveries among infected mothers.



Figure 2. Female genital ulcer secondary to herpes simplex virus

No routine serological screening for herpes in asymptomatic persons. Since active disease causes ulcerative lesions, herpes infection is believed to increase the risk of HIV transmission & acquisition.

Treatment

Acyclovir: 400 mg PO TID or 200 mg PO 5X per day

Famciclovir: 250 mg PO TID

Valacyclovir: 1000 mg BID

The usual duration of treatment is 7 to 10 days

Chancroid (Soft Chancre)

Chancroid is an STD characterized by a painful genital ulcer. However, studies have shown asymptomatic carriers among commercial sex workers. Although this condition can be difficult to diagnosis clinically, suppurative inguinal adenopathy with painful ulcers is pathognomonic and may assist with a preculture diagnosis.

The causative organism is the gram-negative rod *H ducreyi*. Exposure is usually through coitus, but accidentally acquired lesions of the hands have occurred. The incubation period is short: the lesion usually appears in 3–5 days or sooner. An increased rate of HIV infection has been reported among patients with this genital ulcer disease; chancroid is a cofactor for HIV transmission. Moreover, 10% of patients with genital chancroid may have co-infection with herpes or syphilis.



Figure 3: male genital ulcer in chancroid

Symptoms and Signs

The early chancroid lesion is a vesicopustule on the pudendum, vagina, or cervix. Later, it degenerates into a saucer-shaped ragged ulcer circumscribed by an inflammatory wheal. Typically, the lesion is very tender and produces a heavy, foul discharge that is contagious. A cluster of ulcers may develop. Lesions typically occur on the vulva, cervix, and perianal area in

women. Painful inguinal adenitis is noted in over 50% of cases. The buboes may become necrotic and drain spontaneously.

Diagnosis

- ☞ History
- ☞ Physical examination
- ☞ Laboratory Findings

Syphilis must first be ruled out. Clinical diagnosis is more reliable than smears or cultures because of the difficulty of isolating this organism. Isolation of *H. ducreyi* is diagnostic, but isolation occurs in less than one-third of cases.

Differential Diagnosis

Syphilis, granuloma inguinale, lymph granuloma venereum and herpes simplex may coexist with chancroid and must be ruled out.

Treatment

Local Treatment: Good personal hygiene is important. The early lesions should be cleansed with mild soap solution. Sitz baths are beneficial.

Antibiotic Treatment

Recommended regimen: (a) azithromycin 1g orally once; (b) ceftriaxone 250 mg intramuscularly (IM) as a single dose; (c) erythromycin base 500 mg orally 3 times daily for 7 days; and (d) ciprofloxacin 500 mg orally twice daily for 3 days in non-pregnant patients over age 17 years who are not lactating.

Prevention

Chancroid is a reportable disease. Routine antibiotic prophylaxis is not warranted. Condoms can give protection. Liberal use of soap and water is relatively effective. Education is essential.

Lymphogranuloma Venereum

The causative agent of lymphogranuloma venereum is 1 of the aggressive L serotypes (L1, L2, or L3) of *Chlamydia trachomatis*. Transmission is via sexual contact; men are affected more frequently than are women. The incubation period is 7–21 days.



Figure 4: Lymphogranuloma Venereum

Symptoms and Signs

Early in the course of the disease, a vesicopustular eruption may go undetected. With inguinal (and vulvar) ulceration, lymphedema, and secondary bilateral invasion, excruciating conditions arise. Sitting or walking may cause pain. During the inguinal bubo phase, the groin is exquisitely tender. A hard cutaneous induration (red to purplish-blue) is a notable feature. This usually occurs within 10–30 days after exposure and may be bilateral. Anorectal lymphedema occurs early; defecation is painful, and the stool may be blood-streaked. Later, as the lymphedema and ulceration undergo cicatrization, rectal stricture makes defecation difficult or impossible. Vaginal narrowing and distortion may end in severe dyspareunia. In the late phase, systemic symptoms—fever; headache, arthralgia, chills, and abdominal cramp may develop.

Diagnosis

Using clinical features: such as rectal ulceration, inguinal lymphadenopathy, or rectal stricture. Positive complement fixation test

Laboratory Findings: The diagnosis can be proved only by isolating *C trachomatis* from appropriate specimens and confirming the immunotype. These procedures are seldom available, so less specific tests are used

Differential Diagnosis

As with any disseminated disease, the systemic symptoms of lymphogranuloma venereum may resemble meningitis, arthritis, pleurisy, or peritonitis. The cutaneous lesions must be differentiated from those of granuloma inguinale, tuberculosis, early syphilis, and chancroid.

Complications

Perianal scarring and rectal strictures, late complications can involve the entire sigmoid, but the urogenital diaphragm is rarely involved. Vulvar elephantiasis (esthiomene) produces marked distortion of the external genitalia.

Treatment

Chemotherapy: Doxycycline 100 mg twice daily orally should be given for 21 days according to tolerance. If disease persists, the course should be repeated. An alternative regimen is erythromycin 500 mg orally 4 times daily for 21 days.

Local and Surgical Treatment

Anal strictures should be dilated manually at weekly intervals. Severe stricture may require diversionary colostomy. If the disease is arrested, complete vulvectomy may be done for cosmetic reasons. Abscesses should be aspirated, not excised.

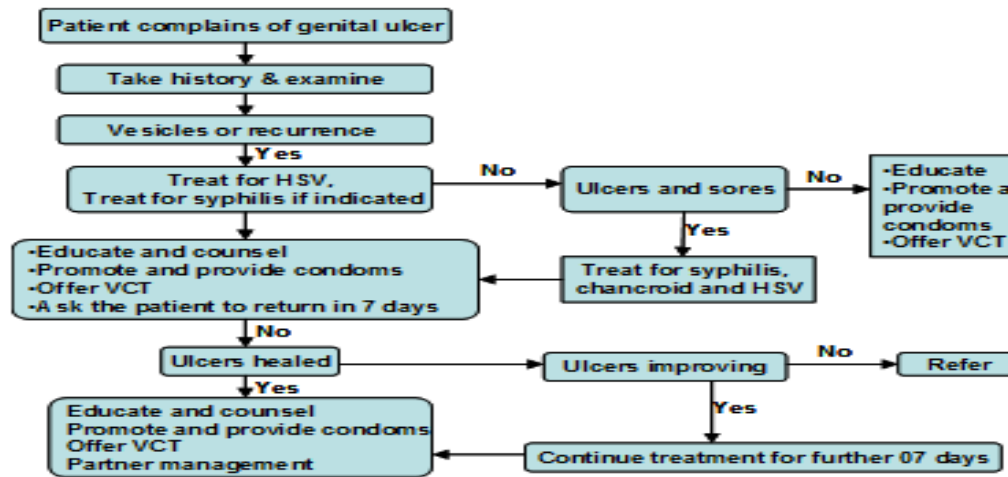
Prevention

Lymphogranuloma venereum is reportable. Avoiding infectious contact with a carrier is achieved by use of a condom or by refraining from coitus. Definite exposure can be treated with sulfonamides or tetracycline

Management of Genital ulcer based on syndromic approach

Treatment should be given as soon as possible owing to the increased risk of HIV transmission. The treatment for this syndrome is similar for both males and females. Treatment should be based on the local epidemiology of genital ulcers. Distinction should be made between vesicular and non-vesicular genital ulceration. Because of the increased risk of HIV transmission, treatment for genital herpes is now strongly recommended. Besides antimicrobial therapy, the other components of STI case management including partner notification and treatment should be given.

Genital Ulcer Syndrome



Abnormal Vaginal Discharge Syndrome

All women have a physiological vaginal discharge which may increase during certain situations. Normally, women will only complain if they perceive the discharge to be abnormal. Abnormal vaginal discharge is one of the most common STI syndrome among women, but also one of the most complicated to manage. The commonest causes of the syndrome are endogenous vaginal infections (bacterial vaginosis and vaginal candidiasis) that are not sexually transmitted.

Clinical features: Abnormal vaginal discharge (indicated by amount, color and odour) with or without lower abdominal pain or specific risk factors.

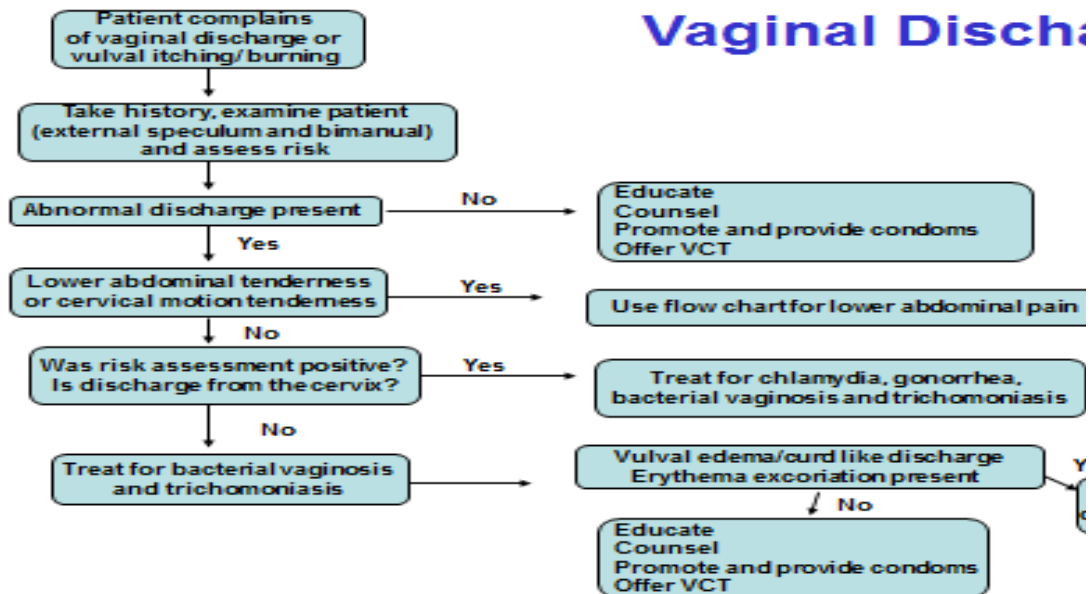
Etiology: Abnormal vaginal discharge is usually due to infection of the vagina (Vaginitis and vaginosis) and rarely due to muco purulent cervicitis, although the latter is more serious. Bacterial vaginosis, vulvovaginal candidiasis and trichomoniasis are the commonest causes of vaginitis. Gonococcal and chlamydial infections cause cervicitis. Distinction between the two on clinical grounds is usually not possible. The symptom of vaginal discharge is highly indicative of vaginitis and poorly predictive of cervicitis which is in most cases asymptomatic. Thus all women with vaginal discharge should receive treatment for trichomoniasis and bacterial vaginosis.



Figure 6: Vaginal discharge

Management of vaginal discharge:

Women with vaginal discharge should be managed according to the flow chart on the next page. The flow chart differentiates between candidiasis and other vaginal discharges. However, all women with abnormal vaginal discharge are treated for bacterial vaginosis and trichomoniasis and candidiasis. At the moment, it is not possible in this country to identify women with cervicitis, and all women with a non-curd like discharge should be treated for cervicitis. While other components of the syndromic management package should be promoted in management of abnormal vaginal discharge, patients should be explained endogenous and recurrent nature of vaginitis to avoid marital discord. Women whose partners have urethral discharge should be treated for cervicitis. Persistent abnormal vaginal discharge should be evaluated to exclude cervical cancer. Speculum examination and referral for specialist management may be necessary.



Lower Abdominal Pain Syndrome

This is perhaps one of the commonest and most serious STI syndromes among women with very serious reproductive health and socio-economic consequences. It can present acutely or chronically and is often very difficult to diagnose given the many differential diagnoses. Patients will often complain of abdominal pain, bleeding, dyspareunia, menometrorrhagia, fever and sometimes, vomiting. Patients should be carefully evaluated for abdominal tenderness, cervical motion and adnexial tenderness, enlargement of uterine tubes, and tender pelvic masses. The temperature may be elevated. Female patients with other STIs should be carefully evaluated to exclude this condition since some may not complain of abdominal pain. This requires bimanual vaginal examination. A thorough history and examination to exclude other surgical emergencies which present in a similar way must be done, and if necessary, referral for specialist attention done.

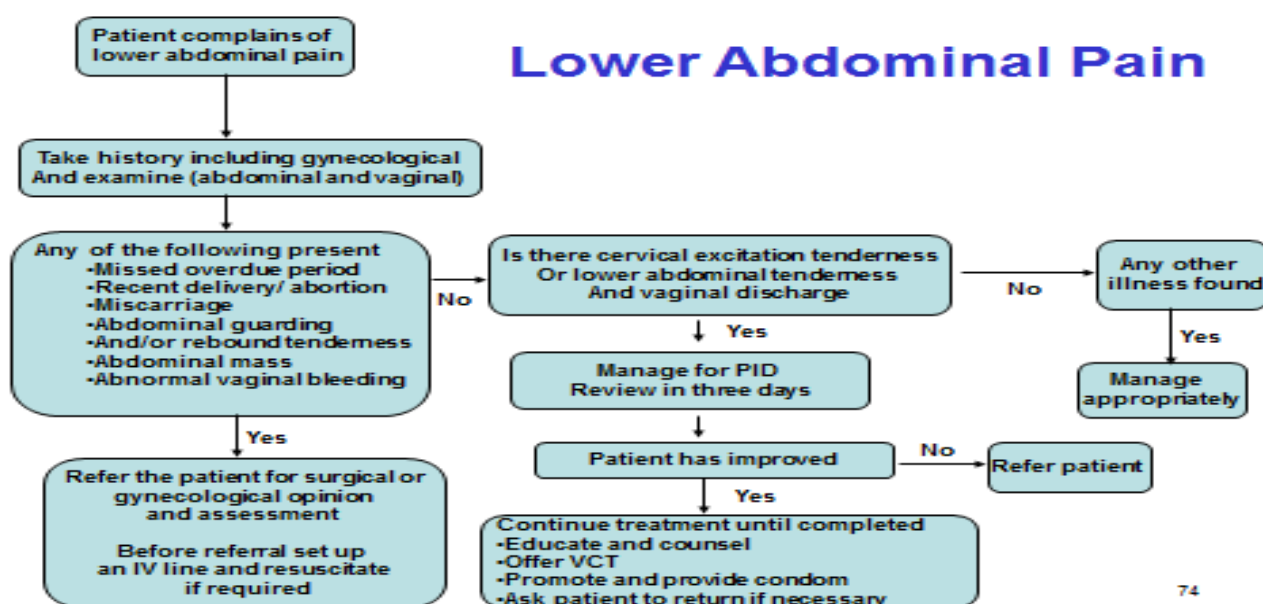
Clinical feature: Symptoms of lower abdominal pain and pain during sexual intercourse, with examination showing vaginal discharge, lower abdominal tenderness on palpation, or temperature $> 38.0^{\circ}\text{C}$.

Etiology:

This syndrome is suggestive of pelvic inflammatory disease (PID), i.e. salpingitis and or endometritis. It may be caused by gonococcal, chlamydial, or anaerobic infection.

Management of Lower Abdominal Pain:

Patients with other surgical emergencies should be referred immediately for in patient admission and management. Lower abdomen pain syndrome is treated with ciprofloxacin, Doxycycline and metronidazole. Antibiotic treatment is clearly syndromic and is directed at the etiological agents since specific diagnosis is not possible. Outpatient treatment should be prolonged due to the chronicity of the condition. Patients with IUCD that are themselves predisposing factors for PID should have the device removed after initiating treatment for at least 2 days. Such patients will require contraceptive counseling. The other components of STI case management should also be provided to patients with Lower abdominal pain syndrome.



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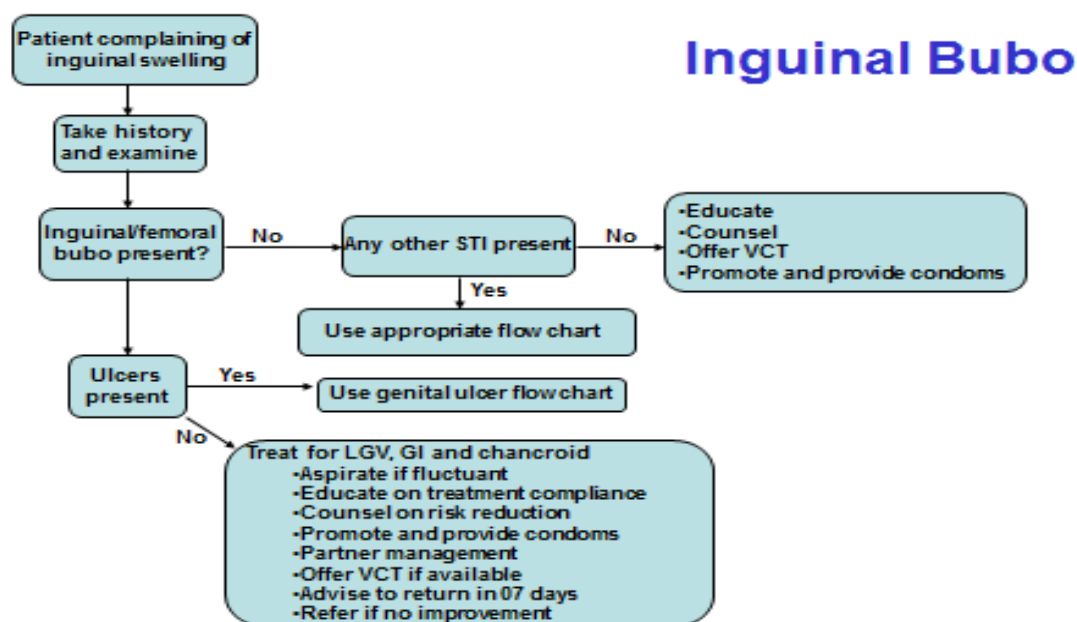
Inguinal Bubo

These are localized swellings or enlarged lymph glands in the groin and femoral area, hence the local term “grenade” used to describe this syndrome. They may be painful and fluctuant. They are usually associated with LGV and chancroid. In the case of chancroid, an associated ulcer may be visible. None sexually transmitted local and systemic infections (e.g. infection of the lower limb or gluteal region) can also cause swellings in the inguinal region and should be excluded.





Figure 7: Inguinal Bubo

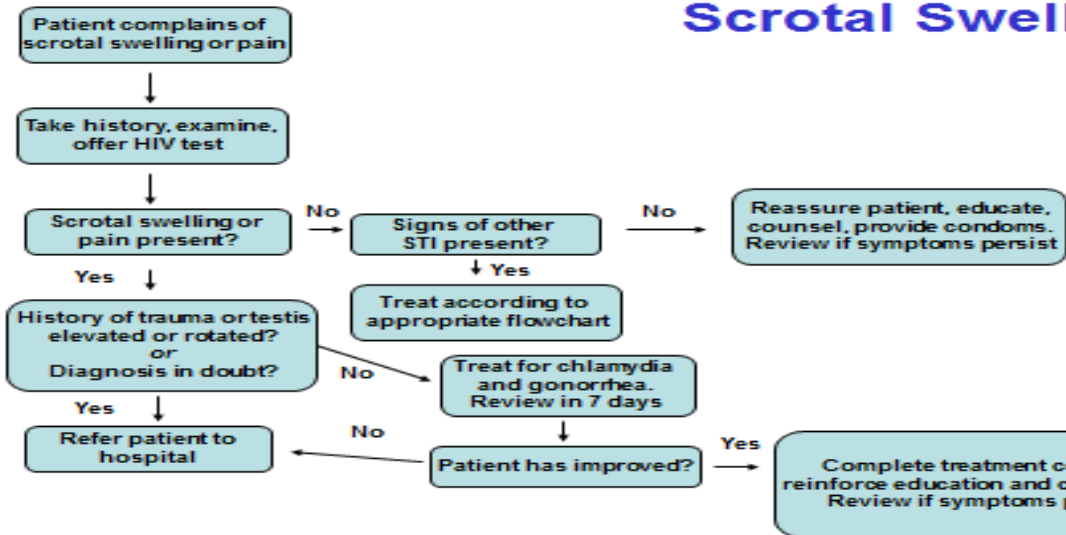


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Painful Scrotal Swelling

Sexually transmitted epididymitis or epididymo-orchitis is inflammation of the epididymis and/or testis, usually unilaterally. It is of acute onset and painful and may be accompanied by urethral discharge. This condition if not treated early can cause secondary male infertility. It is important to exclude other non STI causes of scrotal swelling such as trauma, testicular torsion and tumors which should be referred for surgical attention. Other causes of epididymo-orchitis especially older men include E.coli, Klebsiella spp, Pseudomonas aeruginosa, Brucella spp and Mycobacteria tuberculosis. In children, mumps epididymo-orchitis may accompany parotid

Scrotal Swell



3.2.5. Human Immuno Deficiency Virus (HIV) and Acquired Immuno Deficiency Syndrome (AIDS)

The Virus

The causative agents are human immunodeficiency viruses (HIV) of strains HIV 1 and HIV 2. HIV belongs to retrovirus (double stranded RNA) family. Retroviruses possess the enzyme reverse transcriptase which allows viral RNA to be transcribed into DNA. The viral DNA when gets incorporated into the host cell genome, chronic infection begins.

Mode of Transmission

- **Sexual intercourse** — Women are affected more than the men because in female, larger mucosal surface is exposed and semen contains high viral load. Transmission of virus from male to female is high. Transmission is both by heterosexual and homosexual contact.
- Intravenous drug abusers.
- Transfusion of contaminated blood or blood products.
- Use of contaminated needles, needle stick injuries.

Clinical Presentation

Following exposure to HIV infection, a patient develops antibodies against HIV in about 8–12 weeks. The development of antibodies marks the stage of seroconversion and in some cases manifest clinically flu like syndrome.

Acute infection syndrome is characterized by fever, skin rash, arthralgia, lymphadenopathy and diarrhea. This is called seroconversion illness. It lasts less than 2–3 weeks and resolves spontaneously.

After the initial exposure, the person remains asymptomatic for many years. The median time to develop AIDS is approximately 7–10 years. During this period, the patient shows progressive immune depletion. With increasing immunodeficiency, the person becomes susceptible to secondary infection by opportunistic organisms. Some individuals may just have persistent generalized lymphadenopathy during this period.

AIDS-related complex (ARC) refers to subjects having non-specific clinical features of weight loss, fever, diarrhea, skin rash, lymphadenopathy, herpes simplex, oral or recurrent genital candidiasis, oral or genital ulcers, PID, tubo-ovarian abscess, and thrombocytopenia without full blown pictures of AIDS.

Diagnostic tests for HIV:

- ☞ Detection of IgG antibody to Gp 120 (envelope glycoprotein component) is **most commonly used**. Antibody production may take up to 3 months (window period) since the time of infection. These antibodies are not protective.
- ☞ Viral P-24 antigen can be detected very soon after the infection and it usually disappears by 8–10 weeks' time.

Treatment

Even though they are not curative, nowadays there are drugs called antiretroviral that are aimed and prescribed to prolong and improve their life condition

Preventive measures include

Preventive measures include: 'Safer sex' practice with health education. Barrier methods (*Condoms and Spermicides*) are effective to reduce transmission (80%).

- ☞ Male circumcision reduces transmission by 50%.
- ☞ Use of blunt tipped needles to avoid needle stick injury during surgery.
- ☞ HIV negative blood transfusion (screening of donors).
- ☞ HIV negative frozen semen to use for artificial donor insemination.
- ☞ Post exposure prophylaxis with zidovudine and lamivudine is advisable (given below).

3.3. Managing Low risk conditions and referring high risk conditions to higher health facility

The referral link between a higher-level health facility and you, the midwifery at the Health center, is a two-way street. For this system to be fully functional, you have to know the health workers in the nearby hospital, and they should know all the midwives at the Health centers in their catchment area. One reason is that it is so much easier to write an effective referral note to people you know than to people you don't. Another reason is that if they know you, they will be more able to trust your judgment and act quickly on it when you refer a mother or baby to them. Whether or not a sick can reach a fully functional health facility in time can literally be the difference between life and death. It helps a great deal if:

- You have taken care to develop and establish strong links with the health facilities that you use (and the health workers in them), so that referrals can be dealt with quickly and efficiently.
- You have mobilized the community to be alert to the need for psychosocial, financial and practical support in cases where critically sick individual must reach the health facility urgently.
- You have convinced the patient and family to trust your judgment.
- You are active in following up and checking that the patient get to the health facility.

There are many reasons why a referral doesn't happen at all, or does nothappen in time, including the following:

- Lack of proper counseling to the patient and other caregivers, so they don't realize how serious the problem is.
- Far distance and lack of means of transportation to the health facility.
- The family has not saved the financial resources to make the journey.
- Health facilities are not attractive to some patients. Often they don't haveproper supplies of essential medicines and equipment, or they lack thecorrectly trained person for the service required. Hence, due to the poorreputation of some health facilities, parents may be reluctant to go to them.

3.4. Undertake AYRH Follow up

Within the Ministry of health at the federal, regional, and woreda levels assign a AYRH focal person to lead and coordinate AYRH interventions. This focal person will liaise closely with the Ministry of Youth and Sports and the Ministry of Women's Affairs to ensure that youth RH rights are respected at all levels including the community.

Revitalize the Adolescent Reproductive Health Working Group at federal level to ensure harmonization and collaboration among all ministries and partners. Ensure that youth representatives are members of this working group. Create task forces that include line ministries and partners to work on the priorities identified in the strategy: Redesign existing health care facilities; Strengthen tailored outreach programs; Develop National AYRH guidelines; Develop training and training plan for health care providers on AYRH; Develop AYRH curriculum for the formal and non-formal education sectors.

Self-check -1

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. 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
3. When we sit at Gyne OPD and one client comes with the complaint of offensive vaginal discharge and ulcer around the vagina. The health provider can be treated the client based on her clinical findings without lab investigation. What diagnostic method he/she used?
 - A. Etiologic approach
 - B. clinical approach
 - C. Syndromic approach
 - D. B and C
4. Which one of the following prevention method of STI is secondary prevention?
 - A. Condom use
 - B. Not perform sex at all
 - C. Abstinence
 - D. A&C

Unit 4. Register and document RH records

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

4.1. Collecting and updating RH events timely on the basis of HMIS guideline

4.2. Reporting and communicating RH services to the higher level

4.3. Revising Plan on adolescent and youth RH health 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:**

- Prepare registration book for nutritional events registration according to HMIS standards of FMOH
- Continuously collect, sustain and update timely the RH events data on the basis of HMIS guideline of FMOH
- Report and communicate RH services to the higher level and relevant body on the basis of HMIS procedure of the FMOH
- Revise a plan on adolescent and youth RH health services for the catchments for a specific period of time

Introduction

As information is vital for decision making, data or information generated in the service areas has to be properly handled and managed. And all relevant and appropriate information produced in the health post should be processed and stored in a way that it can easily be accessed whenever desired by official body. Well-functioning health information system supports the delivery of health services by ensuring the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status. Nowadays National HMIS is used to collect record and analyze key service delivery data for management purposes. Particularly it is notable in the area of RH since so many health-related indicators at the regional level derive from the provision of RH services.

4.1. Collecting and updating RH events timely on the basis of HMIS guideline

The HMIS indicators have been selected as the most important tools for monitoring health system and program performance. Broadly, the HMIS indicators are grouped into different thematic/programmatic areas: among which Family health is one with 21 indicators (*for other thematic areas you can refer the national HMIS guideline*). Under the family health program- the RH, Child health and EPI each has 12, 3 and 6 indicators respectively. Therefore Collecting and updating events for each component of family health needs should be managed timely on the basis of HMIS guideline.

● Data registration and documentation

Recording should start at each level where the root of the problems might also be identified for an appropriate action. Therefore, recording at the contact points by health workers give solution for some of the problems associated with data shortage.

Information in health service organizations should full fill the following characteristics.

- ✓ **Appropriateness:** information should be related to the work and objectives of the organization.
- ✓ **Quality:** the information should be complete, accurate and clear. And also represent a true picture of what is happening within the organization.
- ✓ **Timeliness:** it should be recent and represent what is occurring now within the organization.
- ✓ **Quantity:** is there sufficient information available that will lead to accurate conclusions?

● Record keeping or documentation

Records consists of the information kept in the health unit about the work of the unit, health conditions of the customers in general and individual patients, as well as information on administrative matters such as staff, equipment and supplies.

- ✓ **Records** are usually written information kept in note books or fills. They may also be kept on to be computerized. Records should be accurate, accessible, and available when needed, and contain information that is useful to management. Information should not be recorded unless it is known to be accurate and unless there is a use for it. Accurate records help to follow the activities of a program continuously, according to the need

✓ **Registers or ledgers**

Not all records in a health unit consist of loose papers. A number of items are recorded in large books usually called registers or ledgers.

Where to find files, registers and ledgers

Files, registers and ledgers are best kept where they are used; for example, the stock ledger and receipts file in the store room or cupboard, correspondence in the office, and patients' files in the outpatient department. Wherever they are kept, they need a definite place on a shelf or in a cupboard where they can be found easily. Where a number of files are kept in an office the shelves should be clearly labelled. The place where each document is kept is recorded in the office index.

● **Information Management, Monitoring and Evaluation**

All the important data regarding adolescents and youth reproductive health should be properly documented and kept in the health facility for immediate use or any time in the future when the need arises. In this regard the AYRH service provider has to do a number of tasks. These tasks of the health worker include:-

- ✓ keeping record of the number of the target population categorized in sex, age and Occupation.
- ✓ Keeping record of the number of schools, government and nongovernmental Organizations, farmers, youth and women's associations found in the catchment area.
- ✓ Registering the number of health education materials distributed to social and other Organizations in the catchment area.
- ✓ Keeping record of the number of people that received health education as group or in any Gathering places
- ✓ Registering all clients receiving different health services in the health facility and outreach.
- ✓ Keeping the record of the number of service users referred to higher health institutions.
- ✓ The record should include information on whether the client has benefited or not from the next level of health facility;
- ✓ Organizing health data and making it ready to use.

4.2. Reporting and communicating RH services to the higher level

● Report writing

Report writing is among several important activities that should be done based on the need of the existing structure in the health sector including other stake holders. Therefore, the health worker should use the available formats and guidelines to prepare comprehensive reports of the activities performed in adolescents and youth reproductive health package. By Compiling daily performed activities you should prepare and submit monthly, quarterly and annual reports to the governing health office. The report compilation can be done using the existing national or regional standard formats or the HMIS formats

The reports should mainly contain: introduction, the achievements (accomplishments regarding the set objectives), outcomes (the observed results and changes), benefits (advantage it provides to the service users) problems encountered during the implementation of the package and summary

● Communicating RH services

This Reproductive Health Communication Strategy seeks to increase the proportion of national level policy makers knowledgeable on the socio-economic significance of reproductive health and devoting sufficient resources to meet the reproductive health needs. HMIS is one of the major sources for providing that evidence.

The primary purposes of this communication to the higher levels are:

- ✓ To gain support and approval for the annual plan and budget proposal by presenting problem(s) identified, proposing solution(s) and feasible recommendations based on evidence
- ✓ Presenting progress in RH services in terms of key performance indicators and solicit or Advocate for resources or actions for issues beyond the capacity of the service providers

4.3. Revising Plan on adolescent and youth RH health services

Before you provide different adolescents and youth RH problems, as for any service, plan should be prepared ahead of time. **Plan** is a technical document which describes the activities to be performed and the way how they are to be implemented. This guides and gives you full

Information about the overall frame work of the activities you wish to provide.

AYRH services could be delivered through various outlets such as the health facilities, household, community and schools. It can also be provided through other social institutions such

as religious institutions, as well as areas frequented by young people. Before you provide services it is important that you know the size of your target group (target group is the segment of the population appropriate to receive specific services like AYRH services) and what specific services they need and through which outlets you could provide these services.

The following are among the main activities but not limited intended services to be included in adolescent and youth-friendly services. And these activities need target oriented plan and interventions.

- ✓ Information and counselling on sexual and reproductive health issues
- ✓ Promotion of healthy sexual behaviors through various methods including peer education
- ✓ FP information, counselling and methods including emergency contraceptive methods
- ✓ Condom promotion and provision
- ✓ Testing services like HIV counselling and testing (you may not perform it)
- ✓ Prevention and counselling 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

Self check-1

1. How the information in health service organizations can be characterized?
2. List the tasks an AYRH service provider has to do during AYRH service Information Management, Monitoring and Evaluation.
3. Why it is important to communicate RH services to higher levels?
4. List some of RH service activities to be included in your plan.

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