NATIONAL TRAINING MANUAL FOR THE HEALTH & DEVELOPMENT OF ADOLESCENT & YOUNG PEOPLE IN NIGERIA

FMOH

FEDERAL MINISTRY OF HEALTH

in collaboration with

UNITED NATIONS POPULATION FUND (UNFPA)
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POPULATION AND REPRODUCTIVE HEALTH PROGRAMME

NATIONAL TRAINING MANUAL FOR THE HEALTH & DEVELOPMENT OF ADOLESCENT & YOUNG PEOPLE IN NIGERIA

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National Training Manual on Adolescent Health & Development for Nigeria

First Revision

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Acknowledgements

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Advancing the health and development of young people is a multi-disciplinary and multi-sectoral endeavor, which requires the participation of a wide group of dedicated and committed partners. In this respect, I am grateful to all stakeholders who are contributing positively to young people's health in Nigeria, and have made inputs into the development of the revised training manual. These stakeholders include the National Adolescent Health Working Group, Federal Ministry of Youth, Federal Ministry of Women Affairs, Adolescent Health Desk Officers of State Ministries of Health, other international partners such as the United Nations Children Fund (UNICEF), members of the academia, and representatives of Civil Society Organisations. Several young people participated actively in the various stages of the development of this manual; their contribution is especially acknowledged.

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Dr. (Mrs) Philippa N. Momah
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Foreword

Globally, adolescent health and development issues continue to generate significant attention. Adolescence is a unique period of life with distinct strength, needs and challenges. Adolescents are characterized by an abundance of energy, ideas and although they are generally healthy, they are prone to risky behaviours that have the potential to compromise their health and development.

Currently, adolescents and young persons aged 10 – 24 years comprise about a third of the Nigerian population. The number of young people in the country continues to increase as more individuals survive the childhood years and enter into adolescence. The future development of our country and the world largely depends on having healthy adolescents who transit in the nearest future into healthy and productive adulthood. This underscores the importance of giving critical attention to adolescent health issues. While multi-sectoral partnerships and actions are needed for optimal health development and well-being of young people, the health sector has leadership role and unique technical responsibilities. Among others, the health system has responsibility for developing appropriate health workforce to provide quality health services to young people. The health sector is also strategically placed to support the strengthening of human resources capacity in other sectors.

The Nigerian government is conscious of the need to invest appropriately in the health and development of young people, and has continued to strive towards improving the health and development of this unique population sub-group. In rising to this challenge of developing appropriately skilled adolescent-focused workers in the health and related sectors, the Federal Ministry developed the first edition of the National Adolescent Health Training Manual in 2001. Ten years on, there have been significant changes in the knowledge and practice regarding adolescent health nationally and globally; thus, a revision of the national training manual becomes relevant. This will ensure that training activities in the country remain relevant to the evolving needs of young people and accord with current knowledge.

This revised edition is a significant improvement on the first edition, and includes several new modules, including those on school health, chronic diseases, mental health issues, injuries as well as disabilities in adolescents and young people. Presented in a user and learner-friendly format, it is anticipated that this revised edition would have a wide reach within and beyond the health sector to build capacities that would positively impact on the health and development of young people in Nigeria.

The Federal Ministry of Health deeply appreciates all our partners who have continued to support our various initiatives designed to improve the health and development of adolescents and other young people. In particular, the technical partnership and financial support of the following organization have been critical to the development of this revised

manual; the United Nations Population Fund (UNFPA), the World Health Organisation (WHO); and, the Population and Reproductive Health Programme of the Obafemi Awolowo University (OAU), Ile-Ife – supported by the Bill and Melinda Gates Institute for Population and Reproductive Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, USA.

Finally, I strongly commend the use of this manual to all organisations and individuals working in the adolescent health and development field in Nigeria. I sincerely believe that through our continued efforts and the effective use of this manual, together, we can make a positive impact on the life of every young person in Nigeria.

L. N. Awute, mni
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MODULE ONE
OVERVIEW OF ADOLESCENT HEALTH & DEVELOPMENT

The main aim of this introductory module is to provide basic information on adolescent development processes, the rationale for focusing on adolescent health in the context of public health programming, and a snapshot of current situations regarding adolescent health in Nigeria.

SESSION 1: **INTRODUCTION TO ADOLESCENT HEALTH**

SESSION 2: **ADOLESCENT DEVELOPMENTAL PROCESSES AND BEHAVIOUR**

SESSION 3: **FACTORS ASSOCIATED WITH ADOLESCENT HEALTH STATUS AND KEY ISSUES IN PROGRAMMING FOR ADOLESCENT HEALTH AND DEVELOPMENT**

MODULE ONE: OVERVIEW OF ADOLESCENT HEALTH AND DEVELOPMENT
SUMMARY AND TIMING ESTIMATE

SESSION TITLE	DURATION	OBJECTIVES	METHODS	MATERIALS
Introduction to Adolescent Health	1 Hour 30 Minutes	• Explain the concept of adolescence. • Define adolescence, adolescent, youths, and young person. • Discuss rationale for focusing on adolescent health; Discuss demographic and health situation of adolescent and young people in Nigeria. • Discuss key legal and policy provisions regarding adolescent health in Nigeria.	Brainstorming Lecture Group work Discussion	Flip chart stand/ paper Markers, Flip chart Cardboard Scissors Paper tapes PowerPoint Slides Computer & Projector.
Adolescent Developmental process and behaviour	1 hour 30 minutes	• Describe the physical, psycho-social and cognitive changes in adolescence. • List developmental tasks in the various stages of adolescence. • Explain adolescents' health-related behavior in the light of their developmental processes.	Brainstorming Lecture Group work Discussion	Flip chart stand/paper Markers Paper tapes PowerPoint Slides Computer & Projector IEC materials Flipchart Cardboard Scissors.
Factors associated with adolescent health status and key issues in programming for adolescent health and development.	1 hour 30 minutes	• Explain the concept of risk and protective factors regarding adolescent health. • Identify major risk and protective factors relating to key adolescent behaviour • Apply the concept of risk and protective factors to adolescent health situation in Nigeria. • Discuss key issues in programming to improve adolescents' health.	Brainstorming Lecture Group work Case study Discussions	Flip chart stand/ paper Markers Paper tapes PowerPoint Slides Computer & Projector Flipchart Cardboard Scissors

MODULE ONE: SESSION 1
INTRODUCTION TO ADOLESCENT HEALTH

TIME: 1 hour 30 minutes

LEARNERS' OBJECTIVES

At the end of the session participants should be able to:

- Explain the concept of adolescence;
- Define adolescence, adolescent, youths, and young person;
- Discuss rationale for focusing on adolescent health based on the demographic and health situation of adolescents and young people in Nigeria;
- Discuss key legal and policy provisions regarding the definition of adolescents and young persons in Nigeria.

SESSION OVERVIEW

- The concept of adolescence
- Age definition of adolescent, youth, and young persons
- Rationale for focusing on adolescent health
- Key legal and policy provisions regarding the definition of adolescents and young persons in Nigeria

METHOD

- Brainstorming
- Lecture/Discussion
- Group work

MATERIALS

- Flip chart stand and papers
- Markers
- Paper tape
- Cardboard
- Scissors
- PowerPoint slides
- Computer and projector

CONTENT

THE CONCEPT OF ADOLESCENCE

Adolescence is a period in which 'although no longer considered a child, the young person is not considered an adult either'.

DEFINITIONS

Adolescence

Adolescence is the period of transition from childhood to adulthood, and involves physical, psychological, cognitive and social behavioural changes.

In terms of age group, Nigeria's National Policy on the Health and Development of Adolescent and Young People defines adolescents as people between the ages of 10 and 19 years. This definition is in line with the definition used by the World Health Organisation (WHO) and other United Nations agencies.

The age group can be subdivided into three periods:

- Early: 10-14 years
- Middle: 15-17 years
- Late: 18-19 years

Two related terms – youths and young people – have also been defined by WHO as follows:

- **Youths:** Individuals aged between 15 and 24 years.
- **Young** People/Persons: Individuals aged between 10 and 24 years

Despite the usefulness of age group for defining adolescents and young people, it is important to note that adolescents do not constitute a homogeneous group, and therefore the needs of different groups of adolescents may differ,especially on the basis of age, sex, economic background, family status, family structure, sexual orientation, health status and legal context. Table 1.1 highlights how vulnerabilities might differ by the context of individual adolescents.

Table 1.1: Differences in Adolescents Vulnerabilities by their Social and Health Context

Type of marginalisation/vulnerability and examples of affected adolescents	How marginalisation /vulnerability affects adolescents' access to and demand for SRHR
Gender and associated norms. For example, adolescents who are: child brides; unmarried sexually active females; survivors of gender-based violence; females in conservative or patriarchal religious communities; or young men under pressure to conform to gender norms.	Affected adolescents may experience one or all of: **Different types or levels of SRHR needs compared to other adolescents.** For example: adolescents with low literacy may need specific SRHR materials; adolescent orphans may need extra counselling on relationships; adolescent men who have sex with men may have specific needs for condoms and lubricants; or adolescents in prison may need extra support about sexual violence. **Additional or stronger barriers to accessing SRHR services compared to other adolescents.** For example: the SRHR needs of unmarried female adolescents may be ignored in government services for married adults; SRHR services may not be available at times that suit adolescents living on the street; adolescents living with HIV may face discrimination by health workers; or adolescents in poverty or informal labour may not be able to afford the costs of SRHR services. **Weaker opportunities or capacity to demand SRHR services compared to other adolescents.** For example: child brides may not be permitted to take decisions about their SRHR; adolescent migrants may lack regular contact with SRHR services; adolescents in rural areas may lack access to information technology; stigmatised adolescents (such as sex workers) may be excluded from decision-making on SRHR programmes; or criminalised gay adolescents may not be able to voice their needs.
Socio-cultural status. For example, adolescents who are: from ethnic minority, indigenous or 'closed' religious/cultural communities; unmarried mothers; out-of-school; orphans; in/released from prison or remand homes; or people that use drugs.	
Socio- economic status. For example, adolescents who: live in poverty; have low literacy/have dropped out of school; have been trafficked; are migrants; are child labourers; are heads of households; are engaged in transactional sex; live or work on the streets; or are engaged in informal labour.	
Geographic location. For example, adolescents who are: in rural areas; in urban slums; in nomadic communities; or displaced.	
Health status. For example, adolescents who: are pregnant; have physical or mental health disabilities; are living with HIV; or are survivors of sexual abuse or violence.	
Sexual orientation. For example, adolescents who: are identified as lesbians, gay, bisexual or transgender; or are unsure of their sexual orientation.	
Political context. For example, adolescents who live in conflict situations or refugee communities.	
Legal context. For example, adolescents whose status/ behaviour is criminalised (e.g. men who have sex with men, people that use drugs, sex workers).	

RATIONALE FOR FOCUSING ON ADOLESCENT HEALTH

DEMOGRAPHIC AND HEALTH SITUATION OF ADOLESCENTS IN NIGERIA

Background

Adolescents constitute one of the most important population groups – a vital bridge between childhood and adulthood. Given their size and characteristics, they are a country's most valuable assets. With proper investment in their lives and development, they can play a key role in the development of their societies and nations. Properly nurtured and guided, adolescents have the capacity to achieve their potentials and grow into productive adults. On the other hand, wrong decisions and actions may lead to increased morbidity and mortality, and compromise their future. Thus, perhaps more than other groups in the society, adolescents occupy an exciting but potentially dangerous position.

Adolescence is a period of both opportunities and challenges. The opportunities include development of new capabilities and relationships. On the other hand, transition to adulthood often involves periods of stress, innovation, experimentation and disorganization. The fundamental changes that are happening in today's world in almost every sphere of life – including technology, social, political, legal and health field – further create challenges for young people.

Demographic Situation

Nigeria's population, according to the national population and housing census, was 140 million in 2006. With an annual growth rate of approximately 3.2% - one of the highest in the world – the population is currently estimated as 160 million. Nigeria has a "young population" structure, with more than two-fifths of the population currently consisting of children under the age of 15 years. Adolescents (10-19 years) constitute more than a fifth (22.1%) of Nigeria's population while young people (age 10-24 years) constitute almost a third (31.7%).

Health Situation of Adolescents

The leading health problems of young people in Nigeria are: sexual and reproductive health, substance use and abuse, mental health, trauma and injuries, and nutritional problems. The availability of data on these health problems vary considerably, with sexual and reproductive health enjoying higher research attention than others particularly in terms of national surveys.

Sexual & Reproductive Health and Rights

Knowledge of Sexual and Reproductive Health Issues

While awareness of HIV/AIDS is high among adolescents – 87.1% for females and 91.4% for males, "real" knowledge is low. Only half (52.0%) of adolescent females, for example, knew that condom could reduce the risk of HIV transmission compared to 80.2% of males. The proportion of adolescents with comprehensive knowledge about HIV/AIDS based on the UNAIDS indicator is quite low: 19.7% for females and 28.2% for males.

Although the country has adopted the teaching of Family Life and HIV Education (FLHE) at all levels, and the FLHE curriculum was approved for national implementation in 2003, the implementation has been poor. In 2006, only 37% of junior secondary schools students and 45% of teachers were aware of Family Life and HIV Education (FMOE/UNICEF, 2006).

Sexual Behaviour

Early, unprotected sexual exposure is an important reproductive risk factor among young people in Nigeria as many of them lack information and life planning skills to delay the onset of sexual activities. According to the 2008 Nigeria Demographic Health Survey (NDHS), the median age at first sexual intercourse is 17.8 years for women aged 20-49 years; one fifth had initiated sex by age 15 and more than half (52%) by age 18. The median age at first sexual intercourse for men age 25-49 is 20.6 years. Only four percent of the men had initiated sex by age 15 but approximately 4 in 10 (42%) had initiated sex by age 18. Among current adolescents (15-19 years), almost half of the females (46.2%) and approximately a quarter of males (22.1%) had initiated sex. Fifteen percent (15.3%) of the adolescent girls had had sexual intercourse by age 15 compared to 6.2% of boys. Age of sexual initiation varied widely by geo-political zones, particularly for the females with a lower age in the northern areas. This pattern is associated with the wide variation in the rate of early marriage between the different parts of the country; the median age of marriage is just 15.7 years for North West and 15.9 for North East. Teenage sexual activity is mostly pre-marital in the South as compared to the mostly intra-marital setting in the North (Fatusi & Blum, 2008).

Most sexually active young people do not practise contraception, with the resultant effect of high level of unwanted pregnancy and illegal abortion, a high proportion of which are unsafe in nature. Among young people (15-24 years), only a tenth of females and a fifth of males used condom at first sex. Less than four out of every 10 sexually active adolescent females (15-19 years) and only half of female youths (20-24 years) use any modern contraceptive (FMOH, 2008).

Teenage Pregnancy and Motherhood

Almost a quarter (22.9%) of adolescent females in Nigeria had begun childbearing; 18% had had a child and 5% were pregnant with their first child at the time of the 2008 NDHS. Three percent of adolescent females actually became mothers by age 15. In 2003, adolescents contributed 17.7% of total births in Nigeria. The rate of teenage motherhood varies widely by location, zone, and socio-economic status. The north had a much higher rate than the south. Young people contributed 55% of the estimated 760,000 unsafe abortions taking place annually in Nigeria.

Unsafe sexual practices among young people in Nigeria also result in high incidence of HIV/AIDS and other sexually transmitted infections. The 2005 national HIV sero-prevalence survey conducted at sentinel ante-natal care clinics reported a rate of 3.6% and 4.7% for young people aged 15-19 years and 20-24 years respectively. The HIV infection and AIDS among young people were most likely acquired within the last few years preceding the survey and thus gives a frightening indication of the rapidity of transmission currently occurring in these age-groups.

Major factors associated with the poor reproductive health situation of young people in Nigeria include low level of sexual and reproductive health (SRH) knowledge, and limited access to effective reproductive health education programmes and friendly services.

Nutrition

Very little information is available on nutritional habits of adolescents in Nigeria. However, with the high level of poverty in the country, it is likely that many young people may not be having adequate nutrition. Anaemia may also be fairly common among young females particularly those with teenage pregnancy. A national survey carried out in secondary schools reported 30% of the young people assessed had a body mass index below the normal while 4% had values above the normal. The result of the anthropometric measurements carried out as part of the 2008 NDHS indicates that whereas three-quarters (73.7%) of adolescent girls had normal body mass index, about a fifth (19.3%) were thin while 7.0% were either overweight or obese.

Substance Use and Mental Health

Substance use is low among the general population of adolescents in Nigeria. According to NDHS 2008, only 2% of adolescent males and 0.3% of adolescent females use tobacco. Studies in university settings have documented that about a tenth of undergraduates may be using alcohol. The use of mild stimulants is more common among the students. Cannabis is the most common illicit drug taken by young people; it is illegally cultivated in different parts of the country and relatively cheap, making it readily available. A situation analysis undertaken by the United Nations Office of Drug and Crimes (UNODC) in 1999 showed that the use of cannabis accounted for 53.8% of people who received drug-related counselling from formal facilities, while multiple drug use accounted for 35.2% of cases; and heroin alone accounted for 4.2%.

The 2009 World Drug Report also reported that cannabis was the primary drug of abuse in 89.7% of those treated for drug abuse related problems in Nigeria. A previous study of adolescents aged 10-19 years reported that 8% of them had used cannabis at one time or the other. However, a high level of use of heroin and cocaine had been observed among selected group such as street youths. One research work, for example, reported a prevalence of 89% for the use of heroin and 87% for cocaine among street boys and girls ("area boys" and "area girls") in Lagos undergoing rehabilitation. The use of volatile organic solvents, such as petrol, and sniffing of glue had also been reported. Substance use, in general, is higher among selected groups such as street children and those residing in slum areas.

Accidents and Violence

Young people in Nigeria are witnessing increasing rate of accidents from road traffic accidents. Increasing use of motorcycle for commercial transportation is one of the key factors associated with this growing trend. Inter-communal clashes and politically induced violence often involve young people, and subsequently increase the rate of violence-related morbidity and mortality among them. Cult-related violence has been documented in a number of institutions of higher learning; many of these are linked to the use of hard drugs and contribute to violence-related injuries among young people. Recent studies on school violence have documented high level of physical violence in secondary schools in Nigeria: a national study reported 85% prevalence for physical violence in Nigerian schools and 4.7% for sexual violence. A recent study in Osun State reported a one-year prevalence of 89.2% for urban areas and 83.8% for rural areas for bullying.

Suicide is a very uncommon problem in Nigeria unlike in developed countries and South-East Asia. Factors associated with the low prevalence may include the religious and traditional belief system, the social support network, and the taboo or very strong cultural negative perspective regarding suicide. However, suicidal cases may be rising slowly. A study published from Ibadan, south-west Nigeria, in 2008 reported that over 20% of adolescents reported suicidal thoughts and approximately 12% reported that they had attempted suicide in the last one year prior to the study. Adolescents living in urban areas, from polygamous or disrupted families, had higher rates of suicidal behaviour. Multiple psychosocial factors such as sexual abuse, physical attack and involvement in physical fights were significant predictors of suicidal behaviour. Few cases of pre-adolescent suicide were also recently reported from the same town. Increasing economic challenge, breakdown of traditional support system, and mental health challenge may be contributing to that scenario.

Access to Health Services

Adolescent-friendly health services are generally very few in Nigeria despite the fact that the country developed a *Clinical Protocol and Service Guidelines for Adolescent Friendly Health Services* as far back as 2001. Most of the existing adolescent-friendly health services are operated by civil society organisations, with a high proportion of these being dependent on funding from international development partners. On the other hand, many young people are not aware of the locations and opening hours of these few existing youth-friendly health centres/health facilities. The poor state of the school health system, despite the existence of the *National School Health Policy* (2006) and the *Child Health Policy* (2006) which specify school health as a priority area of focus, has served to further compromise adolescents' access to information, counselling and services.

KEY LEGAL AND POLICY PROVISIONS ABOUT ADOLESCENTS IN NIGERIA

Legal Provisions

The Child Rights Act specifies a child as someone less than 18 years. In the Young People's Law of Nigeria, those aged between 14 and 17 years are regarded as young people. Under Family Law, a child becomes eligible for marriage when he/she attains the age of puberty fixed at 14 years for boys and 12 years for girls. Although recently, the minimum age of marriage has been raised to 16 years, traditional marriages of girls who are under age are still being contracted. In Nigeria, the age of consent to sexual intercourse is provided for in the criminal code as 14 years for boys and 16 years for girls unless she is married. Rape and child prostitution are illegal. Public display of obscene materials, described as showing sexual acts in order to cause excitement, is a punishable offence. However, law enforcement agents do not adequately enforce and combat violations of sexual rights such as sexual harassment or abuse, rape and domestic violence.

In case of crime, the minimum age for conviction by a court of law is 15 years. Those between 15 and 17 years who are convicted are sent to remand homes for reformation of character whilst those above 17 years could be sent to prison. With regards to employment, the law prohibits the recruitment of youths less than 15 years of age into the labour market.

Policy Provisions

The lead focal policy on adolescent health in Nigeria is the National Policy on the Health and Development of Adolescent and Young People. This policy, which was developed in 2007, builds upon the 1995 policy and has nine focal areas:

- Sexual and reproductive health and rights;
- Nutrition;
- Accidents and violence;
- Mental health;
- Substance use and abuse;
- Education;
- Career and employment;
- Spirituality;
- Social adjustment and parental responsibilities.

Nigeria has also developed a number of other policies with significant provisions for the health and development of adolescents. These include:

- The National Education Policy (1998)
- The Child Rights Act (2004)
- The National Health Policy (2004)
- The National Population Policy (2004)
- The National Nutrition Policy (2005)
- National Policy on HIV & AIDS for the Education Sector in Nigeria (2005)
- The National School Health Policy (2006)
- The National Youth Policy (2009)
- The National Policy on HIV/AIDS (2009)

As part of the effort to ensure appropriate programmes are mounted for adolescents and young people in Nigeria, the country has developed a Strategic Framework to aid in translating the National Policy on the Health and Development of Adolescent and other Young People into action. Furthermore, in June 2010, the Federal Ministry of Health in partnership with the Federal Ministry of Youth Development and other partners, including UNFPA, developed a *National Plan of Action (2010-2012) for Advancing the Health and Development of Young People in Nigeria*.

SUMMARY

Adolescence is a transitional stage of life, and a period of both opportunities and challenges. With their size and energy, adolescents have great potential to contribute to national development. While Nigeria has developed a good number of policies to address the health and development of adolescents and young people, the sub-optimal health status of today's adolescent signal the need to intensify the implementation of existing policies as well as take other relevant action to improve their health and well-being. It is, therefore, important that all relevant stakeholders – including the government, parents, teachers, and health workers – pay greater attention to adolescent's health and development.

EVALUATION

- Define Adolescence.
- Describe some of the key health problems faced by adolescents in Nigeria.
- List the focal areas of the National Policy on the Health and Development of Adolescents and Young People in Nigeria.

MODULE ONE: SESSION 2
ADOLESCENT DEVELOPMENTAL PROCESS & BEHAVIOUR

TIME: 1 hour 30 minutes

LEARNER'S OBJECTIVES

At the end of the session participants should be able to:

- Describe the physical, cognitive and emotional changes during the period of adolescence.
- Explain adolescent's sexual and social behaviour in the light of the changes above.
- Explain adolescents' sexual lifestyles and the effect on their health and development.

SESSION OVERVIEW

- Physical/cognitive/emotional changes during the period of adolescence
- Adolescent's sexual and social behaviour
- Adolescents' lifestyles

METHODS

- Brainstorming
- Discussion
- Group work

MATERIALS

- Flipchart stand/paper
- Markers
- Paper tapes
- IEC materials
- Flipchart
- Cardboard
- Scissors

CONTENT

INTRODUCTION

Adolescence is characterized by a rapid rate of growth and development. During this period the body develops in size, strength and reproductive capabilities, and the mind becomes capable of more abstract thinking. The development in the adolescence phase of life is triggered off by a cascade of activities that are linked to the production and increased activities of certain hormones or body chemicals.

In terms of growth and development, adolescence is sometimes divided into three periods, which roughly correspond with the phases in physical, social and psychological development in the transition from childhood to adulthood:

- Early: 10- 14 years
- Middle: 15-17 years
- Late: 18-19 years

While these stages are sometimes defined slightly differently in terms of specific age range, this categorization provides a useful framework to understand sequences in adolescent development. Table 1.2 shows the different growth and behavior characteristics relating to the three different periods.

Table 1.2: Developmental Tasks among Adolescents

Stages of adolescence

Category of change	EARLY 10-13 to 14-15 years	MIDDLE 14-15 to 17 years	LATE 17-21years (variable)
Growth	Secondary sexual characteristics appear Growth accelerates and reaches a peak	Secondary sexual characteristics advanced Growth slows down, approximately 95% of adult stature attained	Physically mature
Cognition	Concrete thinking Existential orientation Long-range implications of actions not perceived	Thinking is more abstract Capable of long-range thinking Reverts to concrete thinking when stressed	Established abstract thinking Future-oriented Perceives long-range options
Psychosocial	Preoccupied with: Rapid physical growth Body image Disrupted change	Re-establishes body image Preoccupation with fantasy and idealism Sense of all-powerfulness	Intellectual and functional identity established
Family	Defining boundaries of independence/ dependence	Conflicts over control	Transposition of child-parent relationship to adult-adult relationships
Peer group	Seeks affiliation to counter instability	Needs identification to affirm self image Peer group define behavioural code	Peer group recedes in favour of individual friendship
Sexuality	Self exploration and evaluation	Preoccupation with romantic fantasy Testing ability to attract opposite sex	Forms stable relationships Mutuality and reciprocity Plans for future

Source: WHO

PHYSICAL CHANGES IN ADOLESCENTS

Key physical changes take place in both males and females, leading to easy physical distinction between the two sexes. Some of the key physical changes are listed in Table 1.3. These changes are expected to take place increasingly as the individual moves from early to late adolescence.

Table 1.3. Physical changes during adolescence

GIRLS	BOYS	BOYS AND GIRLS
Wider hips	Broader shoulder	Grow taller
Bigger breasts	Hair on chest	Armpit hair
Menarche	Enlarged penis Enlarged testicles Breaking of voice Production of sperm (spermache) Wet dreams	Hair on legs Pubic hair Sweat more Defined facial contour Gain weight

COGNITIVE AND EMOTIONAL CHANGES IN ADOLESCENCE

Brain Development

Knowledge about adolescents' brain development has grown in recent years due to advances in medical technology that makes it possible to study the brain in living people without causing them harm. One of the striking findings is the realization that the adolescents' brain is a "work in progress". This is contrary to the earlier beliefs that brain development takes place and virtually ends in childhood. Another striking finding is that an area of the brain just behind the forehead, medically referred to as "prefrontal cortex" continues to grow again just before puberty and the growth continues through several adolescent years. This is particularly interesting because this is a part of the brain that relates to organization, controls planning, and modulates mood. In fact, this part of the brain has been dubbed "the area of sober second thought." As the prefrontal cortex matures, adolescents can reason better, develop more control over impulses and make judgments better.

Cognitive Changes

The physical and reproductive changes of adolescence are accompanied by cognitive and emotional changes. Cognitively, the period of adolescence is characterized by transformation from the concrete operational to formal operational stage. At the concrete operational stage, children (primary school children or pre-adolescents) deal with concrete facts as they see them (immediately). To them, it is more of "seeing is believing." They also have the tendency to take to instructions without questioning.

At the formal operational stage, however, the cognitive transformation allows the adolescents to engage in abstract thinking and reasoning. This makes them capable of forming hypotheses and wanting to try them out. They are now able to think about the future, about possibilities and alternative ways of doing things, which are different from the ways the adults or parents, may expect them to do those things. They now become aware of the disparity between the ideal and the real/actual. They become dissatisfied with this disparity. They cherish and envy the ideal and abhor the real. From this perspective, they may see adults as "hypocrites" who never try to achieve the ideal but feel too comfortable with the real. For example, this is the period when an "adopted child" may get dissatisfied with his or her status and insists on knowing the real parents. This is the period when

the physically challenged e.g. those who are crippled in their feet no longer feel satisfied with their status and begin to question people and God why they are what they are.

Similarly, due to the cognitive transformation, the adolescents are no longer comfortable with being dictated to. They move away from complete obedience to authority and they begin to talk back and question adults' authority. They begin to realize that thoughts are private and they do not have to share their thoughts with people. So they find it convenient to pretend. Due to this transformation they also exhibit what is called "intellectual egocentrism". This is a situation in which "the personal self" is at the center of their thought. As a result they may not separate other people's thought from their own. So they believe that every other person except themselves is focusing on them as if they are constantly on stage. As such they create imaginary audiences for themselves. They become particular about their looks and how they dress. They engage in self-analysis, self-criticism and attention-getting behaviours. As a result of the intellectual egocentrism, they have a personal fable about themselves. This makes them to believe that they are unique and special and their experiences are unique to them, such that no other person can go through what they are experiencing. Due to this uniqueness they believe that nothing bad or unusual can happen to them even though it may happen to others, e.g. they cannot get pregnant, they cannot die from abortion, they cannot be infected with STI/HIV/AIDS – these things are far away and they are immune to them.

Emotional Changes

At the emotional level, the adolescents are emotionally unstable. They go through emotional fluctuations and this affects their behaviour. Sometimes they may feel happy, at other times they may be moody and may not even be able to point to what is responsible for the mood changes. The adolescents may feel powerful emotional surges. Some of the issues of concern to them include their feelings and attitude toward themselves, their peers, family members and other adults. These feelings may be impulsive or sexual in nature and may bring about disapproval from adults if such feelings clash with adult values. These feelings may result in unresolved interpersonal (from the adolescents to the adult) and intra-personal (within the adolescents) conflicts. Another source of concern to the adolescent is how to distinguish between what is normal and what is abnormal. This is borne out of the fact that adolescents harbour the fear of being "different" from their peers. So, they tend to equate being "different" to being abnormal especially when they compare themselves to their peers.

Relationship

Due to the strong need for heterosexual relationship, peer conformity and acceptance, they make friends of the same and opposite sex. Among same sex, they have casual and intimate friends. They also form friends with members of the opposite sex but such friendship is based on self-definition and self-interest. For instance, a girl may decide to go out with a boy because he is the most popular guy in her school or neighbourhood. Such friendships often do not last; they are short lived.

The need for conformity, acceptance and self-definition also makes them to behave in ways that conform to peer norms but which may run counter to their previous home training or family values and acceptable behaviour. This is part of the consequences of adolescent egocentrism. The need for heterosexual relationships makes them engage in dating and they may experiment with sexual activities in these relationships.

Interests

In terms of adolescent interests, by mid-adolescence, teenagers are concerned about achieving psychological independence from their parents in the form of freedom to be their own person, to determine their own values, plan their own future, choose their clothes, companions, friends and past times. They feel that at this time they are qualified to run their own lives and be treated as adults. They experience ambivalent feelings and they alternate between mature and childish behaviour.

Heterosexual interests are the most significant interpersonal relationships that emerge in adolescence. Some of the factors that contribute to this interest include:

- Hormonal changes that accompany puberty. These changes produce sexual feelings that motivate boys and girls to seek each other's company.
- Teenagers see heterosexual relationships as part of being grown up.
- Parents and peers expect teenagers to be interested in the opposite sex or else something is assumed to be wrong.
- The need to form a clear and consistent self-image.

Generally adolescents tend to have superficial tastes and preferences and as such they engage in shallow and short-lived relationships.

SEXUAL AND SOCIAL BEHAVIOUR OF ADOLESCENTS

The adolescent is typified by great energy and engages in several social relationships and activities. The adolescent also has growing interest in sexual issues, and a significant proportion of them actually engage in sexual intercourse, sometimes with grave consequences such as sexually transmitted infections and unwanted pregnancy.

Social Behaviour

At the social level, due to their high need for acceptance and feeling of belonging, adolescents prefer to congregate to do things. They organize parties and social sessions for themselves. They may also segregate into groups such as cliques, gangs and secret societies. They tend to hang out together, exchange ideas and thoughts, compare notes about their lives, and engage in experimentation. Such experimentation may include: sporting activities (such as football, basketball, billiard, gambling), listening to music and dancing. Sometimes the experimentation will be in the realm of risky behavior such as cigarette smoking, drinking of alcohols, using psychoactive drugs, and sexual engagements. The adolescents in groups tend to stick together as a means of having an identity, self-definition and sense of belonging. It is the transformation of their body and mentality that predispose the adolescents to these various forms of social behaviour. If, however, they experience a strong feeling of being misunderstood either by peers or adults or both, conflicts can easily occur, and failure to resolve such may drive them into delinquent and truant behaviours.

Dating

The adolescents explore dating as a dimension of social activities, and sometime as a fore-runner of sexual relationships. Technically, asking for or accepting a date is a means of getting to know another person of the opposite sex, sharing friendship and enjoying companionship. Some young people however feel that a date is equal to being a "girlfriend" and a "boyfriend" and starting an exclusive relationship similar to "going steady", which also many times embraces the idea of sexual activities. The adolescents need to be assisted to realize that they are not yet capable of such steady relationships because of their immature status and emotional instability, which make them incapable of giving commitment in relationships. They therefore need to be informed, that starting sexual relationship is not ideal for them.

Sexual Behaviour

The desire to be regarded as the "macho man" makes boys to start having sex early and to indulge in risky sexual behaviour. Most girls are coerced into having sex by adolescent boyfriends that want to prove their masculinity. Others are lured into sexual intercourse with presents, gifts and money by older men ("sugar daddies"). "Sugar mummies" also lure adolescent boys into sexual intercourse with money or gifts. At the time of first sexual intercourse most adolescents lack knowledge about sexuality and reproduction and first sex is often through experimentation in which case the parties involved are not really prepared for it. Adolescent girls may lack the power, confidence and skills to refuse sex or negotiate safer sex especially when the partner is a much older person. For many young girls, therefore, sex is not voluntary. They are products of being pressured by older men in exchange for financial rewards, and coerced by their opposite sex peers using sense of belonging as the bait.

ADOLESCENTS' LIFE STYLE

By examining the patterns of behaviour of the adolescent group, a pattern of life style or what can be called a culture (the "youth culture") stands out. This lifestyle is demonstrated in their way of doing things. For instance, they have a language peculiar to the group, which they use to communicate and interact with each other and understand one another.

They have a frequently changing way of dressing which serves as identification with the group and which may not be acceptable to adults, such as "sagging" of trousers or, in the case of females, wearing micro-mini skirts, topless and tight-fitting blouses that will show their body contour. The youth culture also manifests itself in their make-up, hair styles and other appearances.

The youth culture also exhibits itself in their nutritional behavior – what they prefer or crave to eat seems to be peculiar to them. For instance, many adolescents are fond of patronizing fast food centers and eating junk food rather than eating regular meals and home-cooked foods.

SUMMARY

Adolescence is a period of physical, cognitive and emotional transformation. These transformations, which are largely hormone-driven, have relationships with adolescents' peculiar ways of thinking and doing things. Adolescents' social behavior and sexuality need to be understood within the context of these transformations.

EVALUATION

- List the physical changes that occur in both male and female adolescents.
- Describe the emotional characteristics of adolescence.
- Explain the cognitive changes in adolescents and its possible influence on their behaviour.

MODULE ONE: SESSION 3

FACTORS ASSOCIATED WITH ADOLESCENT HEALTH STATUS AND KEY ISSUES IN PROGRAMMING FOR ADOLESCENT HEALTH AND DEVELOPMENT

TIME: 1 hour 30 minutes

LEARNERS' OBJECTIVES:

At the end of the session, participants will be able to:

- Explain some key factors that affect adolescent development.
- Describe the comprehensive approach to adolescent health and development.
- Identify possible interventions to reduce or eliminate the negative factors.

SESSION OVERVIEW

Explanation and discussion of the following:

- Pre- natal/ genetic factors
- Nutrition
- Social environment – Family life - Traditional practices
- Non-availability of appropriate services/ programmes
- Policies or lack thereof
- Framework for programming for adolescent health and development (AHD)

METHODS

- Brainstorming
- Discussion/lecture
- Group work

MATERIALS

- Flip chart stand and papers
- Markers
- Paper tape
- Cardboard/flipcharts
- Scissors
- PowerPoint slides
- Computer and projector

CONTENT

FACTORS AFFECTING ADOLESCENT DEVELOPMENT

Prenatal/Genetic Factors

The health of adolescents is sometimes determined by conditions and situations that occurred before their conception or while in the womb. These pre-natal factors can be genetic as in the case of sickle cell anaemia or result from conditions during the pregnancy/delivery such as peri-natal asphyxia or infections of the central nervous system leading to brain damage, visual or hearing defects.

Nutrition

The nutritional status of a pregnant woman affects the health of her baby. When adolescents become pregnant especially when they are unmarried, their ability to get resources to take care of themselves is limited. They often give birth to babies with low birth weights. When babies do not in turn receive adequate nutrition, their physical and mental growth is compromised. As the children grow into adolescence, their normal growth and development may be adversely affected by inadequate nutrition, inappropriate and untimely physical stresses, including pregnancy before full maturity. The combination of the energy demands of the growth spurt, excessive physical work, and inadequate diet contributes to poor growth and development of many adolescent girls especially those from low socio- economic background. Adolescent girls require 10% more iron than boys to make up for losses in menstrual blood.

Food preferences and habits established during childhood and adolescence contribute to obesity and hypertension in adulthood. Excessive dieting/ skipping of meals also affect concentration leading to poor performance at school. Adolescents may experience other psychological-related nutritional problems including anorexia and bulimia, which have implications for their overall health, well-being and development.

Social Environment

The home environment has implication on the health and development of young people. Many research findings have clearly demonstrated that adolescents who have strong emotional attachment to their parents and teachers are far less likely to engage in health-risk behaviours such as use of drugs and alcohol, engagement in violence, and early commencement of sexual intercourse. It is important therefore that parents and government should ensure that every child has the right environment to grow. The issues of self-image and self-worth or self-concept have a lot to do with how they were socialized through play, leisure etc. Sex and gender roles are also learnt long before individuals become adolescents. Child abuse also occurs when a parent or caretaker knowingly misuses the privileged position of a caretaker to commit acts not in tune with societal norms and detrimental to the child's well-being. Every child has the right to: live; acquire a name and nationality; enjoy parental care; eat properly and receive medical care; education; religion; leisure; culture and be protected from all kinds of harm. When these rights are not upheld, the child and subsequently the adolescent is negatively affected physically, mentally, spiritually and socially.

A number of other factors in the home environment also have implications for the development of the adolescent. These include the type of friends that adolescents closely associate with, the neighbourhood where they live, who their sexual partners are, and their attachment to religious groups.

School Environment

Schools and schooling have significant implications for the health and development of young people. Schools generally produce a number of positive effects, including improving knowledge and understanding of young people on health issues, provide a platform for interaction with peers, enable young people to be mentored by older people including older students and teachers, and improve their access to health services through school-based or school-linked health care services among others. On the other hand, schools can impact negatively on the health and well-being of young people. Factors such as abusive teachers, high prevalence of bullying among the students and negative peer pressure may impact negatively on sexual and reproductive health status of young people.

Traditional Practices and Gender

Our traditional, cultural and religious beliefs, attitudes and norms affect the health and development of adolescents. While some of these traditions are positive, for example, sexual abstinence till marriage and respect for more elderly people, others are negative and have tendencies to impact on the health and well-being of adolescents negatively. One such negative traditional practice is that of son-preference, which often leads to curtailment of educational, nutritional and economic opportunities for girls. This situation illustrates the differences in how males and females are treated in the society. Female genital mutilation is another example of traditional practices that affects the physical and mental health of girls and women.

Gender issues are also pervasive in our environment. The burden of productive work in society is mostly on the women who are often unpaid for work involving childcare, food preparation, and home care. Increasingly, many females have to combine these heavy family and household non-stipendiary responsibilities, while they also earn a living through productive work that is stressful and underpaid.

Policies

Policy is the end result of a process during which governments and other institutions first recognize that a particular need or problem exists and then state their intention to do something about it. These expressions of general concern and the guidelines for action that follow are the essence of policy. Policies declare governments or a country's intentions; the documents provide a guide as to what needs to be done. As such, policy can provide a platform for action. Appropriate policies can therefore facilitate healthy development of adolescents and vice versa. Policies with implications for adolescent health include those on: affordable or free health care for young people; provision of youth friendly services; banning of cigarette smoking; restricting of sales of alcohol and tobacco to underage; and, prescription of a minimum age for driving.**Availability of appropriate services**

Availability of appropriate services can enhance the development of young people by providing them with accurate knowledge, counselling, health and other social care. Services addressing the needs of young people can be made available through various channels, including the school (e.g. Family Life and HIV Education), mass media (e.g. enter-educative programmes on adolescent reproductive health issues), health facilities (e.g. youth

friendly health centres), community-based programmes (e.g. mentoring programme for young people at community level), workplaces (e.g. workplace-based HIV prevention programmes), and youth development centres (e.g. skills development activities). As such, the services that will meet the health and development needs of young people can be made available through various sectors which entail multi sectoral approach with strong intersectoral collaborations . Different sectors are best suited to meet different needs of young people.

RISK AND PROTECTIVE FACTORS

Research and experiences globally have shown that it is not only important to identify risk factors in addressing the health and development of adolescents and other young people, but also to identify and strengthen protective factors. Risk and protective factors exist at various levels: individual (personal), family; inter-personal relationship, school, community and national level. The various factors that have been described above can serve as risk or protective factors with regards to adolescent health development. Different factors may be associated with a number of risky behaviours (Table 1.3).

- **Protective factors**: Factors are regarded as "protective" if they increase the likelihood of positive health behaviour or moderate and discourage behaviours that might lead to negative health outcomes. Strong connectedness between an adolescent and his parents, for example, is a protective factor.

- **Risk Factors:** Factors are regarded as "risk" if they increase the likelihood of negative behaviours and outcomes or discourage positive behaviours that might prevent them.

Table 1.4: Risk and Protective Factors Affecting the Adolescent Health Status

Risk or protective factors for adolescents	Early Sex	Substance Use	Depression
A positive relationship with parents	●	●	●
Conflict in the family		▲	▲
A positive school environment	●	●	●
Friends who are negative role models	▲	▲	
Positive relationship with adults in the community			●
Having spiritual beliefs	●	●	●
Engaging in other risky behaviours	▲		

Sources: WHO, 2001.

The green balls represents protective factors ● The red triangle represents the risk factors ▲

KEY ISSUES IN ADDRESSING ADOLESCENT HEALTH CHALLENGES

The framework for programming for adolescent health and development highlights key issues relating to addressing adolescent health issues from a public health perspective.

GUIDING CONCEPTS

Efforts to address adolescent health challenges must recognise that:

- Adolescence is a time of opportunity and risk.
- Not all adolescents are equally vulnerable.
- Adolescent development underlies the prevention of health problems.
- Adolescent problems often have common roots and are often inter-related.
- Social environment influences adolescent behaviour.
- Gender considerations are fundamental.

MAJOR INTERVENTIONS

The following categories define the major programmatic approaches that are important to address adolescent health issues:

- Create safe and supportive environment
- Provide information
- Build Skills
- Provide Counselling
- Improve health services

SETTINGS

Adolescent health interventions can be implemented in virtually all settings where young people can be found. These include community settings and streets in neighbourhoods, homes, schools, health facilities, work places, media and entertainment settings and the political and legislative systems.

KEY PLAYERS

Various stakeholders can bring their knowledge and skills to bear positively on adolescent health development and programmes.

- Family and Social environment: Family members, friends, religious leaders.
- Health care environment: formal health care workers such as doctors and nurses as well as lay and informal health workers including lay counsellors and other community resources.
- School and work places: Teachers, other school staff, employers, other employees.
- Entertainment industry and media: Journalists, actors, musicians.
- Political and legal systems: politicians and lawmakers, lawyers and officers of the judiciary system, police.
- Youth development and sport sectors: youth workers, vocational counsellors, sport figures.

SUMMARY

Factors that may affect the health and development of adolescents include genetic/prenatal conditions, nutritional factors, the social and school environments, health services and specific policies. Broadly, and depending on factor, the presence or absence of these factors can be health-enhancing (protective factors) or health-threats (risk factors). It is important to address adolescent health issues through effective interventions; these demand effective programming taking into consideration issues such as the broad guiding concept for AHD programming, specific types of intervention, possible setting, and key players.

EVALUATION

- Explain the concept of protective and risk factors.
- Discuss factors that can affect adolescent health and development.
- Describe some of the issues that should be considered in programming for adolescent health and development.

MODULE TWO
SEXUALITY, SEXUAL BEHAVIOUR & SEXUALLY TRANSMITTED INFECTIONS

This module examines issues of sexuality and sexual behaviour among adolescents as well as consequences of sexual behaviour in terms of HIV and other sexually transmitted infections.

SESSION 1: PATTERNS OF ADOLESCENT SEXUAL BEHAVIOUR

SESSION 2: SEXUAL DYSFUNCTION

SESSION 3: HIV AND AIDS

SESSION 4: OTHER SEXUALLY TRANSMITTED INFECTIONS (STIS)

MODULE TWO: SEXUALITY, SEXUAL BEHAVIOUR & SEXUALLY TRANSMITTED INFECTIONS SUMMARY AND TIMING ESTIMATE

SESSION	DURATION	OBJECTIVES	METHODS	RESOURCES
Patterns of Human Sexual Behaviour	1Hour. 45 Minutes	• Define sexual orientation. • Explain the various patterns of human sexual behaviour. • Associate the different patterns with sexual and reproductive rights provisions. • Explain the implications of the various patterns of human sexual behaviour on health and human rights.	Games Discussion Brainstorming Lecture	Flipchart Stand/paper Chalkboard/chalk Markers
Sexual Dysfunction	45 Minutes	• Identify the stages in the human sexual response cycle. • Define sexual dysfunctions. • Explain the types of sexual dysfunction's in men and women. • List the causes of sexual dysfunction. • Identify support services.	Discussion Experience sharing Lecture	Flip chart Stand/Paper Chalkboard/chalk VCR TV Video tapes
HIV and AIDS	1 Hour 30 Minutes	• Differentiate between HIV and AIDS. • State the mode of transmission of HIV. • List some of the signs and symptoms of AIDS. • Discuss how HIV/AIDs can be prevented. • Explain factors enhancing the transmission of HIV/AIDS.	Brainstorming Discussion Drama and role plays Lecture Plenary	Flip chart stand/Paper Markers Board/Chalks Posters Video cassettes VCR TV OHP Transparencies
Other Sexually Transmitted Infections	1 Hour 30 Minutes	• Explain what is meant by sexually transmitted infection. • List six common STIs. • State major signs and symptoms of STIs. • Discuss the consequences of not treating STIs. • Explain ways of preventing STIs.	Brainstorming Discussion Lecture Plenary	Flipchart stand /paper Markers Board/chalks Posters Video cassettes VCR TV/OHP Transparencies

MODULE TWO: SESSION 1
SEXUAL BEHAVIOUR AMONG ADOLESCENTS

TIME: 1Hour 45 Minutes

LEARNERS' OBJECTIVES:

At the end of this session, participants will be able to:

- Define the patterns of sexual orientation.
- Explain the various patterns of human sexual behaviour.
- Associate the different patterns with sexual and reproductive rights provisions.
- Explain the implications of various patterns of human sexual behaviour on health and human rights.

SESSION OVERVIEW:

- Define human sexual orientation
- Various patterns of human sexual behaviour
- Provisions of reproductive and sexual rights
- Health and Human rights implications

METHODS

- Brain storming
- Lecture
- Experience sharing
- Game

MATERIALS

- Flip Chart Stand/Papers
- Chalk Board/Chalk
- Markers
- Diamond game
- Projector
- Videos and films
- Computer
- Flipcharts

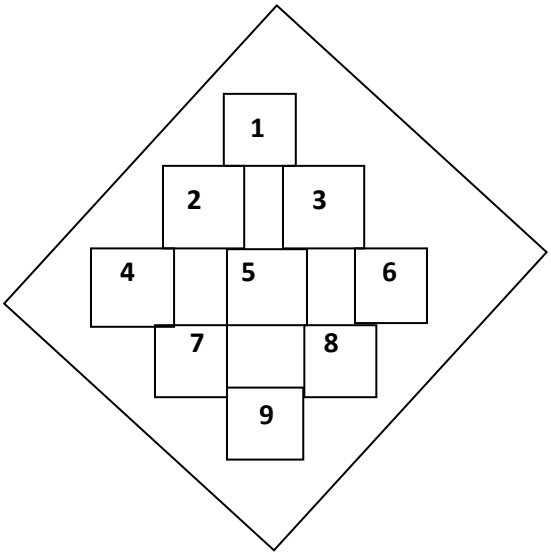
CONTENT

GAME: DIAMOND NINE GAME

Please write a step-by-step detailed instruction about the exercise.

- Write out a set of nine patterns of sexual behaviour, each boldly written on a piece of paper.
- Participants should be divided into groups.
- Each group should be given a set of nine pieces of paper with patterns of sexual behaviour inscribed on them.
- Ask participants to arrange the patterns in order of acceptance to them as a group with the most acceptable topping the list.
- The patterns on pieces of paper should be arranged in a diamond form as follows:

Figure 2.1



- Participants should nominate a member of their group to present their work giving reasons why they found the pattern most acceptable or less or least.

HUMAN SEXUAL ORIENTATION

Sexual Orientation is one's preference for a particular form of sexual expression.

COMMON TYPES OF SEXUAL ORIENTATION

Celibacy

This is the deliberate abstention from sexual activity. This choice is made as a result of various personal reasons not due to any impairment in the reproductive anatomy and physiology of the person. Celibacy could be a permanent or temporary choice.

Heterosexuality

This is the preference to share emotions and sexual feelings with members of the opposite sex. Heterosexuals are often referred to as "**straight"**. A person has a right to choose to be heterosexual.

Homosexuality

This is the preference to share emotions and sexual feelings with members of the same sex. They are sometimes also referred to as **"queers"**. This refers to both men and women. Female homosexuals are called **"lesbians"** while male homosexuals are called **"gays"**. Sexual rights provide for individuals to adopt a sexual orientation of their choice. Where the choice is imposed on a partner, or the relationship is not consensual, then there is violation of rights. Consent is nullified by coercion e.g., bribe, threats, pressure and persuasion.

Bisexuality

This refers to enjoying emotions and sexual feelings with partners of both sexes.

Autoeroticism

This means deriving sexual pleasure from masturbation and fantasy, not requiring the participation of another person.

Asexual

This means having little or no sexual pleasure at all. Though asexual people are physically and psychologically male or female, neither sex stimulates them sexually. They have no desire for sex.

PATTERNS OF HUMAN SEXUAL BEHAVIOUR

The patterns of human sexual behaviour are diverse ways in which humans express their sexuality. Whereas an individual may be able to achieve orgasm only through a particular variation or has a preference for that manner of sexual arousal that does not necessarily mean that they engage in such behaviour or do so often.

- **Oral sex**: this is contact between mouth and vulva, vagina, clitoris, etc, or mouth- to- penis contact.
- **Masturbation:** manual manipulation of one's genitals. Mutual masturbation is two people doing this reciprocally.
- **Sodomy**: anal intercourse. It may be with same gender or partners of opposite sex.
- **Satyriasis:** this is excessive sexual desire in a man.
- **Nymphomania**: excessive sexual desire in a woman.
- **Sado-masochism**: deriving sexual pleasure by hurting/being hurt by another person. This orientation has attracted a lot of debate. In some countries, this practice is condoned for as long as there is no bodily injury resulting from it.

- **Transvestism**: usually a heterosexual, not a homosexual, man who derives pleasure from wearing women's clothes.

- **Drag queen:** usually a male homosexual who dresses flamboyantly in exaggerated imitation of a woman.

- **Voyeurism**: deriving sexual excitement from observing others undressing, making love, kissing, masturbating, petting, etc. Sometimes voyeurs are called "peeping Toms".

- **Exhibitionism**: deriving sexual excitement from showing off or flashing one's sexual parts for others to see.

- **Fetishism**: using objects on erotic parts of one's body for sexual pleasure.

- **Transsexual:** person of a biological sex, usually a man, who believes himself to be member of the other sex trapped in the wrong body. Sometimes this creates so much psychological dissonance for the person that he or she will seek an operation to make his body look more like that of the opposite sex. After the operation, they are called "transgender".

- **Frotteurosexuality:** preferring sexual pleasure gained by rubbing one's genitals against another person.

- **Gerontosexual:** preferring intercourse with an old man or woman.

- **Bestiality**: deriving sexual pleasure from intercourse with animals.

- **Necrophilia:** deriving sexual pleasure from intercourse with a dead person.

- **Incest:** sexual intercourse between blood-related family members

- **Rape**: forced sex, where the partner has not given consent. Consent is violated where there is threat, cajoling, physical force, bribe, etc.

Participants should be encouraged to discuss their views on this subject. However, the amount of time spent on this subject should depend on its relevance to the adolescent community served by the participants. The counsellor needs to be an able and sympathetic listener to any such problem, and it is precisely the more unusual ones which are likely to have been kept secret, and for which the adolescent may be in the greatest need of help.

PROVISIONS OF SEXUAL/REPRODUCTIVE RIGHTS ON SEXUAL ORIENTATION

Sexual and reproductive rights provide for an individual to have a right to:

- Happiness, dreams and fantasies,
- Explore his/her sexuality without fear, guilt, and other obstacles to free expression of desire,

- Live a life that is free of violence, discrimination, and without hindrance to relationships based on equality, respect and justice,
- Choose his/her sexual partner without discrimination,
- Respect of his/her bodily integrity,
- Choose to be sexually active or not, to have sexual relations that are consensual, and to get married of their own free will,
- Be free and independent in the expression of the sexual orientation of his/her choice,
- Express his/her sexuality free of procreation,
- Insist on, and express his/her sexuality without risk in order to prevent undesired pregnancies and sexually transmitted infections including HIV/AIDS,
- Sexual health which involves access to sexuality information / education and services of the best possible quality, and confidentiality.

HEALTH AND HUMAN RIGHTS IMPLICATION

While educating young people on health and human rights implications of the various patterns of human sexual behaviour, the following information should be included:

- Health implications are high where there is a partner involved in multiple sexual activities.
- 80% of HIV transmission in Nigeria is as a result of unprotected heterosexual activity.
- Homosexuals stand a higher risk of contracting HIV/AIDS than heterosexuals.
- Celibacy, which implies abstinence from sexual activity altogether, and autoeroticism, which is masturbation without the involvement of another person, are the only behaviours that do not expose the individual to STIs and HIV/AIDS. They do not infringe on other peoples' rights except if the person opting for these choices is married and does not involve the partner to get his/her consent.
- The other patterns could constitute human rights violations if the partner does not give his/her consent (coercion annuls consent).

Adolescents should be given skills and access to information and services that enable them to protect themselves.

SUMMARY

The knowledge of the different patterns of human sexual behaviour will help prepare the counsellors for the individual differences that exist in the exhibition of their sexual orientation. This will also enable them not to be judgemental in their relationship with their counsellors.

EVALUATION

- Define human sexual orientation.
- List 7 patterns of human sexual behaviour.
- Explain the implications of various patterns of human sexual behaviour on health.

MODULE TWO: SESSION 2
SEXUAL DYSFUNCTIONS

TIME: 45 Minutes

LEARNERS' OBJECTIVES

At the end of this session, participants will be able to:

- Define sexual dysfunctions.
- Explain the stages in the human sexual response cycle.
- Explain types of sexual dysfunctions in men and women.
- List the causes of sexual dysfunction.
- Mention referral opportunities.

SESSION OVERVIEW

- Definition and types of sexual dysfunction
- Stages of human sexual response cycle
- Causes of sexual dysfunction
- Available interventions

METHODS

- Discussion
- Experience sharing
- Mini-Lecture
- Video presentation

MATERIALS

- Flip chart stand/paper
- Chalk board/chalk
- Markers
- Masking Tape
- Video (Human Sexual Response Action Health Incorporated Library)
- VCR/TV/audio visuals

CONTENT

DEFINITION OF SEXUAL DYSFUNCTION

Sexual Dysfunction is defined as the repeated inability to experience the various stages in the human sexual response cycle after appropriate stimulation. Young people also experience sexual dysfunction.

COMMON TYPES OF SEXUAL DYSFUNCTIONS IN MALE AND FEMALE

Table 2.1: Common Types of Sexual Dysfunctions in Male and Female

MEN	WOMEN
Erectile dysfunction/Impotence: This is the failure to develop or maintain an erection. It is stated that every man will experience impotence at least once in his lifetime. Impotence could be temporal or permanent. **Premature ejaculation**: This is very quick ejaculation, faster than can be explained by the human sexual response cycle usually uncontrollable by the person. **Retarded ejaculation**: This is prolonged period between excitement and climax resulting in late orgasm. **Priapism**: This is painful, purposeless, prolonged, penile erection. It is common among people with sickle cell anaemia and requires special management.	**Vaginismus**: Refers to an involuntary spasm /contraction of the muscles of the vaginal wall that interferes with intercourse by making sexual penetration difficult. **Dyspareunia**: This is painful intercourse. **Anorgasmia**: This refers to the lack of interest in sexual activity. It is often referred to as "frigidity". This term has often been used in a derogatory manner, and that is why we use the medical term, anorgasmia.

THE HUMAN RESPONSE CYCLE

There are four recognised phases of the human physiological response to sexual arousal. These are:

- Excitement phase
- Plateau Phase
- Orgasmic Phase
- Resolution Phase

Below is a table of specific reactions of both female and male in each of the phases.

Table 2.2: EXCITEMENT PHASE (Arousal Phase)

FEMALE	MALE
Response is aroused by tactile, visual or psychic stimuli and will result in: • Vaginal lubrication called by Masters and Johnson as the "Sweating reaction of the vagina sweating" • Swelling of the glands of the clitoris • Increase and enlargement of Nipples • Increased muscle tone	Response is usually aroused by tactile, visual or psychic stimuli. These stimuli usually will result in: • Enlargement and erection of the penis • Increase in penile size and angle of protrusion from the body • Increased muscle tone. Shortening of Spermatic cord and retraction of the testes • Thickening of scrotum

Table 2.3: PLATEAU PHASE

FEMALE	MALE
• Enlargement of the labia • Increase in blood pressure,breathing and pulse rate	• Erection continues. • Increased testicular muscles • Increased pulse rate,blood pressure and breathing rate

Table 2.4: ORGASMIC PHASE

FEMALE	MALE
• It is the climax of the sexual response cycle. • Series of rhythmic muscular contractions • Increase in pulse rate • Generalised muscle tension • Orgasms	• It is the climax of the sexual response cycle. • Contraction of the prostate • Expulsion of fluids • Rhythmic contractions • Ejaculation • Uncontrollable behaviour • Orgasm

Table 2.5: RESOLUTION PHASE

FEMALE	MALE
• Released muscular tension • Subsided enlargement and muscle relaxation • At this phase the body slowly returns to its normal state .	• Loss of erection • Refractory period for hours or days

COMMON CAUSES OF SEXUAL DYSFUNCTION

Sexual dysfunction can be caused by:

- Fear e.g. of being caught or getting pregnant
- Guilt e.g. in a situation where personal values are conflicting with the choice to have sex.
- Anger
- Anxiety e.g. financial problems, work difficulties
- Relationship difficulties
- Medical problems e.g. diabetes mellitus, spinal cord injury
- Stress e.g. emotional, physical and work related stress
- Drugs/Effects of medication e.g. Anti-hypertensives

AVAILABLE INTERVENTIONS

It is important to understand that most sexual dysfunctions can be treated successfully if managed on time by the appropriate professionals. Sometimes, management requires a multidisciplinary approach:

- Clinics and health centres for medical support and attention including drugs.
- Trained health care providers working in Youth Friendly centres can provide appropriate counselling.
- Complex situation will need referral to sex therapist, gynaecologist, urologist and psychiatrist.

SUMMARY

The understanding of the human sexual response cycle is needed to help counsel the young people when there is a problem of sexual dysfunction.

EVALUATION

- Mention and explain the common types of sexual dysfunction.
- Mention the four stages of Human Sexual response cycle.

MODULE TWO: SESSION 3
HIV/AIDS

TIME: 1 Hour 30 Minutes

LEARNERS' OBJECTIVES

At the end of the session, participants will be able to:

- Explain what AIDS is, the cause of AIDS and the difference between being HIV positive and having AIDS.
- List the modes of transmission.
- List some of the symptoms and signs of AIDS or the diseases seen in people living with AIDS (PLWA).
- List ways of preventing AIDS.
- Explain the factors enhancing the transmission of HIV.

SESSION OVERVIEW

- Introduction
- Relationship between HIV infection and AIDS
- Transmission of HIV
- Myths on HIV transmission
- Symptoms and signs of AIDS
- Care and support of people living with AIDS
- Prevention

METHODS

- Brainstorming
- Discussion
- Lecture

MATERIALS

- Flip charts and markers
- Film on STI/HIV/AIDS
- Leaflets on STIs and AIDS
- VCR/TV
- Slides/Transparencies
- Overhead Projector (OHP)
- Computer
- Cartoon materials on condoms

CONTENT

INTRODUCTION

AIDS is an acronym for Acquired Immune Deficiency Syndrome (AIDS). It is a viral disease caused by the Human Immuno-deficiency Virus, (HIV). When AIDS emerged two decades ago, few people could predict how the epidemic would evolve, and fewer still could describe with any certainty the best ways of combating it. In the new millennium, we are past the stage of conjecture. We know from experience that AIDS can devastate whole regions, knock out decades of national development, widen the gulf between rich and poor nations and push already stigmatised groups closer to the margins of the society.

The UNAIDS/WHO statistics show that there are over 33.3 million people living with the virus all over the world with 2.6 million people newly infected in 2009 alone with children less than 15 years comprising about 18.5 percent of them. In 2009 alone, 1.8 million people died of AIDS. An estimated 1.9 million people were newly infected with HIV in sub-Saharan Africa in 2007. In total, 22 million people are living with HIV in the region, which is two thirds (67%) of the global population of people with HIV. The epidemic is stabilizing in Africa, while the HIV Prevalence is falling in some countries.

In Nigeria, although the 2007 NARHS, which has HIV testing integrated into the population-based survey, reported HIV prevalence of 3.6 percent among the general population, the 2008 sentinel survey among pregnant women reported a prevalence of 4.6 percent, with approximately three million people estimated to be living with HIV/AIDS. The prevalence was lowest in Ekiti State with 1.0 percent and highest in Benue State with 10.6 percent while seventeen states and Abuja had a prevalence of 5 percent or above. Among the general population, young people, particularly females, constitute an important vulnerable group in terms of HIV risk.

WHY SHOULD YOUTH BE TARGETED FOR HIV INTERVENTIONS?

- Young people constitute about a third of the population and as a result of risky sexual behaviour they stand at a high risk of death from HIV/AIDS.
- The HIV infections among youths in the past decade gave a frightening indication of the rapidity of transmission currently occurring in this age group.
- Young people particularly women are biologically and socially vulnerable to the epidemic.
- Young people have limited access to youth friendly health services, counselling, or family planning.
- If HIV prevention in the large young population fails, Nigeria will have to face the staggering cost of vast numbers of adults with AIDS.
- Young people are a force for change and with support from adults and society at large; they can change the course of the epidemic.
- Youth represent the nation's future and the development of Nigeria rests in their hands.

WHAT IS AIDS?

AIDS is a syndrome in which the body's defence system against diseases is gradually and progressively destroyed. Such a person develops deadly illnesses that healthy people fight off with no problem. AIDS has no cure.

WHAT CAUSES AIDS?

AIDS is caused by the Human Immunodeficiency Virus (HIV). This virus destroys an important component of the immune system called the white blood cells (T-lymphocytes), which are produced in certain parts of the body and are found in the blood.

RELATIONSHIP BETWEEN HIV INFECTION AND AIDS

HIV infection may eventually lead to AIDS if not properly managed. A special blood test can detect HIV infection. Any person infected with HIV can look and feel completely healthy for many years while the virus is slowly destroying his or her immune system. During this period that person who is infected but still appears healthy can infect other people. One cannot tell by looking at a person whether he or she is infected with HIV. Once the immune system is destroyed, the person develops "full-blown AIDS''. It is only a person who is infected with HIV that can develop AIDS.

Being infected with the HIV is not the same as having AIDS. The person who is infected with HIV, however, may eventually develop AIDS. AIDS is the last stage of HIV infection when the multiple signs, symptoms, and disorders are clearly showing and the infected person is progressively dying.

TRANSMISSION OF HIV

HIV is spread:

- through unprotected sexual intercourse - vagina, anal, or oral with an infected person.
- through transfusion with infected blood (blood that was not screened).
- through the sharing of needles, razors and other body-piercing objects with an infected person; and
- from an infected mother to her unborn baby before, during or after birth.

Note: One cannot tell by looking at a person whether he or she is infected. Most transmission of HIV in Nigeria is through unprotected sexual intercourse with an infected partner who may appear normal.

MYTHS ON HIV TRANSMISSION

There are many myths about how HIV is transmitted, including the belief that it is spread through:

- Hand shaking
- Talking
- Sharing meals
- Touching, hugging or casual contact
- Coughing and sneezing
- Dishes, Cups and Spoons
- Towels, linen
- Public toilets/public pools
- Phones, Furniture
- Mosquito and insect bite.

Note: The fact is that HIV is not spread through any of the means listed under this sub-section on myths.

Signs and Symptoms of AIDS

Some of the signs and symptoms related to AIDS are:

- Severe weight loss (loss of 10% body weight)
- Chronic diarrhoea lasting for more than one month
- Fever lasting for more than one month
- Constant cough
- Thrush in the throat and mouth
- Swollen glands
- Tiredness all the time
- Easy bruising or unexplained bleeding
- Night sweats
- Changes in hearing, vision, taste, touch, smell
- Memory loss or difficulty in thinking clearly
- Herpes simplex (cold sores) and/or herpes zoster sores (shingles) that keep coming back
- Others are severe pneumonia, tuberculosis, some forms of cancer, some forms of chronic skin ulcers.

It is important to note that many of these signs and symptoms are also signs and symptoms of other illnesses. The only way to determine for sure if somebody has HIV/AIDS is through a blood test.

Care and Support for People Living with HIV/AIDS

Presently, there is no vaccine to prevent AIDS and no cure for AIDS. However, the UNAIDS has made some recommendations concerning care and support for people living with AIDS. These include:

- Voluntary HIV counselling and testing.
- Psychosocial support for HIV-positive people and their families.
- Diagnosis and treatment of opportunistic infections.
- Official recognition and facilitation of community activities that reduce the impact of HIV infection.
- Anti retroviral therapy (if available).

Prevention of HIV/AIDS

Things to do to help prevent the spread of HIV/AIDS:

- Abstinence
- Avoidance of unprotected sex(always use a condom and use it properly)
- Avoidance of intravenous hard drug abuse
- Avoidance of shared needles in intravenous drug use
- Avoidance of used razor, needles and other sharp objects
- Use of fresh needles and syringes for injection by health workers
- Screening of blood before transfusion
- Prevention of Mother-to-Child Transmission (PMTCT)
- Early diagnosis through voluntary screening and effective treatment of STIs.

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV

For many years, not enough was known about HIV transmission from mother to child, so as to take steps that will help HIV infected women have uninfected babies. In the absence of any intervention, about a third of HIV positive mothers pass the virus to their newborn. In the late 1990s, it was found that around half of all these infections occurred during breast-feeding. In recent years, much has been learnt about how to prevent transmission of HIV from infected mothers to their babies.

However, the challenges in developing countries are also greater than in the high-income countries. First, higher rates of HIV and/or childbearing means that prevention programmes has to reach a much larger number of women. Secondly, there are fewer HIV counselling and testing facilities available. Thirdly, breast-feeding is almost universal, and safe alternatives to breast milk are harder to come by. Finally, the drug regimens used in high-income countries for reducing HIV transmission to infants are too expensive and complicated to be practical for wide scale use in poor countries.

In order to overcome the problems of mother-to-child transmission, once a pregnant woman knows she is HIV positive, she should:

- Use anti retroviral regimen for at least a month during pregnancy.
- Be counselled about options for feeding her infant.
- Be encouraged to use condoms for every sexual activity with the sexual partner during the pregnancy.

SUMMARY

HIV/AIDS currently does not have a cure but can be prevented through education and other preventive interventions. Individuals are encouraged to practise abstinence and if sexually active, practise safe sex (consistent and correct use of a condom). However people are encouraged to support and care for PLWHA.

EVALUATION

The following questions will help in evaluating what has been achieved during the session.

- What is AIDS?
- What causes AIDS?
- Can a person with HIV infection who still looks normal and healthy spread the disease?
- What are the signs and symptoms of AIDS or the diseases seen in AIDS patients?
- How is HIV spread?
- How can you prevent the spread of AIDS?
- Can AIDS be cured?

MODULE TWO: SESSION 4
SEXUALLY TRANSMITTED INFECTIONS (STIs)

TIME: 1 Hour 30 Minutes

LEARNERS' OBJECTIVES

At the end of the session participants will be able to:

- Explain what is meant by sexually transmitted infections.
- Name six common STIs.
- List major signs and symptoms of STIs.
- List consequences of improper treatment of STIs.
- Explain ways of preventing STIs.

SESSION OVERVIEW

- Transmission of STIs
- Signs and Symptoms of STIs
- Management of STIs
- Consequences of STIs
- Prevention of STIs

METHODS

- Brainstorming
- Discussion
- Lecture

MATERIALS

- Flip chart stand/paper and markers
- Posters on STIs
- Films on STIs
- Leaflets on STIs
- Transparencies/OHP
- Audio visual aids

CONTENT

INTRODUCTION

This session is designed to help trainees acquire the knowledge to educate adolescents on the transmission and prevention of STIs, signs and symptoms of STIs, the importance of seeking treatment for STIs and safe sex practices.

Sexually Transmitted Infections (STIs) are a group of communicable diseases caused by >30 micro-organisms transmitted from person to person through unprotected sexual intercourse which may be vaginal, oral, or anal. Common STIs include gonorrhoea, syphilis, herpes, chlamydia, trichomoniasis, candidiasis, genital warts and Acquired Immune Deficiency Syndrome (AIDS). STIs are spreading at an alarming rate all over the world. These infections are also on the increase among young people. Early and unprotected sex is the driving force for increased rate of contracting STIs. Globally, WHO estimates that around 340 million new cases of the four main curable STIs (gonorrhoea, chlamydia, syphilis, and trichomoniasis) occur every year. 85% of these new cases occur in low income countries (LIC). Every year, 1 in 20 adolescents contract a bacterial STI, and the age at which infections are acquired is becoming lower.

In Nigeria there are about three million reported annual cases of STIs mainly caused by Chlamydia, Neisseria gonorrhoea and Trichomonas vaginalis. The highest rates of noticeable STIs are usually observed in the 20-24 year age group, followed by the 15-19 and 25-29 age groups respectively. Although data on STIs are not available in the country, 5 percent of women and 3 percent of men in Nigeria, according to NDHS 2008, experienced a sexually transmitted infection and/or genital abnormal discharge or sore within the last 12 months to the survey, with just about half of them who sought advice or treatment from a clinic, hospital, private doctor, or other health professional.

Most STIs are linked with syndromes such as genital discharge, genital ulcer or abdominal pain. STIs can be painful and uncomfortable; they can also have tragic consequences and complications such as pelvic inflammatory diseases, infertility, tubal blockage and cervical cancer in women. In men, it causes urethral stricture and infertility. Some STIs facilitate HIV transmission; genital ulcer disease boosts HIV shedding in the genital tract. *N. Gonorrhoeae, C. Trachomatis, T. Vaginalis* increase HIV in the genital tract.

Having unprotected sex with an infected partner spreads STIs. A person's sexual behaviour may put him/her at risk of acquiring and spreading these infections. High-risk behaviours include having sex with multiple partners or with a partner who has multiple partners and having unprotected sex (without condoms).

WHY STIS ARE IMPORTANT PUBLIC HEALTH ISSUE IN ADOLESCENTS

- Adolescents run the risks of exposure to STIs with young girls being more vulnerable because of inadequate mucosal defence mechanism and immature lining of the cervix.
- The consequences of infection and disease contracted during adolescence are more severe.
- Diagnosis of STIs can be more problematic during adolescence.
- There are many barriers to access for quality care for the adolescents.
- Adolescents are more likely to have a less stable relationship and therefore involved with multiple partners.

- They have more difficulty with using barrier methods.
- They have less access to STI care due to lack of awareness, lack of money or restrictive policies of clinics.
- Female adolescents are at higher risk of STIs because they initiate sex earlier than their male counterparts usually with older partners; and are vulnerable to sexual coercion and abuse.

TRANSMISSION OF STIs

STIs are spread mainly by sexual intercourse (vaginal, anal or oral). STIs are not spread by casual contact. HIV can be passed from an infected woman to her child during pregnancy, birth, or through breast milk.

Table 2.6: Signs and Symptoms of Common STIs

Women	Men	Women and Men
• An unusual vaginal discharge • Burning or itching around the vagina • Bleeding from the vagina (which is not during the menstrual period) • Pain deep inside the vagina when having sex • Lower abdominal pain	• Discharge from the penis	• Sores, bumps, or blisters near the sex organs or mouth • Burning pain when urinating or having sex • Swelling or redness of the throat • Fever, chills, and aches • Swelling in the groin(the areas around the sex organ)

Management of STIs

Most STIs can be cured (although some cannot e.g. Herpes and HIV) if the person gets prompt correct diagnosis and treatment from health workers. Some STIs have symptoms that go away without treatment e.g. early stages of syphilis. If not treated, the germs stay in the body and cause damage to the organs. Some other STIs have no symptoms, particularly in women. Like HIV infection, the person can look and feel healthy but can still infect others and/or unborn babies. HIV is transmitted more easily to a person with genital sores or discharges from an STI.

It is important to be tested if one thinks that he/she has been exposed to an STI. STIs can be diagnosed at a clinic and should be treated as soon as possible. Recognition of infection and early visit to a doctor or other health care providers are important in the treatment and control of STIs. Early treatment will prevent damage to the reproductive organs and the other complications such as urethral stricture and infertility in male and pelvic inflammatory disease or infertility in female.

The 4Cs of good STI management include counselling, compliance with drugs and treatment, consistent and correct condom use and contact treatment.

Partner Notification /Contact treatment

People should tell their sexual partner(s) in the last three months when they have an STI and encourage them to seek medical treatment. The partner may have no symptoms, and may not be aware that he/she is infected.

This person can re-infect the treated partner, and/or pass on the disease to other partners. Also further spread of the infection to others should be avoided.

Counselling

Patient is, educated on the implications of untreated STI, counselled on the need to change from risky behaviour and STI prevention.

Drug Compliance

Clients are encouraged to avoid self medication, ensure that treatment regimen is completed even after abatement of symptoms. They are also encouraged to abstain from sex until treatment is completed and not to share the drugs with partners.

Condom use

Clients are informed of consistent and proper use of the condom. Condom is provided and demonstration of the right manner of its use is shown to the client.

STI control programmes should aim to: (1) reduce the transmission of STIs; (2)reduce the complications associated with STIs; and (3) reduce the transmission of HIV. The main principles of effective STI control are thus to: (i) prevent new infections, through behavioural change communication (BCC), promotion of male and female condoms, and for the future, use of microbicides and STI vaccines; (ii) treat those with symptoms of infection (STI case management), which has greatly been improved in resource-constrained settings by the adoption of the syndromic approach; (iii) identify and treat those without symptoms; and (iv) motivate prompt and appropriate health-seeking behaviour.

Table 2.7: Signs, Symptoms and Consequences of STIs

Infections	Symptoms	Consequences
Gonorrhoea	• Symptoms begin 2-21 days after infection • Discharge from penis or vagina • Pain/burning sensation during urination (difficulty in urinating) • Lower abdominal (pelvic area) pain • Most women have no symptoms	• Damage to reproductive organs • Sterility/Infertility • Eye infection/Blindness in babies of infected mothers • Transmission of infection to sexual partners • Increased risk of ectopic pregnancy

Infections	Symptoms	Consequences
Syphilis	**1st Stage** Symptoms begin 1-12 weeks after infection: • Painless, open sore on the mouth or sex organ; • Sore goes away after 1-5 weeks **2nd Stage** Symptoms begin 1-6 months after sore appears: • Non-itchy rash on the body • Flu-like symptoms **3rd stage** No visible symptoms, but there may be cardiac and neurological damages. Symptoms begin 2-30 years after infection.	• Syphilis can be passed to sexual partners. • It can cause heart disease, brain damage, blindness, and death. • Can be transmitted from a pregnant woman to her unborn child.
Herpes	• Flu-like feelings • Painful blister-like lesions on or around the genitals or in anus or mouth • Itching and burning around the sex organs before the blister appear • Blisters last 1-3 weeks • Blisters disappear but the individual still has herpes and blister may reoccur.	• Recurring outbreaks • There is no cure for herpes.
Chlamydia	Symptoms begin 7-21 days after infection: • Discharge from the sex organs • Burning or pain while urinating • Unusual bleeding from the vagina • Pain in the pelvic area • Most women and some men have no symptoms.	• Can be passed to sexual partners. • It can cause damage to reproductive organs. • It can cause sterility. • It can be transmitted from mother to child during child birth.
Trichomoniasis (Has been severally called 'Toilet disease' in Nigeria)	• Symptoms begin 7-21 days • Increased vaginal discharge • Discharge is frothy- yellowish green in colour • Itching • Pain during urination	• It may cause low birth weight babies. • It may cause premature labour in pregnant women.
Acquired Immune-Deficiency Syndrome (AIDS)	Symptoms begin several months/ years after infection. They include: • Persistent tiredness • Unexplained weight loss of over 10% of body weight • Persistent diarrhoea • Persistent fever • Cough (PTB)	• AIDS has no cure. It is universally fatal without appropriate treatment, which are capable of increasing longevity and improving the quality of life .

PREVENTION OF STIs

- Abstinence from sex
- Avoidance of unprotected sex (Always use condom for penetrative sex and use it consistently and properly)
- Early health-care-seeking behaviour
- Safer sexual behaviour
- Provision of health education

SUMMARY

STIs have fatal consequences but early diagnosis and treatment can prevent this. Early treatment is encouraged while self-medication is discouraged.

EVALUATIONThe following questions will help in evaluating what has been achieved during the session.

- What are the examples of sexually transmitted infections?
- What are the signs and symptoms of STIs?
- How can you prevent STIs?
- What should someone with symptoms of STI do?

MODULE THREE
PREGNANCY, PREGNANCY PREVENTION AND CHILDBEARING AMONG ADOLESCENTS

This module is an overview of pregnancy-related issues among adolescents, including pregnancy prevention, unsafe abortion and care of the pregnant adolescent.

SESSION 1: **PREGNANCY PREVENTION AND CONTRACEPTIVE CHOICES FOR ADOLESCENTS**

SESSION 2: **ADOLESCENT PREGNANCY**

SESSION 3: **ABORTION AND POST ABORTION CARE**

SESSION 4: **CARE OF ADOLESCENT PREGNANCY AND DELIVERY**

MODULE THREE: PREGNANCY, PREGNANCY PREVENTION AND CHILDBEARING AMONG ADOLESCENTS; SUMMARY AND TIMING ESTIMATE

SESSION	DURATION	OBJECTIVES	METHODS	RESOURCES
Pregnancy Prevention and Contraceptive Choices for Adolescents	1 Hour 30 Minutes	• Explain various methods of pregnancy prevention. • Explain sexual abstinence and its advantages for adolescents. • Explain the importance of the knowledge of contraceptives for young people. • Identify the various contraceptives suitable for young people. • Indicate where young people can obtain contraceptives in the community.	Lecture Discussion Demonstration/ Return demonstration Game	Flipchart stand/paper Markers Chalkboard & chalk, Contraceptive Samples, Penal /Eve's Model
Adolescent Pregnancy	1Hour	• Explain adolescent pregnancy and its contributory factors. • Explain the consequences of adolescent pregnancy. • Discuss how to prevent adolescent pregnancy.	Brainstorming Discussion Role play/drama Lecture Plenary	Flipchart stand /paper Markers Posters Chalkboard/chalk Video cassettes VCR TV/OHP/ DVD, Laptop, Powerpoint projector Transparencies
Abortion and Post Abortion Care	1 Hour	• Define abortion . • Discuss the different types of abortion. • Discuss the legal issues regarding abortion. • State the reasons why adolescents have abortion. • Identify and explain the physical, social and emotional effects of abortion. • Explain post abortion care and the need for preventing future reoccurrence.	Brainstorming Discussion Role play/ drama Lecture Plenary	Flipchart stand /paper Markers Posters Video cassettes VCR TV OHP Transparencies
Care of Adolescent Pregnancy and Delivery	2 Hours	• Identify the needs of the pregnant adolescents before and after delivery. • Identify peculiarities in their antenatal care. • Explain precautions to be taken during delivery. • Discuss post delivery concerns of adolescent mothers.	Brainstorming Discussion Role plays/ drama Lecture Plenary	Flipchart stand /paper Markers Board/ Chalks Posters Video cassettes TV & VCR

MODULE THREE: SESSION 1
PREGNANCY PREVENTION AND CONTRACEPTIVE CHOICES FOR ADOLESCENTS

TIME: 1 Hour 30 mins

LEARNERS' OBJECTIVES

At the end of the session the participants will be able to:

- Explain the importance of the knowledge of contraceptives for young people.
- Explain sexual abstinence and its advantages for adolescents.
- Identify the various available contraceptive methods suitable for young people.
- Indicate where young people can obtain contraceptives in the community.

SESSION OVERVIEW

- Introduction
- Importance of knowledge about contraceptives
- Pregnancy prevention and contraceptive methods for young people
- Sources of contraceptives in the community

METHODS

- Lectures
- Discussion
- Demonstration/return demonstration
- Games

MATERIALS

- Flipchart or chalkboard
- Samples of contraceptives
- Family planning chart
- Penal model/Eve's model

CONTENT

INTRODUCTION

It is crucial for adolescents and young people to make responsible and healthy choices in matters related to adolescent reproductive health. In order to do this, they need adequate, accurate information about reproductive health as well as the resources available within their community. This is essential because sexual activity among young people in Nigeria is on the increase. This session should therefore provide information on various options for avoiding unwanted pregnancy among adolescents of which sexual abstinence is key and a viable option. The various contraceptive methods that are appropriate for youths in preventing unwanted pregnancy are also discussed. The session also helps to dispel some common myths and misconceptions on some contraceptive methods and includes information on where youths can receive contraceptives and related services.

IMPORTANCE OF KNOWLEDGE ABOUT CONTRACEPTIVES

Young people need reliable information about contraceptives and where to obtain them in order to protect themselves from STIs, including HIV/AIDS, and unintended pregnancies. Information about contraceptives is important for all young people whether they are abstaining from sex or are sexually active.

PREGNANCY PREVENTION AND CONTRACEPTIVE METHODS FOR YOUNG PEOPLE

SEXUAL ABSTINENCE

This is the process of avoiding sexual intercourse until the adolescent is able to have a fully responsible and emotionally fulfilling relationship. It is an important principle that must be promoted in helping a young person to delay the beginning of sexual intercourse; though not necessarily all forms of physical contact. The young person needs to know the consequences of early sexual intercourse especially in biomedical terms, including pregnancy, STIs, HIV/AIDS and a high risk of developing cervical cancer for girls in later years. Efforts must be made by counsellors to assist young people make a choice including abstinence. Abstinence can be further achieved where the young person is equipped with skills that will enable him/her reduce the pressure and also say 'NO' to sex until he/she is fully ready.

ADVANTAGES OF SEXUAL ABSTINENCE

Sexual abstinence is the surest way of preventing STIs and unwanted pregnancies. In our society where the norm is sexual abstinence, young people practising abstinence are free of guilt of being found to have violated the norm, and fear of the consequences of sexual intercourse. Sexual abstinence could also add to the sense of self-esteem and self-worth.

- **Skills that enhance the ability of a young person to practise sexual abstinence**
  - Being able to talk to the other party
  - Assertiveness
  - Self control
  - A positive vision
  - Shared value

- Partner's cooperation
- Information
- Knowledge of consequences of unwanted, early pregnancy/STIs
- Ability to identify sexual situation that would put them at risk of unwanted sexual intercourse.

CONDOM

A condom is a barrier device commonly used during sexual intercourse to prevent pregnancy, sexually transmitted infections such as syphilis, HIV etc. There are male and female condoms.

MALE CONDOM

The male condom is made up of latex material and is worn over an erect penis like a second skin. It holds the semen released during ejaculation to prevent spilling into the vagina during sexual intercourse. Most rubber condoms are coated with lubricant while some have sperm-killing chemicals in the lubricant. When used correctly and combined with foaming tablets, condoms can be highly effective. There is no contact between the man's sperm and the woman's egg. Condom is the only method of contraception that also protects against Sexually Transmitted Infections (STIs) including HIV/AIDS.

Advantages

- Easily available
- No serious side effects
- Offers dual protection (Protects against STIs/ HIV/AIDS and unwanted pregnancy)
- Non-prescriptive

Disadvantages

- Must be used every time sexual intercourse takes place.
- Some people feel that it reduces sensation and interferes with pleasure.
- Some people may be allergic to the latex in the condom.
- Poor storage can affect quality and effectiveness.

How to use

- Ensure that the condom is properly packaged and check the expiry date.
- Open the condom from the recommended angle.
- Ensure that the penis is erect before putting it on.
- Use a new condom each time you have intercourse.
- Roll the rim of the condom all the way up to the base of the penis. Pinch the tip of the condom as you roll it on. Be sure not to leave any air in the tip of the condom as this might contribute to a tear in the condom.
- The penis should be withdrawn soon after intercourse to avoid the possible spill of semen near the vagina.
- Do not use petroleum jelly on a condom as it can cause deterioration of the rubber.
- Used condom should be properly disposed e.g. wrapped and thrown into the dustbin (Condoms should not be flushed down the toilet as they may cause blockages in the sewage system) to be burnt or buried..

FEMALE CONDOM

The female condom is made of synthetic material and is worn in the vagina. It has an outer fixed ring (rim) and an inner mobile ring. The female condom is impregnated with a spermicidal – non-oxynol-9.

Advantages

- There is no reaction since it is not made with latex rubber.
- Ensures protection against STIs/HIV/AIDS and pregnancy if used correctly.
- It provides an opportunity for women to share the responsibility for condoms with their partners.
- A woman may be able to use female condom if her partner refuses to use a male condom.
- It can be inserted in advance of sexual intercourse so as not to interfere with the moment.

Disadvantages

- Can be noisy during intercourse but adding more lubricant can lessen this problem.
- Some women may not like the process of insertion.
- May have a hole and leak, thus a higher failure rate in preventing pregnancy than non-barrier methods such as the pill.
- Must be used every time sexual intercourse takes place.
- The outer ring or frame is outside the vagina and can make some women feel self-conscious.

How to Use (Demonstrate the process on a pelvic model and allow participants to practice on it.)

- Ensure that the condom is properly packaged.
- Check the expiry date.
- Wash hands before insertion.
- Spread the lubricant evenly by rubbing the sides of the condom together.
- You can stand with legs astride, squat, lie down or put one leg on a stool/chair to ease insertion.
- Collapse the inner ring between the thumb, index and middle finger.
- Separate the labia with the other hand, insert the squeezed ring deep into the vagina with the index and middle fingers until the inner ring with the outer fixed ring hanging out.
- Gently curve the finger towards the front of the vagina to feel the pubic bone, indicating that the condom has been inserted correctly.
- Smoothen the outer ring over the vulva to ensure that the penis goes into the condom and not along side during coitus. After intercourse, turn the condom and pull out gently.

DIAPHRAGM

It is a dome shaped rubber cup that is filled with spermicide and inserted to cover the cervix before sexual intercourse.

Advantages:

- It is a woman-controlled method
- Reduces risk of cervical STIs including gonorrhoea, chlamydia, cervical dysplasia and Pelvic Inflammatory Disease

Disadvantages

- Does not protect against HIV.
- Not a good method for women who do not like to touch their vagina.
- It requires some skill to put the diaphragm on.
- Has to be worn each time you have sex.
- Not an appropriate method for nulliparous youth.

How to use

- Every client needs to be measured to have the correct size to use.
- Apply some spermicidal jelly prior to its insertion.
- Leave on for six hours post sexual intercourse.
- Avoid using any petroleum –based products e.g. Vaseline to lubricate the diaphragm.
- Clean diaphragm with mild soap and water, rinse, dry, and store in a cool dry place for subsequent use.

SPERMICIDE

These are products that contain sperm-killing ingredients (spermicide). They are inserted into the vagina before a woman has sex. They are very effective when used in combination with condoms or diaphragms.

Types

- Aerosol Foams
- Vaginal tablets
- Jellies
- Cream

Advantages

- Easy to use.
- May provide some protectios against STIs.
- Combined with the condom, can be very effective.
- Serves as a lubricant or a moistener for easy penetration of the penis into the vagina.

Disadvantages

- Must be used every time sexual intercourse takes place.
- Some women find them difficult or messy to use.
- May not be that effective when used alone.
- May cause irritation to women with sensitive skin.
- Causes more wetness of the vagina for several hours after intercourse.

- Does not protect against HIV/AIDS

How to use

- Wash hands.
- Maintain appropriate position for insertion.
- Can commence sexual intercourse immediately after insertion of jelly or foam.
- Allow tablets or suppositories to dissolve for a period of 10-30 minutes before having sexual intercourse.
- If you must douche, wait for six hours after sexual intercourse.

PILLS

Pills are tablets containing synthetic hormones; oestrogen and progesterone normally produced by the woman's own body. The pills prevent ovulation so that the ovaries do not release eggs and pregnancy cannot occur. One pill must be taken every day.

Types

- Progesterone Only Pill (POP)
- Combined Oral Contraceptives (COC)
- Emergency Contraceptive pill (ECP)

PROGESTERONE ONLY PILL (POP)

POPs only contain a progestin and are taken daily. They include Overette, Micronor, NOR-QD, Microlut.

Mechanism of Action

- Inhibits ovulation.
- Suppresses ovulation in about 50 cycles.
- Thickens cervical mucus to prevent sperm entry into the upper genital tract.

Advantages

- Decreased menstrual cramps and pain
- Decreased menstrual blood loss

Disadvantages

- Irregular bleeding pattern leading to more days of bleeding.
- Does not protect against STI/HIV/AIDS/Amenorrheoa from long use.
- Delayed fertility.

How to use

Clients need some assessment to eliminate contra -indications to the use of POPs. Once this is done by a trained service provider, client starts the POPs as follows:

- If breast feeding six weeks after childbirth,
- If not breast feeding- immediately or at any time in the first 4 weeks after childbirth,

- Immediately or in the first 7 days after first or second trimester miscarriage or abortion.
- If menstruating any time is reasonable, however, the **5th day** of the cycle is best; then no 'back up 'method will b**e** required.
- Client must follow the instructions provided to increase actual use effectiveness rate.
- Report all complications at the clinic for immediate management.

COMBINED ORAL CONTRACEPTIVE (COC)

These pills contain oestrogen and progesterone. There are two types of pills. One of these has 28 pills i.e. 21 'active pills' which contain hormones followed by 7 placebo pills of different colour that do not contain hormones. The other type has only 21 "active pills".

Mechanisms of Action

- Inhibits ovulation.
- Thickens cervical mucus, making it difficult for sperm to pass through.

Advantages

- Decreased menstrual cramps/pain
- Treatment for menstrual irregularity (heavy menses and dysfunctional uterine bleeding)
- Decreased menstrual flow

Disadvantages

- Does not protect against STI/HIV/AIDS
- Spotting, particularly during the first few cycles
- Nausea and vomiting
- Excessive Weight gain

How to use

The service provider assesses the client to eliminate contra-indications.

- In the absence of contra-indications, the first day of the menstrual bleeding is best. OR
- Any time during the menstrual cycle if not pregnant; but the woman should use a 'back up" method.
- Take 1 tablet at the same time each day.
- Clients should go to the nearest health facilities or hospital emergency in case they experience any of the following signs and symptoms: (Acronym: " ACHES"):
    - **A** – Abdominal pain (severe)
    - **C** – Chest pain (severe or shortness of breath)
    - **H** – Headache (severe)
    - **E** – Eye problems such as blurred vision or loss of vision
    - **S** – Severe leg pain (calf or thigh)

- Encourage follow up visits especially when complications do arise for immediate management.

IMPLANT e.g. Norplant, Jadelle and Implanon

It is a set of small, plastic rods/pellets about the size of a small matchstick, which is inserted under the skin of the woman's upper arm.

Advantages

- Long acting
- Suitable for youth who may have had a child as it is long acting and may help prevent repeated pregnancy
- Easy return to fertility
- Helps to prevent iron deficiency anaemia
- Once inserted, client does not have to remember to use the method every time she has sexual intercourse
- Effective within 24 hours after insertion

Disadvantages

- Insertion and removal require minor surgery
- Menstrual changes such as light spotting or bleeding in between periods
- Amenorrhoea
- Weight gain

EMERGENCY CONTRACEPTION

These are approaches to prevent pregnancy after unprotected sexual intercourse. The approach only reduces the risk of pregnancy but does not cause abortion if pregnancy has already occurred.

Types:

- Emergency Contraceptive Pill (ECP) using COCs
- POPs (Overette 20 plus20)
- CopperT380-A insertion

EMERGENCY CONTRACEPTIVE PILLS (ECPS)

2 large doses of COC with oestrogen and progesterone

This should be taken as soon as possible after an unprotected sexual intercourse. 1st dose is taken within 72 hours after unprotected sexual intercourse, 2nd dose 12 hours later. If vomiting occurs, within 2 hours of taking the 1st dose or 2nd, the client may repeat the dose. To avoid vomiting give antihistamine few minutes before commencing ECPs.

Advantages

- Prevention of pregnancy after forced sexual intercourse
- Creating awareness for the need to use regular contraceptives

Disadvantages

- Next period may be early

- Menstrual irregularities in subsequent cycles
- Nausea
- No protection against STI/HIVAIDS

Instruction to clients

- Take pill as soon as advised.
- If period does not commence within 21 days (or is more than one week late) visit your clinic for examination and pregnancy test.
- Start regular contraceptive as soon as possible.
- Use condom until the chosen contraceptive method is commenced.

OTHER CONTRACEPTIVE METHODS

Other methods of contraception are available, but they are often not recommended for youths who have never had children. These methods include Intra-Uterine Devices (IUD), Injectables (Depo-Provera and Noristerat), Tubal ligation, Vasectomy.

Sources of various contraceptive methods within the society

- Patent medicine store
- Maternity Centers
- Youth friendly centers
- Village health workers/Traditional birth attendants
- Youth Centers
- Hospitals
- Peer Educators
- Family planning clinics (e.g. Planned Parenthood)
- Pharmacy stores

DUAL PROTECTION

Since there is no single method that is 100% effective against pregnancy and in order to avoid unwanted pregnancy and STIs including HIV/AIDS, "dual protection" is recommended. Dual protection refers to the practice of using a method, which is very effective in pregnancy prevention e.g. hormonal contraceptive in combination with another method like condom which provides good protection against STIs and HIV. Also the singular use of condom protects against pregnancy, STIs and HIV/AIDs.

METHODS THAT ARE INEFFECTIVE FOR ADOLESCENTS

Douching

This means washing out of the vagina immediately after having sexual intercourse with the hope of washing out the sperm. This method is not effective because the sperm cannot be completely flushed out.

Rhythm

The idea of this method is that a woman keeps track of her past menstrual cycle and tries to figure out the days when she is least likely to become pregnant (i.e. "Safe" days to have sexual intercourse). This may be ineffective for young people for the following reasons:

- Young girls often do not have regular menstrual periods and do not ovulate regularly, so this method can be highly ineffective.
- Since sperm lives for 3-5 days, it can be easy for women to get pregnant when they think they are safe – even during their menstrual period.
- Lack of knowledge of how to accurately calculate the safe period.
- Some have short cycles such that even when they are menstruating they are not safe.

Withdrawal

Withdrawal involves removing the penis from the vagina before ejaculation takes place. Since a man may produce some semen soon after erection, withdrawal method is ineffective. Seminal fluid introduced outside the vagina can cause pregnancy.

SUMMARY

Majority of youths believe that they can never be pregnant and therefore engage in unprotected sexual intercourse. For them to use contraceptives, they need to have confidential and safe services in a conducive environment.

EVALUATION

- Identify the various available contraceptive methods suitable for young people.
- Indicate where young people can obtain contraceptives in the community.

ACTIVITIES

Contraceptive Methods

Time: 30 Minutes

Preparation:
Obtain samples of condoms, pills and spermicide for display and demonstration.

Steps:
Pose the following situation to participants:
Your friend is sexually active, and you are concerned that she will get pregnant (or he will make his girlfriend pregnant). Your friend has refused to abstain from sexual activity. What else could be done to prevent pregnancy?
Note: The purpose of this question is to determine what the current level of knowledge of participants is concerning contraceptives.

a. List responses on a flipchart, even those that are not really effective methods or are myths or misconceptions.
b. Present a brief lecture covering the three methods of contraception, which are most appropriate for young people – pills, condoms and spermicide e.g. foaming tablets. For each method, the following should be covered: what it is, how it works, advantages and disadvantages. As you talk about each method, pass round samples for participants to examine.
c. Mention that other methods of contraception are available, but these are not recommended for youths and why.
d. Refer back to the responses on the flipchart. Correct any wrong information. For example if withdrawal was mentioned as a method, explain why withdrawal may not be effective.
e. Allow participants to ask questions about each method. Pass round the "Question Box" for anonymous questions.
f. Inform participants of where they can go for further information about contraceptives.

Attitudes about Sex and Contraception

Time: 30 Minutes

STEP 1: Explain that youths often do not use family planning methods because they are reluctant to acknowledge that they are sexually active. They are uncomfortable with planning for sexual intercourse, so each time, "it just happens". This activity will help participants better understand how personal feelings about sex affect an individual's use of contraception.

STEP 2: Distribute a note card to each participant. Ask participants to imagine a male who has just had intercourse for the first time. On the card, write a few sentences describing how you think the person might be feeling. Participants should not sign their names on the card. Collect the cards, and read several aloud. Now ask participants to repeat the exercise for a female who has just had intercourse for the first time. Read some of the cards aloud.

Discussion:

- Were the statements about first intercourse generally positive, negative or mixed? Was it different for boys and for girls?
- What, in your opinion, does a person gain or lose at a first intercourse?
- How might having intercourse change a couple's relationship?
- Which of these attitudes might discourage a person from using contraception the first time he or she has intercourse? Which attitudes might encourage a person to use contraception?

Read the following cases aloud:

Case I: We have been having sexual intercourse fairly regularly for the past 4 months without using contraceptives . Last month, we had a pregnancy scare. Fortunately, the test was negative. A friend asked me why I wasn't using anything to prevent pregnancy. I guess it's just too hard to admit to myself that we are having intercourse. Whenever I feel guilty about what we are doing, I just push it out of my mind.

Case II: Making a decision about whether to have sex or not is not easy. I know I would feel guilty about having sex; my family has strict values about sex. One thing I know for sure is that I'm not ready to be a parent. Last month I got some contraceptives just in case I decided to have sex. Whether I decide to do it or not, at least I know I'll be safe.

Case III: Everyone makes such a big deal about sex. I think about it a lot too and wonder what it will feel like the first time. I'm in a relationship, but right now I would feel guilty about having sex. Our relationship just isn't close enough. So I've decided I'm not going to have sex yet.

Discuss

- What common problem exists in all three cases?
  (Answer: All three individuals feel guilty about having sex.)
- How has each person coped with the problem?

TABLE 3.1: CONTRACEPTIVE METHODS FOR ADOLESCENTS

Method	Description	How to Use	Advantages	Disadvantages
Abstinence	Total avoidance of sexual intercourse.	Application of skills required to make abstinence work. E.g. assertiveness, self control.	Full protection against pregnancy and STIs including HIV/AIDS	Not all can practice it.
Condom	Male condoms are rubber sheaths made of latex or natural membranes.	It is worn on an erect penis before sexual intercourse.	• Protection against STIs, HIV, unwanted pregnancy, • male involvement, inexpensive	• Allergy to rubber, • May decrease sensation, • Some people feel embarrassed purchasing it.
Female condom	It is made up of polyurethane materials.	Before intercourse the woman places the sheath in her vagina. During sex the man's penis enters the female condom.	• Controlled by the woman. • Prevents STIs and HIV. • It can be inserted (8) hours before intercourse.	• Difficult to place in the vagina • Expensive, woman must touch her vagina. • Makes noise during sexual intercourse.
Spermicides	Agents that kill sperm before it enters the uterus. It comes in forms of foam, tablets, jelly or cream.	Insert the spermicide few minutes before sexual intercourse. It can be used with condom or diaphragm.	• Serves as lubricant, • easy to apply, • easily available.	• Provides little protection against STIs and HIV when used alone. • Not as effective as pill.
Pill	Contraceptive tablets taken everyday for either 21 or 28 days.	Anytime during the menstrual cycle. However, 5th day of the menstruation cycle is the best.	• Decreased menstrual flow. • Decreased menstrual pain. • Treatment of menstrual pain. • Fertility returns after stopping the pill.	• Spotting, • Nausea and vomiting, • Weight gain, • Do not protect against STIs, HIV/AIDS.
Emergency contraceptive pills	Contraceptive pills taken as soon as possible after an unprotected sexual intercourse.	Take (4) Tablets of a low dose (30-35 mg EE) within 72 hours of unprotected intercourse. Take four more tablets in 12 hours. Total is 8 tablets. OR Take 2 tablets of a high dose orally within 72 hours of unprotected intercourse. . Take 2 more tablets in 12 hours.	• Provides opportunity to prevent pregnancy after forced or unplanned sexual intercourse. • Generate the need to initiate contraceptive use.	• Does not protect against STIs/HIV AIDS; • Causes Irregular menstrual bleeding, • Nausea/vomiting

MODULE THREE: SESSION 2
ADOLESCENT (TEENAGE) PREGNANCY

TIME: 1 Hour

LEARNERS' OBJECTIVES

By the end of the session participants will be able to:

- Explain the term adolescent pregnancy and its contributory factors.
- Explain the consequences of adolescent pregnancy.
- Discuss how to prevent adolescent pregnancy.

SESSION OVERVIEW

- Introduction to adolescent pregnancy
- Factors contributing to adolescent pregnancy
- Consequences of adolescent pregnancy
- Prevention of adolescent pregnancy

METHODS

- Brainstorming
- Discussion
- Role play/drama
- Lecture
- Plenary

MATERIALS

- Flip charts and markers
- Posters on teenage pregnancy
- Chalkboard/ chalk
- TV and VCR
- Video and film on teenage pregnancy
- Handouts
- DVD, Laptop, Powerpoint projector
- Powerpoint Slides

CONTENT

INTRODUCTION TO ADOLESCENT (TEENAGE) PREGNANCY

Teenage pregnancy refers to pregnancies, which occur in girls who are below the age of 19 years. Regardless of being married or the conferment of any new status by culture, religion or legally (laws of a country) any pregnancy in a female before she is 19 years is referred to as Teenage Pregnancy.

Rates of teenage pregnancy in the world range from 143 per 1000 in some sub-Saharan African countries to 2.9 per 1000 in South Korea. About 16 million children are born annually to teenagers of less than 20 years worldwide (11 percent of total births), with a high proportion of this occurring in Sub-Saharan Africa.

The rapid globalisation, industrialization and urbanisation now occurring in low and middle income countries have resulted in lots of significant changes in the lives of adolescents. In addition, the decreasing average age at menarche, early onset of unprotected sexual experience, misinformation about sex and its consequences and little or no knowledge on reproductive health and contraception, all have significant impact on the health and development of adolescents in Nigeria.

In Nigeria, according to the 2008 National Demographic Health Survey (NDHS), approximately a quarter (23 percent) of females aged 15-19 have begun childbearing; 18 percent have had a child and 5 percent are pregnant with their first child. Most teenage pregnancies result in poor pregnancy outcomes, including maternal deaths, maternal morbidities, neonatal morbidities and/ or deaths and lifelong social and economic consequences for the adolescent.

Although pregnancy is expected, prepared for and a thing of joy for the adult; it is often unexpected, unwanted and ill-prepared for by the adolescent. It is also often associated with shame, fear, social stigmatization, family abandonment and economic/financial neglect. The period is emotionally distressing for the adolescent who is unprepared to raise a child and lacks the means to do so if she wants to.

Teenage parents often do not have the financial resources to take care of their babies. They usually have to rely on their families and relations to assist them. Teenage pregnancy leads to a breakdown in vocational development. Also pregnant teenagers are often expelled from schools and may not have the opportunity of being re-absorbed to the school system. This break can hinder the future developmental opportunities as well as the quality of life of the young person.

Teenage mothers also do not have the maturity to meet the emotional needs of children. Socially, they may feel isolated and deserted by their friends who are continuing with their education.

FACTORS CONTRIBUTING TO TEENAGE PREGNANCY

- Declining age of menarche
- Early sexual debut
- Early marriage: In some parts of Africa including Nigeria, early pregnancy is viewed as an indication of the young woman's fertility and therefore seen as a blessing.

- Pressure to have children
- Sexual coercion and rape
- Socio-economic factors e.g. economic hardship often leads girls to exchange their bodies for monetary gains.
- Lack of access to reproductive health information and services: Parents often are not accessible when it comes to issues relating to sex and reproductive health education. Some who would like to counsel their adolescents lack the capacity and wherewithal to discuss reproductive health issues with them. Most times, schools that should be the agents of proper sex education lack experienced teachers to give this and sex education is not included in the curriculum.
- Many teenagers do not have the capacity to deal with peers who pressurise them to have sex.
- Sexual experimentation
- Unprotected sexual intercourse: The National HIV/AIDS and Reproductive Health Survey (NARHS) reported the proportion of sexually experienced adolescents aged 15-19 years who were current users of condom in 2007 as 11 percent for females and 36 percent for males.
- Sexual exploitation of girls by older men for financial gains and male relatives/acquaintances.
- Risky behaviour e.g. substance use and alcohol abuse: Inhibition-reducing drugs and alcohol may possibly encourage unintended sexual activity.
- Childhood experiences: A study in USA found out that women exposed to abuse, domestic violence and family strife as children have an increased tendency to become pregnant as teenagers, and this risk increases with the number of adverse childhood experiences.

CONSEQUENCES OF TEENAGE PREGNANCY

The consequences of teenage pregnancy to the teenager and the baby are myriad.

Consequences for the mother can be classified as:

- Physical
- Psychological/ emotional and
- Socio-economic

Physical Consequences

Complications during pregnancy include:

- Premature labour and delivery
- Hypertensive diseases of pregnancy (pre-eclampsia)
- Anaemia
- Sexually Transmitted Infections(STIs)/Human Immunodeficiency Virus(HIV) infection
- Greater severity of malaria especially in primigravida(1^{st} pregnancy) that can lead to abortion, Intra Uterine Growth Retardation and foetal death
- Poor health of the mother due to lack of appropriate antenatal care
- Risks associated with abortion

Complications during labour and delivery

- Obstructed labour occurs because the birth passage and bones have not been sufficiently developed to allow easy passage of the baby during delivery. This can lead to foetal death and affect the mother's health and well-being to varying degree, including the development of long-

life devastating consequences such as vesico-vaginal fistula (VVF) and/or recto-vaginal fistula (RVF).
- VVF/RVF: This is a "hole" caused by weakening of the wall between the bladder/rectum and the vagina leading to uncontrolled leakage of urine and faeces. VVF/RVF is a debilitating disability associated with stigma, abandonment with grave consequences.
- Puerperal sepsis, eclampsia, post-partum depression etc.

Psychological/Emotional Consequences
- Regret, shame and having to put up with a lot of ridicule and gossip from her schoolmates and/or peers.
- Fear and embarrassment may force her into having unsafe abortion with its attendant risks.
- May have doubts about themselves leading to loss of self-esteem.
- Fear of the immediate and the future consequences (e.g. parents and/or guardians may refuse to pay school fees).
- Disappointment and self-hatred.
- Pain of being exploited.
- Having to marry someone you may not truly love.
- Expulsion from school.
- Inability to look after the baby.

Socio-economic Consequences
- The teenage mother with little or no training is limited to low paying jobs with low socio-economic status.
- Unmarried teenage mother is usually financially dependent on her parents/guardians and is therefore not in a position to support herself and her baby.
- Parents, relatives and friends may reject teenage mother.

Consequences on the child
- Low birth weight resulting in respiratory infection, and failure to thrive.
- Higher risk of dying in infancy.
- Feeling rejected and having emotional problems because teenage parents do not want them and cannot give the emotional nurturing needed.
- Stigmatisation.
- Poverty and lack of stability leading to the vicious cycle of the children also becoming teenage parents.
- Inadequate nutrition due to poor breastfeeding.

PREVENTION OF ADOLESCENT PREGNANCY
- Adolescents can abstain from sex.
- Sexually active adolescents should use contraceptives when having sex.
- Adolescents should develop positive values about boy/girl relationship.
- Girls should avoid getting too close and being alone with boys/men in isolated places.
- Adolescents should have goals and work towards them, that is, give themselves something useful to think about always.
- Promotion of Family Life and Health Education (Sexuality Education).

SUMMARY

Teenage pregnancy has far reaching effects on the teenagers and their babies but early exposure to Family Life Education can reduce the incidence of teenage pregnancy among the adolescents.

EVALUATION

- What is teenage pregnancy?
- What are the factors contributing to teenage pregnancy?
- What are the consequences of teenage pregnancy?
- How can teenage pregnancy be prevented?

MODULE THREE: SESSION 3
ABORTION AND POST ABORTION CARE

Time: 1 Hour

LEARNERS' OBJECTIVES

At the end of the session participants will be able to:

- Define abortion.
- Mention different types of abortions.
- Discuss the legal issues regarding abortion.
- State the reasons why adolescents have abortion.
- Identify and explain the physical, social and emotional/consequences of abortion.
- Explain post abortion care and the need for preventing reoccurrence.

SESSION OVERVIEW

- Introduction
- Types of abortion
- Factors responsible for abortion
- Describe signs and symptoms of abortion and its complications
- Social and emotional consequences of abortion
- Prevention of unsafe abortion
- Post abortion care

METHODS

- Brainstorming
- Discussion
- Lecture

MATERIALS

- Flip charts stand/paper
- Markers
- Chalkboard/chalk
- VCR/TV/Video Cassettes
- Overhead Projector/Transparencies

CONTENT

INTRODUCTION

Teenage pregnancy outside marriage could result in:

- Continuation of the pregnancy and an out-of-wedlock birth.
- Unplanned marriage.
- Termination of the pregnancy.
- Delivery of the baby and return to school afterwards.

In most cases, in order not to disrupt their education or vocation, pregnant adolescents are involved in clandestine (unsafe) abortion.

Abortion is the termination of a pregnancy on or before twenty-eight weeks of pregnancy. Abortion can occur on its own in which case it is referred to as spontaneous abortion/ miscarriage or can be induced. Induced abortion is a common phenomenon among adolescents and young adults all over the world. Unsafe abortion is induced abortion carried out to terminate an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal standards or both.

Abortion is not legal in Nigeria but a 2006 report by the Campaign Against Unwanted Pregnancy (CAUP) and Guttmacher Institute (GI) estimated the number of induced abortion taking place in the country annually as 760,000. More than half (55 percent) of females who had abortion were younger than 25 years, 63 percent were never in marital union and 60 percent had never had a child in the past . Hospital-based studies suggest that the majority of females who experienced abortion-related complications and deaths were young people (Bankole et al, 2006). However, abortion can be performed if the life of the woman is at risk. It is usually performed by a qualified medical personnel in a medical facility using sterilised instruments and is therefore safe.

Although each adolescent and her family individually bear an economic burden in terms of cost for unsafe abortion and its complications, an estimated $US460-550 million is paid by governments annually to treat serious consequences of unsafe abortion. The complications of abortion are multiple especially when it is unsafe. Once the process of abortion has started, it is important that safety of the woman be considered the topmost priority to prevent death or other complications of abortion. Avoiding pregnancy through appropriate counselling and refraining from unplanned sexual relations can prevent abortion.

TYPES OF ABORTION

Abortion can be broadly divided into two viz: spontaneous and induced abortions. Spontaneous abortion can be complete or incomplete while the induced one can be legal or illegal, safe or unsafe.

A. SPONTANEOUS ABORTION/MISCARRIAGE

Spontaneous abortion commonly referred to as miscarriage occurs when pregnancy ends before the baby has any chance of survival. Most spontaneous abortions occur in the first 12 weeks of pregnancy.

It may occur if a woman has a serious febrile illness such as malaria, severe fall, or if the pregnancy is ectopic, i.e. the fertilized egg was implanted outside the uterus (womb) usually in the fallopian tubes. Spontaneous abortions are not deliberately induced, they occur naturally.

I. **Complete abortion**:

Abortion is described as complete when all the tissues of the developing embryo or foetus and the placenta have passed out through the vagina. When abortion is complete, the bleeding will stop after a few days.

II. Incomplete abortion:

Abortion is incomplete when part of the products of pregnancy remains inside the uterus.

The dangers of Incomplete Abortion include:

- Severe bleeding which can lead to hypovolaemic shock
- Infection
- Infertility
- Death

B. INDUCED ABORTION

This is the deliberate termination of pregnancy for various reasons such as threat to the life of the pregnant woman or for social reasons. Other reasons for induced abortion include ill health and foetal abnormality.

Unsafe abortions

This usually occurs where abortion is illegal. Most cases of unsafe abortions occur in developing countries, where a high proportion of women with unwanted pregnancy cannot access safe abortion services as a result of legal restrictions, stigma, poor quality health services and poverty. In some cases, women or adolescents may try to terminate their pregnancies by themselves or with the assistance of untrained personnel. Some of the traditional methods used in unsafe abortions include inserting objects into the vagina, swallowing special concoctions, taking very high doses of quinine, forcefully massaging the abdomen or washing out the vagina with harsh chemicals such as bleach. Unsafe abortions can be incomplete.

Abortions done by unqualified personnel are not safe because the instruments used are not sterile. This increases the risk of infection and subsequently infertility. Most times, these unqualified personnel lack the capacity to differentiate an ectopic pregnancy (which is pregnancy outside the uterus) from a normal pregnancy, such that clients are erroneously made to believe that an abortion has been done only for the client to come to the hospital in shock from bleeding into the peritoneum from the ectopic site which can lead to death.

FACTORS RESPONSIBLE FOR ABORTION

There are many reasons why adolescents will want to have an abortion. Some of the reasons are:

- Shame and stigmatisation associated with adolescent pregnancy
- The desire to continue school/education

- Pregnancy as a result of rape or incest
- Pregnancy which endangers the health of the girl
- Pressure to abort the pregnancy from the partner responsible for it
- Fear of parents

SYMPTOMS AND SIGNS OF UNSAFE ABORTION

- Fever or chills
- Pain in the abdomen, or backache
- Severe bleeding
- Foul smelling discharge from the vagina
- Yellow discolouration of the eyes
- Vomiting
- Fainting and dizziness

COMPLICATIONS OF ABORTION (PHYSICAL CONSEQUENCES)

- Perforated uterus
- Blocked tubes/ infertility
- Death
- Repeated spontaneous abortion in subsequent pregnancy due to Rhesus incompatibility in a female who is Rhesus negative if the aborted foetus was Rhesus positive.
- Laceration /tear of the vagina

SOCIAL AND EMOTIONAL CONSEQUENCES OF ABORTION

- Ridicule by others
- Guilt
- Depression
- Disruption of normal schooling if complications occur
- Long term effect of secondary infertility

POST ABORTION CARE

Post Abortion Care (PAC) consists of emergency health care services for treatment of abortion-related complications, provision of post-abortion contraceptive counselling and services, provision of other sexual and reproductive health (SRH) services, and referral to other level of care as deemed necessaryfor females who have undergone either an induced or spontaneous abortion. Post abortion care is essential because most women seek abortion outside professional healthcare. Studies by CAUP/GI have revealed that about a quarter of women including adolescents who abort have serious complications that lead to significant maternal morbidity and mortality. PAC should be integrated with other SRH services in the same facility to optimize availability and use. These kinds of services are embraced by adolescents who may not wish to be seen seeking stand-alone abortion care.

1. Counselling

This is to help clarify feelings and thinking. The counsellor can help the adolescent to get over the feeling of shame and guilt. During counselling, education is given to the adolescents to help

minimize the emotional and physical effects of abortion. The counselling session is also an opportunity to discuss pregnancy prevention with adolescents. Good counselling addresses related SRH and other problems and helps the client seek support from family and friends. It also helps adolescents to understand their sexual rights and needs with the aim of developing the autonomy and resources to make decisions about safe sex and reproduction to prevent unplanned pregnancy in the future. Negotiating skills against sexual coercion and gender based violence are also emphasised.

2. Contraceptives

The counsellor will use this opportunity to provide information on contraceptive options available to forestall future occurrences. The counsellor can encourage the client to commence a contraceptive method immediately. The advantages and disadvantages of the various options are highlighted and the client is allowed to make the choice of the method to use and referred to the appropriate place to receive the contraceptive either in the same facility or referred to another place.

3. Referral Services

Many women seeking abortion services are at risk of acquiring STIs and HIV, all of which are the result of unprotected sex. They may also be experiencing gender-based violence.When these are found during screening or counselling they are referred to appropriate places within the facility or external referrals. Referral is for family planning, treatment of complications and protection if such services cannot be provided.

4. Emergency Health Care Services

In the case of induced abortion, the client can have an incomplete abortion, which could result in infection, bleeding and physical trauma. **Emergency Health Care Services** would include blood transfusion to treat anaemia from bleeding, manual vacuum aspiration or dilatation and curettage for incomplete abortion, intravenous antibiotics and oxytocic as appropriate. In cases of perforation there might be need for surgery. The adolescent will need medical referral for emergency treatment of these complications if the services are not present within the same facility.

PREVENTION OF UNSAFE ABORTION

- Encourage abstinence.
- For sexually active adolescents, stress the need for dual protection through the use of condom (male or female types) to prevent STIs/AIDS and pregnancy.
- Encourage the education of the adolescent girl.

SUMMARY

Unsafe abortion can cause untold damage to the health of the adolescent girl. However information on pregnancy prevention can reduce the need for abortion.

EVALUATION

- Explain the term abortion and list the different types of abortion.
- State some of the reasons why adolescents have abortion.
- What are the physical, social and emotional consequences of abortion?
- What is post abortion care?
- How can we prevent future reoccurrence of abortion?

MODULE THREE: SESSION 4
CARE OF THE ADOLESCENT DURING PREGNANCY AND DELIVERY

TIME: 1 Hour

LEARNERS' OBJECTIVES

At the end of the session participants will be able to:

- Identify the needs of the pregnant adolescent before and after delivery.
- Identify peculiarities in their antenatal care.
- Explain precautions during delivery.
- Identify and discuss post delivery concerns of adolescent mothers.

SESSION OVERVIEW

- Introduction to care of adolescent pregnancy and delivery
- Physical, social and emotional needs of pregnant adolescents
- Quality antenatal care services and Information
- Effective management of labour and delivery
- Emotional, social and economic issues after delivery
- Options for adolescent mothers

METHODS

- Brainstorming
- Discussion
- Role plays/ drama
- Lecture

MATERIALS

- Flip charts and markers
- Film on teenage pregnancy e.g. 'No one ever told me'
- Chart on Human Reproduction
- Handouts

CONTENT

INTRODUCTION TO CARE OF ADOLESCENT PREGNANCY AND DELIVERY

When adolescents become pregnant, they are more likely to seek abortion. There are however many reasons why some of them actually carry their pregnancies to term.

These reasons include:

- Strong positive family values.
- Late detection of the pregnancy.
- Fear of complication of abortion.
- Early marriage.
- Lack of access to resources needed.
- Failed attempt at abortion.

In the rural areas and especially in the northern part of Nigeria, the practice of early marriage has resulted in a situation where adolescent pregnancies are legitimately accepted within the community and the expectations of the families are for safe deliveries.

Within the context of reproductive rights, all pregnant adolescents have a right to appropriate care, information and services. It is therefore imperative that all youth-friendly service providers should learn about the basic care of pregnant adolescents from antenatal period to pueperium.

PHYSICAL AND PSYCHOLOGICAL PROBLEMS COMMON IN PREGNANT ADOLESCENTS

The needs of pregnant adolescents can be categorized as physical, emotional and psychosocial.

PHYSICAL PROBLEMS

Nutrition

Since adolescents are still growing, they need adequate calories and nutrients to meet the requirements for their own growth and support the wellbeing of the foetus. Also adolescents are known to skip meals, take a lot of fast foods which are high in fat and sugar but low in nutritional value. Two-thirds of protein required in pregnancy should be from animal origin e.g. milk, meat and eggs. Carbohydrate should be slightly reduced, to compensate for the caloric value of protein. Fat will be adequate if the above protein intake is observed. There should be increased intake of minerals especially iron, calcium and phosphorus.

Some constraints to adequate nutrition in pregnancy and a successful outcome are:

- Lack of financial resources
- Food taboos/beliefs
- Food restriction
- Pre-pregnancy nutritional status
- Hyperemesis gravidarum/Persistent vomiting in the first trimester.

Anaemia

The pregnant adolescent is particularly prone to developing anaemia during pregnancy because of pre-existing nutritionally induced anaemia and the consequences of untreated malaria in pregnancy. Mild to moderate anaemia – usually without symptoms, can be corrected by giving iron, folic acid supplement and adequate diet.

Malaria

Although malaria is preventable and can be treated, it remains a potent cause of complication in any pregnancy including abortion, prematurity, low birth weight and stillbirth. Malaria is associated with 11 percent of all maternal deaths and 71 percent of morbidity in pregnant women. The WHO strategy for malaria prevention and control during pregnancy, which essentially consists of the use of insecticide-treated nets, delivery of two doses of intermittent preventive treatment with sulfadoxine-pyrimethamine (SP) and prompt case management is a key strategy to reduce the burden of malaria in pregnancy.

STIs/HIV

There is the need for preventive counselling and services against STI/HIV even if there is evidence that this has already been contracted. In the latter instance, using condoms for sex will reduce the incidence of multiple infections in the case of HIV infection. Counselling should also be given on mother-to-child transmission.

Problems of excessive workload

The pregnant adolescent should limit her workload to tolerable levels as excessive workload could lead to poor growth and malnutrition.

Delivery of a low birth weight baby

This problem should be avoided through the application of the measures highlighted above.

PSYCHOLOGICAL PROBLEMS

The following psychosocial disturbances should be minimised through counselling:

- Guilt feelings
- Low self-esteem
- Isolation

All these negative feelings will increase the possibility of:

- Unsafe abortions
- Child abandonment
- Child battering and even
- Suicide

The pregnant adolescent requires counselling and support services to enable her return to her studies or further acquisition of skills in the area of her choice after delivery of the baby. This will promote her chances of attaining her life ambition and optimal reproductive health status.

SOME IMPORTANT FACTORS IN CARING FOR THE PREGNANT ADOLESCENTS

Early diagnosis of pregnancy

Although adolescents deny pregnancy for a long time, early diagnosis of pregnancy is the first step in instituting care. Early diagnosis of adolescent pregnancy requires the cooperation of the adolescents, adults in the family and the community. A supportive environment in the home and community is important to foster acceptance and diagnosis. The health workers must respect the adolescents' desire for confidentiality and privacy; and invest time to build trust with the adolescent at the first antenatal visit.

Peculiarities in antenatal care for adolescents

The outcome of each pregnancy and the well being of the newborn child is dependent on quality ante-natal care. Effective pregnancy care is through Focused Antenatal Care (FANC) which is goal directed, client centred, evidence based and provided by a skilled birth attendant. FANC comprises the following:

- **Early detection and treatment of problems and complications** such as malaria, anemia, pre-eclampsia/eclampsia, HIV and STI. This is done through regular history taking, physical examination, screening and testing during routine visits.
- **Prevention of complications and disease** such as malaria (IPT and ITN); tetanus prophylaxis to prevent maternal and neonatal tetanus, iron and folate supplements to prevent anemia.
- **Birth preparedness and complication readiness plan.** Birth preparedness is a relatively new concept in health care delivery which is aimed at averting the delays of pregnant woman in seeking, reaching or receiving care through advance preparation and rapid action. Birth preparedness and complication readiness involve the plans and actions that can be implemented to avert delays at each of these points. It is the process of planning for safe delivery and anticipating the actions needed in case of emergencies. Among others, the pregnant woman (and her family) needs to decide and plan for : presence of skilled birth attendant at delivery, place of delivery, transportation to reach the place of delivery any hour of the day or night, funds, blood donation in the case of emergency, who will provide support for other members of the family in the absence of the woman (for example, who will take care of other young children at home when the woman goes in for delivery), and who will take relevant decisions in emergency and who can be sure to be readily accessible at all times.
- **Health promotion** which involves information, counselling and education on health issues of relevance to pregnancy including nutrition, personal and environmental hygiene, danger signs of pregnancy and labour, breast feeding, care of the newborn.

The adolescent should be encouraged to start ANC on time and to come for antenatal care as scheduled or whenever there is need to do so. The attitude of the health provider is also important as that might affect the adolescent's attendance for antenatal care. It is important therefore that the health worker/provider has the right attitude.

Management of labour and delivery

Every pregnancy has risks but some women face more risks than others. Risk assessment is done during, but is not restricted to the antenatal period. It is not necessary to consider all adolescents as high risk. Assessment of social background and any abnormal findings during antenatal visits are

more objective parameters of risk. It is important that delivery should be managed by a skilled birth attendant. Adolescents who develop complications need to be referred for emergency obstetric care (EMOC). The three most important things to be on the look out for are:

- ***Pre-term labour****- The birth attendant needs to be prepared for this or referred to a health facility that is equipped to handle such babies.*
- ***Slowly progressing labour****- Augmentation of labour and assisted delivery should not be more frequent in adolescents if labour is properly monitored.*
- ***Postpartum haemorrhage with moderate to severe*** *anaemia and ensure that there is Cardiovascular support.*

Post-natal period

In addition to the above, the adolescent mother will require greater support for the care of the baby e.g. with exclusive breast-feeding or with the adoption of the baby if this is the preferred choice. The adolescent mother should be counselled and assisted to make informed decisions on child spacing and family planning. Exclusive breastfeeding of the baby is encouraged and the adolescent must be counselled on the importance of getting the baby fully immunised. Care is geared to the return of the adolescent to pre-pregnancy state and treatment of any abnormality detected.

SUMMARY

A pregnant adolescent needs a lot of physical and psychological care and support. This can only be given if she presents herself for antenatal care early.

EVALUATION

- What are the needs of the pregnant adolescent before and after delivery?
- What are the important factors in providing care for pregnant adolescents?
- What are the post delivery concerns of teenage mothers?

MODULE FOUR
NUTRITION

This module provides a general overview of the nutritional requirements for adolescents, management of obesity, under-nutrition and micronutrient deficiency as well as the harmful food habits and eating disorders among adolescents.

SESSION 1: NUTRITION

SUMMARY AND TIMING ESTIIMATE

SESSION TITLE	DURATION	OBJECTIVES	METHODS	MATERIALS
Nutrition	1 hour 15 minutes	• Define nutrition, obesity, under-nutrition, micronutrient deficiency. • Discuss Adolescent nutritional requirement. • List the local food items that provide adequate healthy diet. • Discuss the management of obesity, under nutrition and micronutrient deficiency. • Identify the immediate and underlying causes of malnutrition. • Discuss the harmful food habits and eating disorders that affect adolescent health.	Brainstorming Group work Experience sharing Lecture	Flipcharts Wall papers OHP/OHT Posters/handbills Local food items

MODULE FOUR
SESSION 1: NUTRITION

TIME: 1 Hour 15 Minutes

LEARNERS' OBJECTIVES

At the end of this session, participants will be able to:

- Define nutrition, obesity, under nutrition, micronutrient deficiency.
- Discuss adolescent nutritional requirement.
- List the local food items that provide adequate healthy diet.
- Discuss the management of obesity, under nutrition and micronutrient deficiency.
- Identify the immediate and underlying causes of malnutrition.
- Discuss the harmful food habits and eating disorders that affect adolescent health.

SESSION OVERVIEW

- Definition of nutrition
- Adolescent nutritional requirement and local food items that provide adequate healthy diet
- Nutritional needs among special groups including pregnant teenagers
- Harmful eating habits and disorders that affect adolescent health
- Malnutrition in adolescents and young people
- Management of obesity, under-nutrition, and micronutrient malnutrition

METHODS

- Brain storming
- Group work
- Discussion / experience sharing
- Lecture

MATERIALS

- Slides/transparencies
- Flipchart Stand/paper
- Markers
- Local food items
- Posters and handbills
- Overhead projector
- Computer

CONTENT

INTRODUCTION

Adolescence is the only time following infancy when the rate of growth actually increases. This sudden growth spurt is associated with hormonal, cognitive, and emotional changes that make adolescence an especially vulnerable period of life with respect to nutrition. First, there is a greater demand for calories and nutrients due to the dramatic increase in physical growth and development over a relatively short period of time. Second, adolescence is a time of changing lifestyles and food habit - changes which affect both nutrient needs and intake.

Nutritional health is a key component of adolescent health and being a healthy adult depends on being a healthy adolescent. Life-long food habits are established during adolescence. During this important period, there is a high incidence of nutritional deficiencies and poor eating habits. Immediate and long-term complications include obesity, hyperlipidemia, osteoporosis, sexual maturation delays and poor cognitive development, resulting in decreased learning ability, poor concentration, and impaired school performance. Development of eating disorders is also prominent during this period.

Adolescents can be at risk for dietary excesses and deficiencies. Dietary excesses of total fat, saturated fat, cholesterol, sodium, and sugar commonly occur. Most adolescents do not meet dietary recommendations for fruits, vegetables, and calcium rich foods. Other nutrition-related concerns for adolescents include high soft drink consumption, unsafe weight-loss methods, micronutrient deficiencies, especially iron-deficiency anemia, and eating disorders. Nutrition problems may also occur as a result of tobacco and alcohol abuse, pregnancy, disabilities, or chronic health conditions.

DEFINITIONS

- **Nutrition**

This is the processes by which components of food are made available to an organism for meeting energy requirements, for building and maintaining tissues and for maintaining the organism in optimal functional health.

- **Adequate Diet**

An adequate diet consists of all classes of food in the right proportion e.g. carbohydrates, protein, fats, vitamins and minerals. The adolescent needs nutritionally adequate diet, which must provide enough of protein, carbohydrates, fats, vitamins, and minerals to meet their needs.

- **Malnutrition**

This is a broad range of clinical conditions that result from deficiencies in one or a number of nutrients. It is caused by eating too little, too much or not the right food. It is a state in which the physical function of an individual is impaired to the point where he or she can no longer maintain

adequate bodily performance processes such as growth, pregnancy, lactation, physical work, and resisting and recovering from disease.

ADOLESCENT NUTRITIONAL REQUIREMENT

Energy

Three nutrients — carbohydrate, protein and fat — provide energy in the form of calories. Carbohydrates and protein each contain 4 calories per gram; fat contains 9 calories per gram. Non-pregnant and non-lactating female adolescents require between 2,000 and 2,200 calories each day and adolescent males require about 2,500 to 3,000 calories per day. Of this total amount of calories, 60% is needed for basal metabolism - the body's basic energy needs. These include tissue growth and repair, and basic involuntary functions such as those performed by the heart and lungs. An additional 30% of each day's energy requirement is needed to meet the demands of physical activities. The energy costs of digesting and absorbing food accounts for the remaining 10%. However, energy needs vary with physical activity. An additional 600 to 1,000 calories per day are needed if the adolescent is involved in vigorous physical activity. Examples of carbohydrate include yam, cassava, rice etc.

Protein

Protein needs depend on the individual's rate of growth. On the average, adolescent females require 0.8g/kg body weight/day while adolescent males require 1.0g/kg body weight/day. Most teens meet or exceed their daily protein requirements. Adolescents at risk for protein deficiency include strict vegetarians and those using extreme measures to restrict their food intake to lose weight. Examples of foods which contain protein are: meat, fish, soya beans, milk, eggs, beans, etc.

Fat

Fat is a necessary nutrient and most teens exceed recommended levels for fat intake. Adolescent girls are, however, at risk for deficiency due to their efforts to lose or avoid gaining weight by severely reducing their fat intake. Recommendations for fat intake for adolescents are the same as those for adults: Fat from all sources should represent 30% or less of the day's calories – or about 65 to 100 grams for a 2,000 to 3,000-calorie diet. This 30% recommendation is further divided into equal portions for the three major forms of dietary fat: saturated fat - found primarily in animal products and some processed foods; monounsaturated fat — found in olive and canola oils; and polyunsaturated fats — in safflower, soybean, and corn oils, among others. For a 2,000- to 3,000-calorie diet, this would come to 21 to 33 grams from each fat source. It is important to teach teenagers to read food labels and learn about fat content of foods.

Vitamins and Minerals

Vitamins are complex chemical substances that — together with minerals — have a role in most or all processes that take place in the body. The demands of growth and development - coupled with the typical poor eating habits of adolescents places them at risk for deficiency of several vitamins and minerals.

- Calcium-This is essential for bone mass deposit which occurs majorly during adolescence. Daily requirement for calcium is between 1200 to 1500 mg/day.

- Iron-Iron requirements are high during adolescence because of growth with increased requirement in menstruating females. Adolescent males require about 12mg/day while females require about 15mg/day.
- Vitamins- Most commonly, adolescents are deficient in vitamins A, B6, E, D, C, and folic acid. Usually, adolescents who are eating normal daily requirements of nutrients are not deficient in vitamins. Vitamin supplements may be added to meet requirements.

Fiber

The average fiber intake for adolescents is approximately 12 grams per day. The suggested recommended daily intake of fiber for adolescents is calculated by the following formula:

(Adolescent's age in years) + 5 to 10 grams per day = recommended daily fiber intake.

For example, the recommended daily fiber intake for a 15-year-old would be:
15 years + (5 to 10) = 20 to 25 grams per day.

Water

Water is involved in virtually every life-sustaining body process. It carries nutrients and oxygen to body cells, takes waste products away, and regulates body temperature. It provides no energy and thus has no calories.

Good hydration is however important to keep the body functioning normally. By the time someone experiences thirst — the first conscious sign of dehydration — some percentage of fluid has already been lost. It is important to continue to drink water and other fluids throughout the day to prevent dehydration. The body loses water through urination, perspiration, respiration, and feaces. Drinking water and other beverages is the best way to replace body water. Solid foods, especially many fruits and vegetables, also provide water, however this amount is difficult to measure.

An adolescent approaching adult size should drink about 170 - 227 ml of fluid per day, with more during exercise and in hot weather. Caffeinated beverages such as coffee, tea and many sodas are not the best sources of water as caffeine acts as a diuretic causing the body to lose water through increased urination.

NUTRITIONAL CONSIDERATION OF SPECIAL ADOLESCENT GROUPS

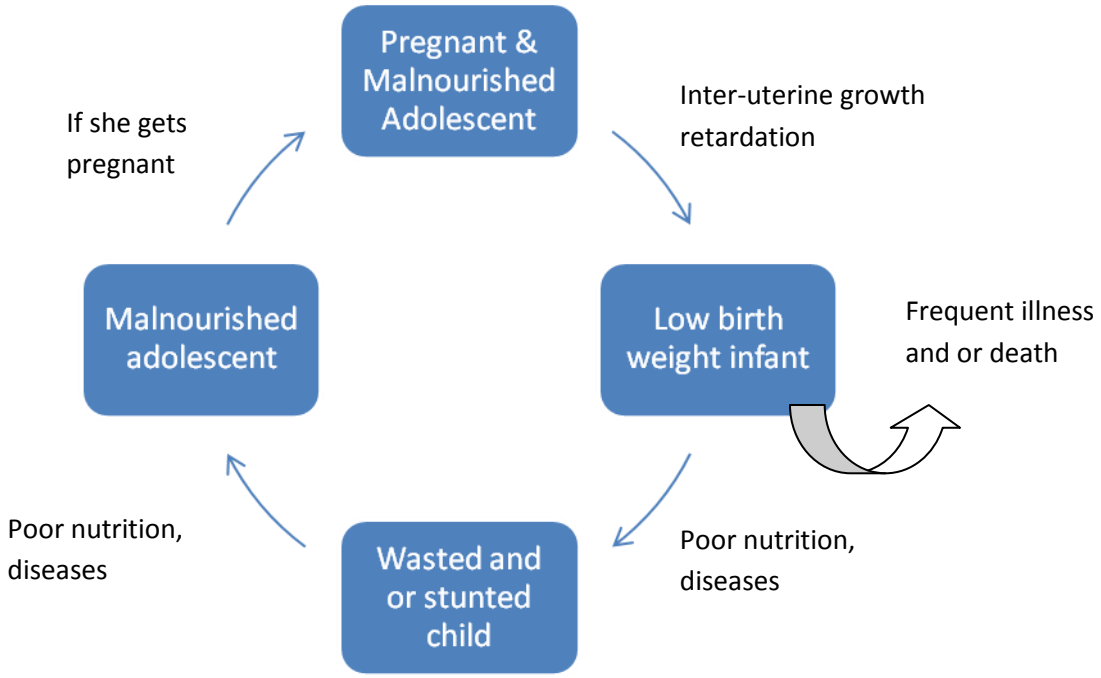
Pregnant Teenagers

One of the factors in the outcome of pregnancy is maternal age at the time of conception. There are greater risks of pregnancy complications in very young adolescents, including an increased incidence of low birth weight (LBW) infants and prenatal morbidity and mortality. In addition, there is higher incidence of premature delivery and anaemia. Malnourished mothers are likely to give birth to low birth weight (LBW) infants, who are then susceptible to disease and premature death, continuing the cycle of poverty and malnutrition.

Early age at conception, smaller maternal size and poor nutritional status of young adolescents have been given as explanations for poor pregnancy outcome. Young adolescents who become pregnant

have not yet completed their own growth and therefore require extra nutrient. Competition for nutrients between the mother's growth need and those of her fetus is one of the factors that contribute to unfavourable pregnancy outcome. The pregnant adolescent requires an extra 300 calories and 30g of protein per day.

Figure 4.1 Diagram Showing the Nutritional Challenges of a Pregnant Adolescent



Adolescents Infected with HIV

Pregnant adolescents with HIV are particularly at high nutritional risk as a result of their higher dietary requirement. Infants born to HIV-positive mothers are more likely to be malnourished with low birth weight and impaired postnatal growth.

Malnutrition is common in HIV infection and it is one of the complications of AIDS. Wasting has been associated with increased infectious complications and reduced survival.

Vitamin A deficiency leads to rapid progression of HIV to AIDS, higher rate of mother- to-child-transmission and increased mortality.

HARMFUL EATING HABITS AND DISORDERS

Adolescents spend a good deal of time away from home and usually consume fast foods, which are convenient, but are often high in calories and fat. It is common for adolescents to skip meals and snack frequently. The social pressure to be thin and the stigma of obesity can lead to poor body image and unhealthy eating practices, particularly among young female adolescents. Males in contrast, may be susceptible to the use of high-protein drinks or supplements as they try to build additional muscle mass. An individual's cultural background strongly influences his or her food

choices and preferences. People from different cultures may also view body weight differently. For example, some cultures may see excess weight as a sign of wealth and health.

Religion, social and economic status, and the environment where one was raised or where one currently lives (urban, rural, or suburban) can influence food preferences. Adolescents also have their own particular "teen" culture that can strongly influence their food choices. This effect would be more striking when they are away from home.

Class Activity : Adolescents' perception of food consumed

Adolescents' perception of nutrient dense foods strongly affects their food choices. In a recent study (Chapman, G., 1993), 11- to - 18 years old adolescent girls were asked to describe the different situations and feelings they associated with "junk food" (e.g. chocolate, candy, chips, and soda) and "healthy food" (e.g. fruits, vegetables, chicken, fish, bread and low-fat milk).

Below is their description. See how many people agree with them. Take note of the variation in sex (if any).

Junk Food	**Versus**	**Healthy Food**
Normal		Weird
Snacks		Meals
Gaining weight/going off diet		Losing weight/dieting
Enjoyment, pleasure, parties		Concerned with weight
Being with friends		Being with parents
Being away from parents/home		Staying home
Not being in control		Self-control
Having money		Managing money

Nutrition Supplements

Dietary supplements may supply some vitamins and minerals, but they cannot provide all the nutritional components that food offers for good health. No supplement can fix an ongoing pattern of poor food choices. Hence it is important for adolescents to eat a balanced diet and not rely fully on supplements.

EATING DISORDERS THAT AFFECT ADOLESCENT HEALTH

Eating disorders are characterised by severe disturbances in eating behaviour. They are more common among adolescent girls because of the current socio-cultural emphasis on thinness and physical fitness as a symbol of beauty and success. Many adolescent girls control their eating patterns by emotional rather than physiological needs. For example, they consume snack foods, carbonated drinks and sweets of low nutritional value. Due to lack of resources or time, some of them skip their regular meals. Another factor which could predispose to eating disorders among female adolescents is the problem of gender inequality and discrimination in the area of food distribution. In some households, adolescent boys are served more quantity and quality of food than the girls.

Eating disorders include:

- Anorexia Nervosa

- Bulimia Nervosa (Binge + Purge)
- Binge eating or compulsive over eating

I. **Anorexia Nervosa:** This is a clinical syndrome of self-induced starvation characterized by a voluntary refusal to eat due to an intense fear of fatness and disturbed perception of body size.

II. **Bulimia Nervosa**: This is defined as recurrent episodes of rapid uncontrollable ingestion of large amounts of food in a short period of time usually followed by purging, either by forced vomiting and/or abuse of laxatives or diuretics. The purging techniques are used to "un-do" the threatened weight gain, relieve fullness, and restore the individual's self-control. Bulimics are like anorectics in that they have an exaggerated fear of fatness and pursue sliminess as a means of bringing control and a sense of effectiveness into their lives.

III. **Binge Eating or Compulsive Overeating**: This is an eating problem, which is not followed by purges as in bulimia nervosa. Those affected usually become obese. It occurs in response to stress or an anxiety as an emotional eating pattern to soothe or relieve painful feelings.

Prevention of eating disorders in adolescents

- Initiate preventive action through nutrition and dietary education.
- Involving schools in programmes through education and counselling adolescents on issues such as:
  - Reducing body dissatisfaction (to be pleased with the way they look).
  - The relationship between socio-cultural norms and diet.
  - Understanding the importance of nutrition and physical development.

Such programmes would improve adolescents' knowledge about nutrition and weight control.

Management

This may require individual or team care by a sensitive experienced group of professionals, including a physician, clinical psychologist, clinical nutritionist and nurse.

- Organise education and counselling for individuals/ groups.
- Effect behavioural changes by developing a plan with the adolescent for dietary improvement (some form of self-help with written material).
- Ensure better nutrient intake and still maintain body shape.
- Set goals for weight maintenance or weight gain.
- Take client's concerns seriously and develop a sense of trust.
- Arrange for individual outpatient psychological treatment, including cognitive behaviour therapy.
- Carry out follow up counselling sessions with adolescent alone and together with the parents to understand the issues for effective behavioural change.

Suggested Interventions

- Encourage family meals whenever possible.
- Encourage the selection of healthy foods when eating out. It is unrealistic to expect adolescents not to go to fast food restaurants frequently. The aim should be less frequency and better menu selections at fast food restaurants.

- Concrete approaches are best. “Try a slice of bread for breakfast” is clearer than “eat more grains,” or “gradually switch from whole or low-fat milk to 1% or non-fat milk’ is more concrete than “eat less fat.”
- Encourage adolescents to set goals, develop action plan towards achieving them and have positive mental models of themselves.

MALNUTRITION IN ADOLESCENTS AND YOUNG PEOPLE

Poor or inappropriate dietary habits increase the risk and/or incidence of chronic disease among adolescents. Of great concern is the increasing rate of obesity among adolescents as well as obesity-related health risks, such as diabetes and cardiovascular disease. Inadequate iron intake increases the incidence of iron-deficiency anemia, especially among adolescents at highest risk such as pregnant teens, vegetarians, and competitive athletes.

A typical adolescent diet does not include adequate amounts of fruit vegetables, and whole grains. These foods are significant sources of vitamins and minerals such as folate. Folate deficiency is of special concern for girls as many of them will be mothers in the future and folate plays an important role in preventing neural tube defects in the baby in-utero.

Consumption of soft drinks among adolescents has risen dramatically and continues to replace milk, fruit juice, and water as the beverage of choice. Health concerns associated with this increased soft drink intake include excess caloric intake (contributing to overweight/ obesity), dental caries, and possible interference with calcium absorption due to high content of phosphorus in soda. Adequate calcium intake during adolescence is essential for peak bone mass, yet evidence suggests that most adolescents do not meet the recommended daily intake. Adolescent nutritional problems can be grouped into three major categories:

- Under-nutrition
- Micronutrient deficiency
- Overweight and Obesity

UNDER-NUTRITION

Under nutrition is manifested in the form of stunting (short-for-age) or wasting (thin-for-age).

- **Stunting**
  Is observed when the height-for-age is less than two standard deviation units from the median height-for-age of the NCHs/World Health Organization reference values. Stunting is usually a consequence of chronic under-nutrition or deprivation of food.

- **Wasting or thinness**
  Is the result of acute energy deficiency leading to the individual being underweight for his or her height (i.e. a Body Mass Index (BMI),weight/Height^{2,} below 18.5) Some of the consequences are:
  - Lack of energy to participate actively in sports and other activities.
  - Delayed physical development.
  - Delayed onset of menarche in girls.
  - Menstrual disorders.
  - Delayed growth of pelvic bones in girls with risk of obstetric complications in future.

- Low pre-pregnancy weight leading to delivery of low birth weight and still born babies.
- Suppressed immunity making them more prone to infection and illness.
- Failure of the brain to attain its full intellectual capacity.

Management

- Carry out regular assessment to determine the nutritional status through:
  - Anthropometrics measurement
  - Physical/clinical examination
  - Dietary assessment
- Counsel adolescents to maintain and improve upon food choices and eating habits.
- Educate adolescents and their parents to improve on food choices and eating habits so as to satisfy the energy needs of the adolescents.
- Encourage adolescents from poor background to include low-cost nutritious foods in their diets.

MICRO-NUTRIENT DEFICIENCY

This includes the following:

Iron Deficiency Anaemia (IDA)

Anaemia is one of the major nutritional problems of adolescents. The prevalence is higher among adolescent boys than girls due to a greater demand for muscle mass and blood development. The onset of menarche in girls leads to regular loss of blood and this leads to more demand for iron. During the growth spurt period, iron deficiency anaemia is also a serious problem among young adolescents but the problem increases with age for girls. Anaemia could also be caused by hookworm infestation. Some of the consequences of iron deficiency anaemia are:

- Pregnancy outcome is affected leading to low birth weight babies, prematurity, stillbirth, neonatal infection and maternal mortality.
- Reduced work capacity.
- Reduced endurance of athletes.
- Causing apathy and reduced ability to concentrate.
- Reduced cognitive functions leading to poor school performance.
- Reduced resistance to infection.

Prevention

- Give dietary advice.
- Deworm and treat other parasites.
- Check haemoglobin regularly.
- Emphasise personal and environmental hygiene.

Management

- Emphasise dietary sources of iron e.g. Dark green leafy vegetables, meat, and liver.
- Give dose of iron preparation and folic acid.
- Involve parents/guardians in planning meals to effect behaviour change.
- Consume vitamin C rich foods to improve Iron absorption.
- Educate both parents and adolescent to diversify diet.

Iodine Deficiency Disorders (IDD)

Iodine deficiency disorders (IDD) are associated with brain damage, mental retardation, reproductive failure, child death and goitre.

Prevention

- Use only iodised salt for cooking.
- Diversify diet to include foods rich in Iodine.
- Counsel both adolescents and parents to improve food choices and eating habits.

Management

- Diversify diet to include foods rich in Iodine.
- Counsel both adolescents and parents to improve food choices and eating habits.

Vitamin A Deficiency (VAD)

Vitamin A deficiency can lead to poor night vision, blindness and death in children. It hinders physical growth and lowers resistance to infections.

Prevention

- Diversify diets to include vitamin A rich foods.
- Use red palm oil regularly for cooking without bleaching.
- Eat fruits and vegetables (both dark green vegetables and orange coloured fruits).

Management

- Counsel adolescents and parents to diversify diets to include vitamin A rich foods.
- Encourage use of red palm oil for cooking without bleaching.
- Eat fruits and vegetables.

OVERWEIGHT AND OBESITY

Obesity is defined as excess deposit of fat. The indicator for assessment is the Body Mass Index (BMI) which is weight in kilograms divided by the height in meters squared (Wt/Ht^2). Obesity is BMI > 30 while overweight is BMI between 25 and 30. BMI < 18.4 is reported as underweight. Obesity is caused by excess energy intake, high fat diets and sedentary lifestyles or low physical activity.

Obesity and overweight in childhood and adolescence leads to a higher risk of developing diabetes and other diet-related conditions and its persistence into adulthood puts a further strain on health. The obese adolescent is less active with psychological and emotional problems such as depression because of low self-esteem.

Prevention

- Promote healthy living through consumption of a balanced diet.
- Avoid excess intake of high fatty foods and sugar foods.
- Encourage physical activity through exercises.
- Build self-esteem.
- Promote behaviour change.

Management

- Promote healthy living through consumption of fruits and vegetables, complex carbohydrates.
- Avoid excess intake of high fatty foods and sugar foods.
- Encourage physical activity through exercises.
- Counsel on behaviour change.
- Refer to nutritionist, dietician, and psychotherapy.

SUMMARY

Adolescents' inappropriate eating habit increases their risk of chronic nutritional problems that pose greater risks in future. The dangers of malnutrition are particularly increased in the pregnant adolescents and adolescents living with HIV/AIDs. Adolescents must be concerned about what they eat, and not just filling the stomach, to ensure they grow into healthy adults in later years.

EVALUATION

- Define nutrition, obesity, under nutrition, micronutrient deficiency.
- Discuss adolescent nutritional requirement and list the local food items that provide adequate healthy diet.
- Discuss the management of obesity, under nutrition and micronutrient deficiency.
- Identify the immediate and underlying causes of malnutrition.
- Discuss the harmful food habits and eating disorders that affect adolescent health.

MODULE FIVE
INTENTIONAL AND UNINTENTIONAL INJURY

This module presents an overview of intentional and unintentional injury among adolescents, risk factors for injury as well as interventions for the prevention of injuries among adolescents.

SESSION 1: INTRODUCTION TO INTENTIONAL AND UNINTENTIONAL INJURIES

SESSION 2: INTENTIONAL INJURIES (VIOLENCE) IN ADOLESCENTS

SESSION 3: SEXUAL VIOLENCE - ISSUES

SESSION 4: SEXUAL VIOLENCE - INTERVENTIONS

SESSION 5: UNINTENTIONAL INJURIES IN ADOLESCENTS

SESSION 6: PREVENTION OF INTENTIONAL AND UNINTENTIONAL INJURIES AMONG ADOLESCENTS

MODULE FIVE: INTENTIONAL AND UNINTENTIONAL INJURIES
SUMMARY AND TIMING ESTIMATE

SESSION TITLE	DURATION	OBJECTIVES	METHODS	MATERIALS
Introduction	1 hour 30 minutes	• Define injury. • Review the magnitude of the problem of injuries among adolescents. • Discuss the types of injury. • Discuss sources of injury data; • Socio-economic impact of injuries on adolescents.	Brainstorming Lecture Discussion	Flip charts stand/ paper Markers Paper tapes Overhead projector (OHP) Transparencies
Intentional injuries (violence)	1 hour	• Explain the concept of intentional injuries. • Explain the types of intentional injuries. • Discuss the magnitude of the problem. • Examine the role of antecedent risk factors in the occurrence of intentional injuries.	Brainstorming Lecture Discussion	Flipchart stand /paper Markers Paper tapes Overhead projector (OHP) Transparencies VCR/TV/video tapes
Sexual violence - issues	1hour 20 minutes	• Define sexual violence/abuse. • Classify the types of sexual violence. • Identify common reactions to sexual abuse. • Describe risk reduction strategies. • Discuss the relationship between gender inequality and sexual violence.	Group Work Brainstorming Experience sharing	Flip chart stand/paper Chalkboard/chalk Markers VCR/TV/video tapes
Sexual violence – intervention	45 minutes	• Describe types of crisis intervention. • Explain the objectives of crises counselling. • Discuss safety and security issues. • Explain support and health care provision. • List penalties for sexual offences.	Lecture Discussion Experience sharing	Flip charts stand/paper Chalkboard/chalk VCR/TV/video tapes
Unintentional injuries	1 hour	• Explain the concept of unintentional injuries. • Explain the types of unintentional injuries. • Describe the magnitude of the problem. • Examine the role of antecedent risk factors in the occurrence of unintentional injuries.	Brainstorming Lecture Discussion	Flipchart stand /paper Markers Paper tapes Overhead projector (OHP) Transparencies
Prevention of intentional and unintentional injuries	1hour 30 minutes	• Define the levels of prevention of injuries. • Describe the Haddon's matrix. • Describe the public health approach to injury prevention. • List various interventions which can be used to prevent injuries.	Brainstorming Group work Discussions	Flipchart stand /papers. Markers Paper tapes Overhead projector (OHP) Transparencies

MODULE FIVE: SESSION 1
INTRODUCTION TO INJURY

TIME: 1Hour 30 Minutes

LEARNERS' OBJECTIVES

At the end of the session, participants should be able to:

- Define injury.
- Appreciate the magnitude of the problem of injuries among adolescents.
- Differentiate between the types of injury.
- Discuss sources of injury data.
- Discuss socio-economic impact of injuries on adolescents.

SESSION OVERVIEW

- Introduction
- Definition of injury
- Types of injury
- Magnitude of the problem of injuries
- Sources of information on injuries
- Summary
- Evaluation

METHODS

- Brainstorming
- Lecture
- Discussion

MATERIALS

- Flipchart
- Markers
- Paper tape
- Overhead projector
- Screen
- Slides
- Projector

CONTENT

INTRODUCTION

Injuries in all age groups have become a major public health problem globally. The World Health Organization estimates that more than 875,000 children and adolescents under 18 years are killed every year (Global Burden of Disease Project, WHO 2002). The numbers who require hospital care for non-fatal injuries are considerably larger and many of these suffer life-time disabilities as a result. Injuries also disproportionately affect those in low and middle income countries and even within high income countries; those in the lower socio-economic groups bear the greatest burden (Peden M et al 2008).

Until recently, little or no attention was paid to injuries in low and middle income countries. This was due to a number of reasons mainly because these countries were still encumbered with the burden of communicable diseases. However, because of development, these countries are now undergoing a transition and are faced with the burden of both communicable and non-communicable diseases. In addition, successes of the child survival programmes resulted in more children surviving into their adolescent years and injury is now being recognized as a major cause of morbidity and mortality amongst them.

DEFINITION

An injury is defined as a physical damage that results when a human body is suddenly or briefly subjected to intolerable levels of energy. It can also be a bodily lesion resulting from acute exposure to energy in amounts that exceed the threshold of physiological tolerance. An injury can also be an impairment of function resulting from a lack of one or more vital elements (i.e. water, air, warmth) as in drowning, strangulation or freezing (Baker SP, O'Neill B, Karpf RS; 1984).

TYPES OF INJURY

Injuries can be classified based on intent i.e. whether or not they were deliberately inflicted:

- Intentional (deliberate)
- Unintentional (accidental) and
- Undetermined intent – in this case, it is difficult to judge whether an injury was accidentally or deliberately inflicted.

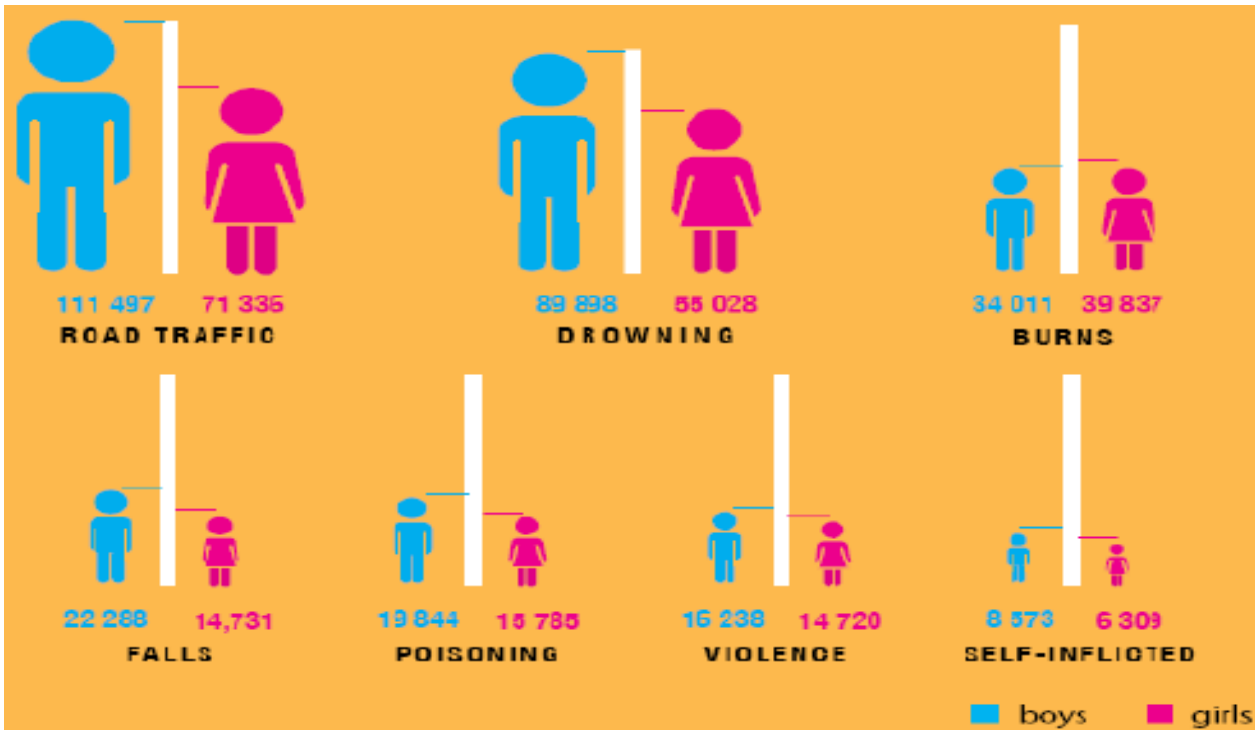
Injuries can also be classified based on the mechanism of occurrence:

- Road traffic crashes
- Poisoning
- Falls
- Fires/ burns
- Drowning/ near-drowning
- Firearms

MAGNITUDE OF THE PROBLEM

Injuries affect everyone although some groups are at higher risk compared to others. Injuries are the leading cause of death among adolescents worldwide (Krug, 2000). Annually, more than 20,000 adolescents in developed countries and almost a million adolescents in developing countries are victims of a fatal injury (A league table of child deaths, 2001). Poverty is an important risk factor for injury. Studies have shown that males are at higher risks for most injuries compared to females. For every adolescent killed, many more suffer injuries and disabilities.

Table 5.1: Injury and deaths in children and adolescents aged < 15years by cause and sex



Source: WHO, Global Burden of Disease project, 2002. Version 5
(Adapted from Holder Y, Peden M, Krug E, et al (E). Injury surveillance guidelines. Geneva, World Health Organization, 2001).

SOURCES OF INFORMATION ON INJURIES

Injuries affect everyone. Many times, injuries sustained are minor and the affected individual does not seek for healthcare outside the home. In addition, in many parts of the country, care is obtained from patent medicine sellers and unorthodox health facilities. This leads to under-reporting of injury events and an under-estimation of the problem.

Sources of information on injuries include the following:

- Hospital accident and emergency departments
- Hospital registers
- Community surveys
- Police records
- Insurance records
- School-based injury surveillance systems.

Hospital records capture moderate to severe injuries. However, information on minor injuries is missed out as those with minor injuries rarely present in the hospital. Problems of improperly filled out hospital records also arise and this would limit the use of hospital records.

While ***community-based studies*** tend to capture a lot of injury events, the problem of recall arises because of the tendency of people to remember severe injuries and trivialize and even forget minor ones. This leads to problems of under-reporting.

Police records do not capture many injuries because most people do not report incidents of injury to the police unless it is mandatory e.g. injuries from gun shots or major road crashes, or if they want to pursue legal action against the assailant.

Insurance records are detailed in countries where insurance is well established.

School-based injury surveillance systems are also a very good source of information. Unfortunately, in societies where the numbers out-of-school adolescents are high, they tend to be missed out.

Socio-economic impact of injuries: The economic impact of injuries is enormous and is felt more by poor families. Studies conducted in some parts of the world have shown that injury contributes significantly to hospital and healthcare costs (WHO, 2006). In addition to funds spent on treatment and rehabilitation, adults who have to stay away from work in order to take care of the injured adolescent also lose income. The injured adolescent is unable to go to school or participate in regular activities while recuperating. The siblings of the injured adolescent are also affected in a number of ways. They usually receive less attention than usual because the injured person has to be taken care off. Sometimes, another sibling has to leave school to support the family financially or help to take care of the recuperating individual. Funds intended to meet other family needs may also need to be diverted to take care of the injured individual.

Injuries also cause significant physical and psychological discomfort which is difficult to quantify in monetary terms. The sudden and unexpected death of a child from any type of injury has immense emotional impact on the family. The effect of intentional injury on an adolescent often has far-reaching and lifelong effects on the victim.

SUMMARY

An injury is the physical damage that results when a human body is suddenly or briefly subjected to intolerable levels of energy. An injury can be intentional, unintentional or of undetermined intent. It is a leading cause of morbidity and mortality among adolescents and causes significant economic losses. Those in the low socio-economic classes are most affected.

EVALUATION

- Define injury.
- List types of injury.
- Mention four effects of injury on adolescents.
- Mention four sources of information on injury.

MODULE FIVE: SESSION 2
INTENTIONAL INJURY

TIME: 1 Hour

LEARNERS' OBJECTIVES

At the end of the session, participants will be able to:

- Explain the concept of intentional injuries.
- List types of intentional injuries.
- Understand the role of risk factors in the occurrence of intentional injuries.

SESSION OVERVIEW

- Concept of intentional injury
- Types of intentional injury
- Magnitude of the problem of injuries
- Risk factors for intentional injury
- Summary
- Evaluation

METHODS

- Brainstorming
- Lecture
- Discussion

MATERIALS

- Flipchart
- Markers
- Paper tape
- Overhead projector
- Screen
- Films on bullying
- VCR/TV/DVD
- Computer

CONTENT

DEFINITION

An intentional injury also referred to as violence is defined by WHO as, 'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation (WHO; 2002).

It includes a threat of psychological harm as well as the use of physical power resulting in injury.

TYPES OF INTENTIONAL INJURY

Interpersonal violence

This is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation (WHO, 1996).

Examples include assault, homicide, intimate partner violence, sexual violence, neglect and abandonment, and other forms of maltreatment. It was estimated that in 2002, over 500,000 people died as a result of interpersonal violence globally (WHO, 2002). Globally, the highest rates of interpersonal violence were found in the Americans among males aged 15 - 29 years.

Self-directed violence or self-harm

Examples include deliberate overdose of drugs and alcohol, self-mutilation, self-immolation, suicide.

Suicide is defined as "a death arising from an act inflicted upon oneself with the intent to kill oneself" (Rosenberget al, 1988). Globally, an estimated 100,000 to 200,000 young people commit suicide annually and suicide has been estimated to be the fifth identifiable cause of death for youth and young adults (Barker, 2000; WHO, 1993). Suicide rates vary widely among countries. In most industrialized countries, it is estimated to be the second leading cause of death among adolescents. Suicide rates are increasing globally and a likely explanation for this is the increasing access to lethal weapons. Worldwide, suicide is more common among males than females. Although girls are more likely than boys to attempt suicide, boys are more likely to commit suicide than girls (National Institute of Mental Health, 1998).

Legal intervention

Legal interventions include lawful actions taken by the by police or other law enforcement personnel.

War, civil insurrection and disturbances such as demonstrations and riots

Deaths resulting from war are on the increase, especially in developing countries where the majority of soldiers are reported to be young people aged 10 to 24 years. According to a report by WHO, more than 100 million young people have been involved in armed conflict as soldiers, civilians, or

refugees. A 1996 UNICEF report documented that adolescents have been used as combatants in conflicts in countries such as Liberia, Mozambique, Cambodia, Myanmar, and Sierra Leone.

MAGNITUDE OF THE PROBLEM

Youth violence is a global public health problem. The impact of violence on young people, their families and the society at large is enormous. According to the WHO World report on Violence and Health, the global incidence of fatal violence related deaths was 2/ 100,000 persons among 5 – 14 year olds and 13/100.000 among 15 – 24 year olds.

According to a study conducted by WHO, the proportion of adolescent males who reported being involved in a physical fight in school was 22% in Sweden; 44% in the US and 76% in Israel. A number of African countries are currently experiencing armed conflict. In Nigeria, incidents of all forms of violence are on the increase and most of these are perpetrated by youth.

RISK FACTORS FOR INTENTIONAL INJURY

These are factors which are in the adolescent, his family or his environment and which influence the likelihood of the adolescent perpetrating a violent act. An understanding of these factors is necessary for the development of effective interventions to address health-risk behaviours including violence among adolescents.

Risk factors for violence
Individual level
Sex
Illness
Temperament
Being out-of-school
Early puberty
Aggressive behavior
Impairment/ disability/ handicap
Poverty
Inadequate education
Family level
Low parental education
Ethnic group (minority)
Mental illness e.g. depression
Large family size
Overcrowding
Poverty
Access to weapons
Engaging in health compromising behaviors
Exposure to violence within the family
Environmental Factors
Macro environment – the nation/ society
Legislation
Media violence
Political instability/ unrest
Unavailability of employment
Poverty
Natural disasters
Access to negative influences e.g. violent films, pornography etc via media

Community
Rate of arrests in the community
High school dropout rates
Poverty
Presence of gangs In the community and exposure to violent media
Access to tobacco, alcohol, drugs, firearms etc
Value system
Lack of good adult role models

School (influence of teachers, other students and peers)
High school dropout rates
Size of school
Absenteeism
Suspension
Abusive teachers
Lack of school connectedness
Unsafe school environment- Bullying
Violence in schools
Accessibility to drugs, alcohol, cigarettes etc
Relationship with peers e.g. prejudice from peers perception of threat, gangs.

SUMMARY

Intentional injury refers to injury which is deliberately inflicted on oneself, another person or groups of people. There are various forms of intentional injury. Certain factors (risk factors) place young people at risk for violence. An understanding of these factors is important in designing effective interventions to tackle the problem of violence among adolescents and young people.

EVALUATION

- Define intentional injury.
- List types of intentional injury.
- Mention six risk factors for intentional injury.

MODULE FIVE SESSION 3
SEXUAL VIOLENCE – ISSUES

TIME: 1Hour 20 Minutes

LEARNERS' OBJECTIVES:

At the end of this session, the participant will be able to:

- Define sexual violence.
- Classify sexual abuses.
- Describe types of sexual abuses.
- Identify common reactions to sexual abuse.
- Discuss the relationship between gender inequality and sexual violence.

SESSION OVERVIEW:

- What is sexual abuse?
- Classification of sexual abuse.
- Types of sexual abuse.
- How do victims react to sexual abuse?
- What are the risk reduction strategies?
- What is the relationship between gender inequality and sexual violence.

METHODS

- Brain storming
- Group work
- Discussion / experience sharing
- Lecture
- Video Session

MATERIALS

- Flipchart stand/paper
- Chalkboard/chalk
- Slide/transparencies
- Markers
- Masking tape
- Video tape/CD/VCD (Child sexual abuse)
- VCR/TV
- Computer

CONTENT

INTRODUCTION

Sexual abuse is any psychological and/or physical form of abuse, which has sexual implications. ***Sexual Violence*** is a type of sexual abuse. It is any form of sexual activity that is not consensual on the part of the victim. It is important to note here that consent is always abrogated by bribe, threat, pressure, blackmail etc.

Sexual harassment is when a victim is sexually provoked, singled out, pestered, persecuted, frustrated or hounded in a manner that causes him/her emotional or psychological harm. A person in position of authority over a victim normally perpetuates it. Sexual abuse becomes sexual harassment when there is a power relationship between the abuser and the victim. It is often referred to as victimisation.

CLASSES/TYPES OF SEXUAL ABUSE

Sexual abuse is not restricted to sexual intercourse alone rather it covers a wide range of behaviours.

Table 5.1: CLASSES OF SEXUAL ABUSE

IMAGES	**PHYSICAL CONTACT**	***VERBAL***	***NON-VERBAL***
They can be: • Photographs; • Cartoons or graffiti that are offensive; • Explicit, depicting nudity; • Sexual act and abuses e.g. child pornography; • Writings on walls such as 'Toto' 'vagina the home of bacteria', borehole' or brusher'.	Physical contacts that constitute sexual abuse are determined by the '**touch continuum'**: • Who is doing the touching, • Where is being touched, • How is the touch being interpreted E.g. pinching, rubbing and -touching. **Battery** is a type of physical spousal abuse, which causes harm. **Rape/Sexual Assault** – sexual intercourse without consent, even though Nigerian law only recognises penetration without consent as rape.	*Verbal remarks and sounds that have sexual undertones and negatively impact on the dignity, self-esteem and security of the victims e.g.* • Kissing sounds, • Howling, • Saying sexual things, • Making comments about body parts, • Sexual rumours, • Telling dirty jokes, • Pressure from dates.	They are actions that cause discomfort to the recipients e.g. • Staring looks, • Gestures with the hands/body, • Winking, • Licking lips, • Facial expressions, • Clothing and appearance.

SEXUAL ABUSE IN MALE ADOLESCENTS

Many claim that the problem of sexual assault is not a man's problem. This claim assumes that only girls and women get sexually abused. Also, the Nigerian law does not recognize rape in males above the age of 14, and therefore does not make registered provisions for sanctions against offenders. The provision in the Nigeria law protects male children against carnal knowledge only when they are below the age 14. Anecdotal evidence reveals that some boys and men are victims of sexual violence, as shown by some studies conducted in northern Nigeria. There is however no accurate data on the prevalence of sexual assault in males.

Even though, the larger part of this session presents the female as the victims and the male as the assailants, there is the awareness that sometimes boys and men experience sexual abuse. Since sexual abuse occurring in male adolescents is as dehumanising and discriminatory as when it occurs in women and girls, it should be treated with equal seriousness and compassion.

Patterns of Abuse by Male Assailants

From the emerging cases in clinics and non-governmental organisations, it has been confirmed that when other boys or men abuse boys sexually, it is usually by oral or anal penetration.

Effects

In addition to psychological effects, physical effects of this abuse include the following:

- Anal bruises and lacerations
- Faecal incontinence due to frequent anal penetration
- Rectal gonorrhoea
- HIV/AIDS

Patterns of Abuse by Female Assailants

When boys are abused by girls or women, in a few cases, the boys see it as an opportunity and not an abuse. They are able to have an erection and penetrative sex through the vagina, thereby exposing them to STIs and HIV. In some cases, the boys are unable to have an erection, so the sexual activity is mostly through oral sex and digital penetration. In this context, boys are likely to suffer from infections such as pharyngeal gonorrhoea.

Intervention

- Care providers should educate the male children on their rights to say "No" to sex rather than the defective socialization that makes them see offers from women as an opportunity.
- Boys should also be given skills on saying "no to sex" (Refer Module 5 Session 5).

COMMON REACTIONS TO SEXUAL ABUSE

- Shock
- Loss of control/confusion
- Carrying on as "normal"
- Sleeping difficulties
- Eating disturbances
- Fear
- Shame

- Guilt
- Feelings of being dirty and violated
- Powerlessness
- Physical repulsion/sexual difficulties
- Depression
- Anger
- Post traumatic stress disorder
- Rape Trauma Syndrome

RISK REDUCTION STRATEGIES

- Acquire self defence skills.
- Avoid dark alleys.
- Avoid being alone with the opposite sex in isolated places.
- Avoid single dates.
- Adolescents dress modestly.
- Avoid use of alcohol and drugs.
- Clear communication of sexual limits.

RELATIONSHIIP BETWEEN GENDER INEQUALITY AND SEXUAL VIOLENCE

In our traditional societies, which are based on patriarchy, the skills given to boys while growing up are different from those given to girls. The differences in upbringing result into power imbalance between boys and girls, men and women in favour of the males. This makes females to be more susceptible to sexual violence.

- **THE BOYS ARE SOCIALISED TO:**

- Be aggressive, macho, dominant and in control.
- Be ready, and willing for sex always.
- Not to control sexual urge.
- Always get whatever they want.

- **THE GIRLS ARE SOCIALISED TO:**

- Be passive and submissive.
- Need a man to be in control.
- Give in to a man's sexual power and desires.

There is the need for us to give the same skills given to the boys to the girls to bring about equity and equality in the power-relationship. This will enable girls negotiate their relationships better and will contribute to a reduction in sexual violence. This does not imply that boys and men could not fall victims of sexual violence.

Others

Most women and girls have, and continue to experience violence from their male partners.

- In more than 60% of all rape cases, the victim knows the rapist.
- 40%-50% of all sexual assaults are against girls below the age of 15.

- Some boys and men are also victims of sexual violence.

SUMMARY

Sexual abuse is a violation of individual human rights. This should be discouraged. Young people should be encouraged to report all forms of sexual abuse.

EVALUATION

- Define sexual violence.
- Describe types of sexual abuses.
- Identify common reactions to sexual abuse.

MODULE FIVE SESSION 4:
SEXUAL VIOLENCE – INTERVENTIONS

TIME: 45 Minutes

LEARNERS' OBJECTIVES:
At the end of this session, participants will be able to:

- Describe types of crises intervention.
- Explain the objectives of crisis counselling.
- Discuss safety and security issues.
- Explain support and health care provision.
- List penalties for sexual offences.

SESSION OVERVIEW
- Types of crisis counselling/intervention
- Reasons for crises counselling/intervention
- Safety issues in sexual abuse
- Options for care of victims
- Sexual offences and Penalties in Nigerian law

METHODS
- Brainstorming
- Group work
- Experience sharing
- Lecture
- Video Session (Video clips on sexual violence)

MATERIALS
- Flipcharts stand/papers
- Chalk Board/Chalk
- Markers
- VCR/TV/
- Videotapes

CONTENT

TYPES OF CRISIS INTERVENTION

When an act of sexual violence is committed against an individual there are some immediate care the individual should receive in the form of counselling or medical treatment as listed below:

- Interpersonal or face to face counselling
- Telephone Counselling
- Referral for further management e.g. appropriate treatment such as suture and contraceptive options etc
- Legal Aid.

REASONS FOR CRISIS COUNSELLING/INTERVENTION

Crisis is a critical or crucial state of affairs characterised by trauma, intense mental emotional or physical disturbances resulting from stress. Therefore crisis counselling/intervention will:

- Enable the victim to regain control.
- Stabilise the victim's equilibrium.
- Help the victim cope with his or her crisis situation.
- Address and prevent secondary injury.
- Provide tangible assistance to the victim.
- Provide opportunities for victims to tell stories related to their experiences.

SAFETY/SECURITY ISSUES IN SEXUAL ABUSE

The first concern of any crisis intervener or counsellor should be for the physical safety of the victim. Other issues should be put aside until it is clear that the victim is not physically in danger or in need of medical attention. Security is also ensured if the adolescent knows that his/her reactions and comments and pains will be kept confidential.

Counsellors should provide appropriate information on other sources of support for the victims, discourage the destruction of evidence (taking a bath after being raped) and encourage formal report of the crime.

AVAILABLE SOURCES OF CARE AND SUPPORT

- In youth friendly centres where there are trained health care providers that can provide appropriate counselling care and support to victims.
- Clinics and health centres for medical support and attention.
- Legal aid centres for legal support and assistance with prosecution where necessary (WRAPA, FIDA, Local Police Stations).
- Government establishments e.g. Ministry of women affairs, youth and social development where there are welfare departments that provide support services.

OFFENCES AND PENALTIES

Most offences connected with sexual violence are punishable in law. However, persons who are considered minors (under 16 years) may not be held liable for certain related offences. The following table seeks to highlight the situation of minors under the laws of Nigeria, vis-à-vis liability for sexual offences committed against minors.

Table 5.2: SEXUAL OFFENCES AND PENALTIES

Offences	Penalties
Attempted rape	Up to life imprisonment
Buggery	Up to life imprisonment
Incest (under 13 years)	Up to life imprisonment
Incest (otherwise)	Up to 7 years imprisonment
Unlawful sexual intercourse (13-16 yr.)	Up to 2 years imprisonment
Unlawful sexual intercourse (under 13 yr.)	Up to 2 years imprisonment
Indecent assault	Up to life imprisonment

The maximum penalties for sexual offences in law are hardly applied to the maximum unless some "aggrieved factor" exists, such as extreme violence or a considerable degree of previous conviction for a similar offence. However, law enforcement agents do not adequately enforce and combat violations of sexual rights such as sexual harassment or abuse, rape and domestic violence.

REHABILITATION

Young offenders found guilty of an offence are sent to borstals normally within the prison yards for reformation. Others are sent to approved schools or remand homes.

SUMMARY

It is important that counsellors are familiar with the necessary intervention available for a young person who is a victim of sexual violence in order to help restore their self esteem.

EVALUATION

- List 4 types of crisis counselling.
- Give 5 reasons for crisis counselling.
- Give the options for care of victims of sexual violence.

MODULE FIVE: SESSION 5
UNINTENTIONAL INJURY

TIME: 1 Hour

LEARNERS' OBJECTIVES

At the end of the session, participants will be able to:

- Explain the concept of unintentional injuries.
- List the types of unintentional injuries.
- Explain the role of risk factors in the occurrence of unintentional injuries.

SESSION OVERVIEW

- Concept of unintentional injury
- Types of unintentional injury
- Magnitude of the problem of unintentional injuries
- Risk factors for unintentional injury
- Summary
- Evaluation

METHODS

- Brainstorming
- Lecture
- Discussion

MATERIALS

- Flipchart
- Markers
- Overhead projector
- Screen
- computer

CONTENT

DEFINITION

An unintentional injury also referred to as an accident is an injury that was not deliberately inflicted on the victim or victims. Unintentional injuries are the leading cause of death among children aged 10 – 19 years.

TYPES OF UNINTENTIONAL INJURY

These include the following:

- Road traffic injury
- Poisoning
- Falls
- Burn
- Drowning
- Other unintentional injuries e.g. sports injuries.

Road Traffic Injury

This is an injury due to crashes originating from, terminating or involving a vehicle partially or fully on a public highway (WHO, 1991). Road traffic injury (RTI) is the leading cause of death among 15 – 19 year olds and the second leading cause of death among 10 – 14 year olds. RTIs result in significant disability for victims and many victims still retain some level of disability for 6 months to up to a year after the crash.

Poisoning

This refers to injuries that result from being exposed to an exogenous substance that causes cellular injury or death. Poisoning ranks fairly high among the leading causes of mortality among 15 – 19 year olds. Generally, death rates from poisoning are higher in low and middle than high income countries.

Poisons can be inhaled, ingested, injected or absorbed. Exposure to the harmful agent could be acute or chronic. The common agents that cause poisoning vary between high and low/middle-income countries. Whereas medicines, recreational drugs such as cannabis and cocaine, household products like bleach, detergents, pesticides, poisonous plants and animal or insect bites are common agents in high income countries and some developing countries, hydrocarbons used for fuel and lightening (paraffin oil/ kerosene) are the predominant causes of poisoning in low and middle income countries.

Several factors influence the severity and outcome of poisoning. These include: the type of poison, the dose of the poison, the formulation (whether oral, injectable etc), the route of exposure, age of the individual, the presence of other poisons, the nutritional status of the person affected and the presence of other diseases or injuries in the victim.

Falls

A fall is an event which results in a person coming to rest inadvertently on the ground or floor or other lower level (WHO, 2008). Non-fatal falls were reported to be the 13th leading cause of disability-adjusted life years lost. Falls occur more among boys than girls and more among those in the low socio-economic groups.

Burn

A burn is defined as an injury to the skin or other organic tissue caused by thermal trauma. It occurs when some or all of the cells in the skin or other tissues are destroyed by hot liquids (scalds), hot solids (contact burns) or flames (flame burns), injuries to the skin or other organic tissues due to radiation, radioactivity, electricity, friction or contact with chemicals (WHO, 2006). Respiratory damage resulting from smoke inhalation is also considered to be burns. Worldwide, about 3.9% of burns occur in individuals aged 15 – 29 years.

Drowning

This is an event in which the individual's airway is immersed in a liquid medium, leading to difficulty in breathing (Idris A.H. et al, 2003). This event may result in death or survival. Although mortality from drowning varies amongst countries, up to 98% of these deaths occur in low and middle income countries.

MAGNITUDE OF THE PROBLEM

In developed countries, unintentional injuries are the number one cause of mortality among those aged 15 to 29 years. The incidence of unintentional injuries is also increasing in developing countries (WHO, 2001). A survey of the causes of death among adolescents in South Africa, reported that 57% of all deaths in those aged 10–19-years were as a result of unintentional injuries (WHO, 1995). Similar findings were obtained in Nigeria. Traffic-related fatalities are by far the most common cause of unintentional injuries in most world regions.

Unintentional injuries result in significant morbidity, mortality as well as economic losses to the victim, his/her family and the society at large.

Table 5.3 RISK FACTORS FOR UNINTENTIONAL INJURY

Risk factors for unintentional injury
Individual level
Age
Sex
Temperament
Out-of-school
Early puberty
Aggressive behavior
Impairment/ disability/ handicap
Poverty
Inadequate education
Not living with biological parents
Some illnesses e.g. Attention deficit hyperactivity disorder

Family level
Low parental education
Mental illness e.g. depression
Large family size
Overcrowding
Poverty
Access to weapons
Engaging in health compromising behaviors

Environmental Factors
Macro environment – the nation/ society
Legislation
Availability of employment
Poverty
Natural disasters
Community
Arrests
High school dropout rates
Poverty
Access to tobacco, alcohol, drugs, firearms etc
Value system
Lack of good adult role models

School (influence of teachers, other students and peers)
School environment
Size of school

SUMMARY

Unintentional injuries are inadvertently caused. They have a huge impact on adolescents, their families and the society at large. Injuries from road crashes are an important cause of mortality among adolescents.

EVALUATION

- Define unintentional injury.
- List types of unintentional injury.
- Mention four risk factors for unintentional injury.
- Mention four protective factors for unintentional injury.

MODULE FIVE: SESSION 6
PREVENTION OF INTENTIONAL AND UNINTENTIONAL INJURIES AMONG ADOLESCENTS

TIME: 1Hour 30 Minutes

LEARNERS' OBJECTIVES

At the end of the session, participants will be able to:

- Define the levels of prevention of injuries.
- Describe the Haddon's matrix.
- Describe the public health approach to injury prevention.
- List various interventions which can be used to prevent injuries.

SESSION OVERVIEW

- Levels of injury prevention
- The Haddon's matrix
- Public Health approach to injury prevention
- Interventions to prevent injuries

METHODS

- Brainstorming
- Lecture
- Discussion

MATERIALS

- Flipchart stand /papers
- Markers
- Paper tapes
- Overhead projector (OHP)
- Transparencies

CONTENT

INTRODUCTION

In the past, injuries were seen as inevitable events which could not be prevented and controlled. However, this concept has changed over the years as knowledge of injuries and predisposing factors have increased. It is now known that injuries can be prevented or controlled.

Injury prevention interventions have traditionally been viewed in terms of the "three 'E's" which are; education, enforcement and engineering and within the framework of the Haddon's matrix.

Lessons learnt from countries that have achieved significant reductions in injury incidence have shown that positive leadership, and wide-spread multi-sectoral efforts aimed at providing safer physical and social environments can lead to a sustained reduction in injury morbidity and mortality. Countries that have a designated government focal point responsible for addressing injury have also made significant progress in injury prevention. In Nigeria, the Federal Road Safety Commission (FRSC) is the designated government agency that has the responsibility of ensuring safety of all road users on Nigerian roads.

Levels of injury prevention

Primary prevention - This comprises interventions which focus on preventing new injuries. These interventions aim to ***prevent the event causing the injury from occurring*** or prevent it from leading to injuries. Examples include wearing protective gear when working or participating in sports.

Secondary prevention – interventions aimed at ***reducing the severity of injuries***. These focus on early diagnosis and appropriate management of an injury e.g. applying basic first aid at the scene of an incident to prevent an injury from having more serious consequences.

Tertiary prevention – interventions which ***decrease the frequency and severity of disability after an injury*** e.g. giving a person with an injury to the lower limb a walking stick or crutches to use.

The Haddon matrix

This was developed by William Haddon in the 1960's and used to apply the principles of public health to road safety. It comprises 12 cells arranged in four columns and each of these relates to the host, agent/vehicle, physical environment and the social environment. The three rows relate to the period – before, during and after the injury each of which corresponds to the primary, secondary and tertiary levels of prevention. The Haddon matrix has since been used to develop interventions for preventing other types of injuries. It provides a means to identify the following:

- strategies and priorities for injury prevention in terms of the costs and effects of such strategies
- research gaps i.e. existing research and what research still needs to be undertaken
- the allocation of resources in the past as well as in the future and the effectiveness of allocation of these resources.

Figure 5.2: THE HADDON MATRIX

	Human (or host)	**Vector**	**Physical Environment**	**Socio-economic Environment**
Pre-event	Is the host predisposed or over-exposed to risk?	Is vector hazardous?	Is environment hazardous? Does it have hazard-reduction features?	Does environment encourage or discourage risk-taking and hazard?
Event	Is host able to tolerate force or energy transfer?	Does vector provide protection?	Does environment contribute to injury during the event?	Does environment contribute to injury during the event?
Post-event	How severe is the trauma or harm?	Does vector contribute to trauma?	Does environment add to the trauma after the event?	Does the environment contribute to recovery?

Source: Holder Y, Peden M, Krug E, et al (E). Injury surveillance guidelines. Geneva, World Health Organization, 2001.

Haddon also described 10 strategies to accompany the matrix. These describe the ways in which the harmful transfer of energy which results in an injury can be prevented or controlled. The matrix and the injury prevention countermeasures both highlight the fact that society can do a lot to prevent injury and the interventions can occur at different stages.

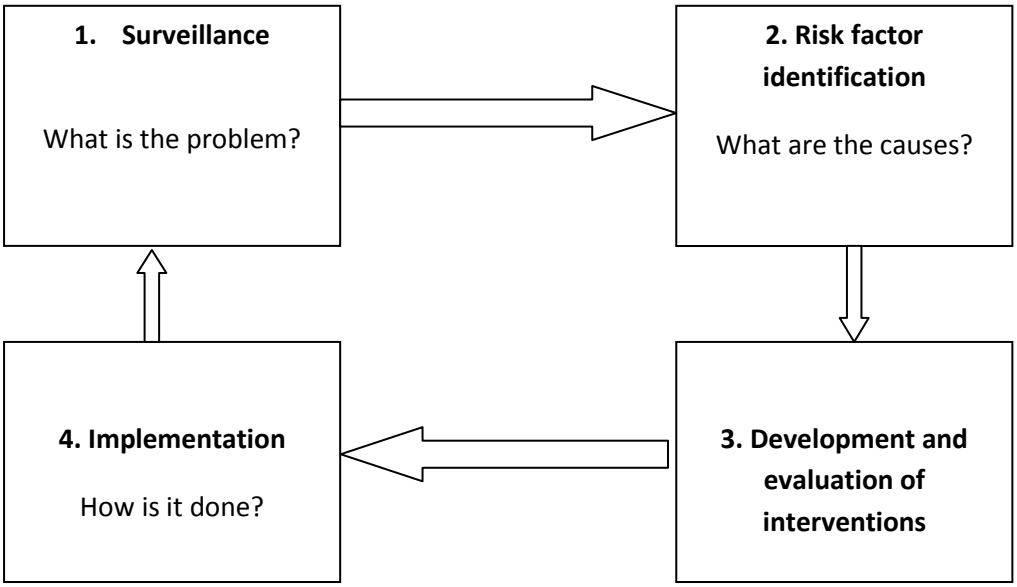
Table 5.4: TEN COUNTERMEASURES FOR INJURY OCCURRENCE

Strategy	
1.	Prevent the creation of the hazard in the first place.
2.	Reduce the amount of energy contained in the hazard.
3.	Prevent the release of the hazard.
4.	Modify the rate or spatial distribution of the hazard from its source.
5.	Separate people in time or space from the hazard and its release.
6.	Separate people from the hazard by interposing a material barrier.
7.	Modify the relevant basic qualities of the hazard.
8.	Make the person more resistant to damage.
9.	Counter the damage already done by the hazard.
10.	Stabilize, repair and rehabilitate the injured person.

THE PUBLIC HEALTH APPROACH TO INJURY PREVENTION

This utilizes the public health model and approaches to injury prevention in a systematic and logical manner (Figure 5.3). It makes it possible for injury prevention to be viewed in a holistic manner and brings together the various agencies involved in injury prevention. It comprises 4 steps each of which requires that evidence-based activities are carried out.

Figure 5.3: THE PUBLIC HEALTH APPROACH TO INJURY PREVENTION



EXAMPLES OF INJURY PREVENTION INTERVENTIONS

Primary prevention

- Prevention of occurrence of the injury event.
- Use of tamper-proof covers on medicine bottles.
- Use of stair gates at the head and foot of stairs.

Secondary prevention

- Legislation on seatbelt use and helmet use.
- Use of smoke alarms in buildings.

Tertiary prevention

- Provision of first aid for road traffic crash victims at the venue of the incident.

SUMMARY

Injuries can be prevented and controlled. Interventions can be implemented at three levels – primary, secondary and tertiary. The public health approach to injury prevention is a logical mechanism for injury prevention which requires that activities carried out are evidence-based. A multi-sectoral approach to injury prevention is advisable because several factors predispose to the injury event.

EVALUATION

- What are the levels of prevention of injuries?
- Describe the Haddon's matrix.
- What are the four steps in the public health approach to injury prevention?
- List four examples of injury prevention interventions.

MODULE SIX
MENTAL HEALTH

This module is divided into three sessions. It is designed to help participants appreciate some mental health challenges that impact on the health of young people as well as the problems associated with substance abuse. Participants will be equipped to counsel young people on these issues and refer appropriately where necessary.

SESSION 1: **MENTAL HEALTH**

SESSION 2: **MENTAL DISORDERS**

SESSION 3: **DRUG/SUBSTANCE USE DISORDERS**

SESSION 4: **INTERNET ADDICTION**

MODULE 6: MENTAL HEALTH / SUBSTANCE USE
SUMMARY AND TIMING ESTIIMATE

SESSION TITLE	DURATION	OBJECTIVES	METHODS	MATERIALS
Mental Health	1 Hour	• Define mental health. • Discuss the scope of mental health in adolescence. • Identify factors that affect mental health. • Identify signs of poor mental health. • Identify factors that maintain good mental health.	Brainstorming Lecture Discussion Presentation	OHP/OHT Flipcharts/papers Markers VCR/TV/Video cassette
Mental Disorders	2 Hours	• Define mental disorders. • Identify and describe common mental disorders. • Describe the causes of mental disorders. • Identify referral sites for mental disorders management. • Identify factors that aid prevention of mental disorders.	Brainstorming Lecture Discussion	OHP/OHT Flipchart stands/papers Markers VCR/TV/Video cassette
Drug/ Substance abuse	1Hour 30 Minutes	• Define substance, substance abuse, misuse tolerance, withdrawal symptoms and dependence. • Discuss the burden of substance misuse. • Identify factors for drug abuse. • Identify different types of substances commonly abused. • Describe the consequences of substance abuse on the individual, family and the community. • Identify preventive measures of substance abuse.	Brainstorming Lecture Discussion Presentation	OHP/OHT Flipcharts/papers Markers VCR/TV/Video cassette
Internet addiction	1 hour	• Define internet addiction • Describe the types of internet addiction • Discuss the epidemiology of internet addiction • Identify the consequences of internet addiction • Discuss the management of internet addiction Identify preventive mearsures	• Brainstorming • Lecture • Discussion • Presentation	• OHP/OHT • Flipcharts/papers • Markers • VCR/TV/Video cassette

MODULE SIX: SESSION 1
MENTAL HEALTH

TIME: 1 Hour

LEARNER'S OBJECTIVES

At the end of this session, participants will be able to:

- Define mental health.
- Discuss the scope of mental health in adolescence.
- Identify factors that affect mental health.
- Identify signs of poor mental health.
- Identify factors that maintain good mental health.

SESSION OVERVIEW

- Definition and scope of mental health in adolescence
- Factors that affect mental health in adolescents
- Signs of poor mental health
- Factors that maintain good mental health

METHODS

- Brainstorming
- Lecture
- Discussion

MATERIALS

- OHP/OHT
- Flipchart stand/paper
- Markers

CONTENT

MENTAL HEALTH

INTRODUCTION

Health has been defined by the World Health Organisation as a state of physical, mental and social well-being of an individual and not merely the absence of disease or infirmity. This definition emphasizes the need to perceive health at physical, mental and social levels. This underscores the need to appreciate the fact that the brain (mental health) controls the body and that good mental health is necessary for normal human functioning within the society.

Definition of Mental Health

It refers to the capacity of an individual, a group and the environment to interact with one another in ways that promote the feeling of well-being. This entails the optimal development and use of mental abilities (thinking, reasoning, understanding, feeling and behaviour) required for normal level of functioning. Mental health therefore involves satisfactory social relationship with others and it is not the same as mental disorders.

The World Health Organisation defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".

Scope of Mental Health in Adolescence

Mental health in adolescence may be characterized by a roller coaster of emotional and psychological highs and lows. Intense feelings are a normal and healthy part of the psychological landscape of youth, but it is also true that many mental health disorders of adulthood begin in childhood or adolescence. Recognition of the signs and symptoms of these mental health disorders is important because early intervention may be critical to restoring health.

Mental health disorders are typically marked by disruption of emotional, social, and cognitive functioning. Those disorders that most commonly affect adolescence are anxiety disorders, which manifest through phobias, excessive worry and fear, and nervous conditions; and depression disorders, characterized by states of hopelessness or helplessness that are disruptive to day-to-day life. Other mental health conditions affecting youth include bipolar disorder, conduct disorder, attention-deficit/hyperactivity disorder, learning disorders, eating disorders, autism, and childhood-onset schizophrenia.

Factors that affect mental health

The most common view is that mental disorders tend to result from genetic vulnerabilities and environmental stressors combining to cause patterns of dysfunction (Diathesis-stress model). A practical mixture of models is often used to explain particular issues and disorders. In many cases, mental illness emerges as a consequence of biological and environmental interactions.

For example, the predisposition for disorders such as schizophrenia, bipolar disorder, and depression are genetically heritable and may be activated by particular environments.

Environmental factors that lead to chemical imbalances in the body or damage to the central nervous system may also create biological vulnerabilities. The primary model of modern day psychiatry is the biopsychosocial model (BPS), which merges together biological (genetic, trauma, infections), psychological (psychoanalytic and cognitive) and social factors.

SIGNS OF POOR MENTAL HEALTH

The following may be warning signals for poor mental health:

- Always worrying.
- Unable to concentrate on jobs at hand for unrecognised reasons.
- Continually unhappy without justified cause.
- Losing your temper easily and often.
- Not sleeping well (insomnia).
- Wide fluctuations in mood (from depression to elation, back to depression) which incapacitates the person.
- Continually dislikes to be with people.
- Undue shyness.
- Upset when the routine of your life is disturbed.
- Children consistently getting on your nerves.
- Afraid without cause.
- Always right and the other person always wrong.
- Always suspicious of people around.
- Have numerous aches and pains for which no doctor can find a physical cause.

FACTORS THAT MAINTAIN GOOD MENTAL HEALTH

1. **Build Confidence**
   Identify your abilities and weaknesses together, accept them, build on them and do the best with what you have.

2. **Eat right, Keep fit**
   A balanced diet, exercise and rest can help you to reduce stress and enjoy life.

3. **Make Time for Family and Friends**
   These relationships need to be nurtured; if taken for granted they will not be there to share life's joys and sorrows.

4. **Give and Accept Support**
   Friends and family relationships thrive when they are "put to the test".

5. **Create a Meaningful Budget**
   Financial problems cause stress. Over-spending on our "wants" instead of our "needs" is often the culprit.

6. **Volunteer**

Being involved in community gives a sense of purpose and satisfaction that paid work cannot.

7. **Manage Stress**

We all have stressors in our lives but learning how to deal with them when they threaten to overwhelm us will maintain our mental health.

8. **Find Strength in Numbers**

Sharing a problem with others who have had similar experiences may help you find a solution and will make you feel less isolated.

9. **Identify and Deal with Moods**

We all need to find safe and constructive ways to express our feelings of anger, sadness, joy and fear.

10. **Learn to Be at Peace with Yourself**

Get to know who you are, what makes you really happy, and learn to balance what you can and cannot change about yourself.

SUMMARY

Mental health is an integral and equally important component of the well being of an individual. Mental health enhances satisfactory inter-personal and social relationships. A good knowledge of early signs of poor mental health and tips for promoting optimal mental health among adolescents is important.

EVALUATION

- Define mental health.
- List five signs of poor mental health.
- List five factors that promote mental health.

MODULE SIX: SESSION 2
MENTAL DISORDERS

TIME: 2 Hours

LEARNER'S OBJECTIVES

At the end of this session, participants will be able to:

- Define mental disorders.
- Identify and describe common mental disorders.
- List causes of mental disorders.
- Identify referral sites for the management of mental disorders.
- Identify factors in the prevention of mental disorders.

SESSION OVERVIEW

- Definition of mental disorders
- Identification of common mental disorders
- The causes of mental disorders
- Referral sites for mental disorders management
- Prevention of mental disorders

METHODS

- Brainstorming
- Lecture
- Discussion

MATERIALS

- Slides/transparencies
- Overhead projector
- Flipchart Stand and paper
- Markers
- Computer

CONTENT

MENTAL DISORDERS

INTRODUCTION

Mental disorders account for a large proportion of the disease burden in young people in all societies. Most mental disorders begin during youth (15–24 years of age), although they are often first detected later in life. Poor mental health is strongly related to other health and development concerns in young people; notably lower educational achievements, substance abuse, violence, and poor reproductive and sexual health.

Those disorders that most commonly affect adolescence are anxiety disorders, which manifest through phobias, excessive worry and fear, nervous conditions; and depression disorders, characterized by states of hopelessness or helplessness that are disruptive to day-to-day life. Other mental health conditions affecting youth include bipolar disorder, conduct disorder, attention-deficit/hyperactivity disorder, learning disorders, eating disorders, autism, and childhood-onset schizophrenia.

DEFINITION OF MENTAL DISORDER

It can be defined as an illness with psychological or behavioural manifestations and or impairment in functioning due to social, psychological, genetic, physical or biological disturbance. Mental disorders are characterised by abnormalities in a person's emotions, thoughts, cognition, sensory perceptions, beliefs and behaviour.

TABLE 6.1 COMMON TYPES OF MENTAL DISORDERS

Anxiety disorders	**Signs and symptoms**
Panic disorders Specific phobias or social phobias Generalized anxiety disorder Obsessive compulsive disorder Acute stress reaction Post-traumatic stress disorder	• **F**ear • Pounding heart or accelerated heart rate • Trembling • Sweating • Difficulty in sleeping at night • Abdominal distress • Sensation of shortness of breath • Feeling dizzy, unsteady, light-headed and faint • Feelings of unreality or being detached from oneself • Fear of losing control or going crazy • Fear of dying • Numbness or tingling sensations • Chills or hot flushes
Mood disorders	**Signs and symptoms**
Major depressive disorder	• Depressed mood most of the day, nearly everyday • Markedly diminished interest or pleasure in all or almost all activities • Fatigue or loss of energy

	• Poor appetite and significant weight loss • Insomnia particularly early morning wakening • Psychomotor agitation or retardation in movement and thinking • Feeling of worthlessness or inappropriate guilt • Diminished ability to think or concentrate • Recurrent thought of death • Suicidal thought and/or attempts
Manic episode	• Inflated self-esteem or grandiosity • Decreased need for sleep • More talkative than usual or pressure to keep talking • Subjective experience that thought are raising • Attention too easily drawn to unimportant or irrelevant external stimuli • Increase in goal directed activity • Disinhibition e.g. engaging in unrestrained buying sprees, sexual indiscretions or foolish business investment.

Conduct Disorders	**Signs and symptoms**
A repetitive and persistent pattern of behaviour in which either the basic rights of others or major age-appropriate societal norms or rules are violated.	• Aggression to people and animals • Destruction of property • Deceitfulness of theft • Serious violation of rules
Substance (drug) related disorders	• Substance intoxication • Recurrent use of habit-forming drug resulting in a failure to fulfill major obligations • Recurrent substance use in situations in which it is physically hazardous • Recurrent substance related legal problems, continued substance use despite having persistent or recurrent social or interpersonal problems used or exacerbated by the effects of the substances. • A need for markedly increased amount to the substance to achieve intoxication or desired effect (tolerance) • Withdrawal symptoms.
Adjustment disorders Emotional or behavioural symptoms that occur in response to stressful life events	• Marked distress that is in excess of what would be expected from exposure to the stressor • Significant impairment in social or occupational functioning • Adjustment disorder can manifest with depressed mood, anxiety, or disturbance of conduct.
Disorders of human sexuality ***Non organic sexual dysfunction*** Sexual disorders (paraphilia) Abnormal sexuality is sexual behaviour: • That is destructive to oneself or others. • That cannot be directed toward a partner. • That excludes stimulation of the primary sex organs.	• Sexual desire disorders • Sexual arousal disorders • Orgasm disorders • Sexual pain disorders • Substance induced sexual dysfunction • Sexual dysfunction due to general medical conditions e.g. diabetes, hypertension. • Exhibitionism • Fetishism • Paedophilia

• That is inappropriately associated with guilt and anxiety or that is compulsive.	• Sexual sadism • Voyeurism • Transvestic fetishism
Organic braindDisorders These are mental illnesses caused by physical problems such as infections, trauma, substance abuse, epilepsy etc.	• Disturbance of consciousness e.g. confusion • Memory deficits • Development of perceptual disturbance e.g. Visual hallucinations.
Schizophrenia	**Signs and symptoms**
These are mental disorders characterized in general by fundamental and characteristic distortions of thinking and perception, and by inappropriate or blunted affect. Clear consciousness and intellectual capacity are usually maintained, although certain cognitive deficits may evolve in the course of time.	• Characteristic symptoms: Two or more of the following, each present for much of the time during a one-month period (or less, if symptoms remitted with treatment). - Delusions - Hallucinations - Disorganized speech, which is a manifestation of formal thought disorder - Grossly disorganized behavior (e.g. dressing inappropriately, crying frequently) or catatonic behavior. - Negative symptoms: Blunted affect (lack or decline in emotional response), alogia (lack or decline in speech), or avolition (lack or decline in motivation). • Social/occupational dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care, are markedly below the level achieved prior to the onset.

Eating disorders	Signs and symptoms
Eating disorders Anorexia nervosa	• There is weight loss or, in children, a lack of weight gain, leading to a body weight of at least 15 % below the normal or expected weight for age and height. • The weight loss is self-induced by avoidance of 'fattening foods'. • There is self-perception of being too fat, with an intrusive fear of fatness, which leads to a self-imposed low weight threshold. • A widespread endocrine disorder involving the hypothalamic-pituitary-gonadal axis is manifest in women as amenorrhea, and in men as a loss of sexual interest and potency.
Bulimia nervosa	• There are recurrent episodes of overeating (at least twice a week over a period of 3 months) in which large amounts of food are consumed in short periods of time. • There is persistent preoccupation with eating, and a strong desire or a sense of compulsion to eat. • The patient attempts to counteract the 'fattening' effects of food by one or more of the following: - self-induced vomiting. - self-induced purging. - alternating periods of starvation. - use of drugs such as appetite suppressants, thyroid preparations or diuretics.

CAUSES OF MENTAL DISORDERS

Mental illness does not come without a warning. It is the combination of unsuccessful reaction to life problems and long term failure to adjust to real life situations. The causes may be attributed to:

- Emotional experiences in infancy and childhood, broken home and socio-economic problems.
- Psychosocial stressors e. g. failure of examination, unwanted pregnancy, parental quarrels.
- Brain injuries e.g. at childbirth, accidents etc.
- Substance abuse e.g. alcohol, cannabis.
- Biological factors including genetic factors.

REFERRAL CENTRES

Persons with mental disorders can be referred to:

- Primary health care centres.
- Secondary and tertiary health facilities e.g. State and General hospitals, Teaching hospitals, and Psychiatric hospitals.

PREVENTION

Primary prevention: It aims at reducing the number of new cases, includes efforts at education concerning risk factors and protective factors of mental disorders e.g. need for adequate antenatal

and delivery methods to prevent birth injury and mental retardation or the dangers of substance abuse.

Secondary prevention: It aims at reducing the number of identified cases through early detection and appropriate treatment. It is important to advocate prompt referrals to enable quick and effective management of every case.

Tertiary prevention: It aims at reducing the effect of the illness on individual and the society through rehabilitation and reintegration of the patient back into the society after the illness has been treated successfully. This usually involves vocational training, occupational therapy, support groups etc.

SUMMARY

Recognition of the signs and symptoms of mental health disorders is important because early intervention may be critical to restoring health. Mental health disorders are typically marked by disruption of emotional, social, and cognitive functioning. A good knowledge of cases, signs and common types of mental disorders will go a long way to help in promoting mental health among adolescents.

EVALUATION

- Define mental disorders.
- List three causes of mental disorders.
- Name three types of mental disorders and their signs and symptoms.
- List three preventive factors for mental disorders.

MODULE SIX: SESSION 3
SUBSTANCE ABUSE

TIME: 2 Hours

LEARNER'S OBJECTIVES

At the end of this session, participants will be able to:

- Define drugs, licit and illicit drugs, substance abuse, tolerance, withdrawal and dependence.
- Identify the different types of drugs commonly abused.
- Describe the consequences of using substances on the individual, family and the community.
- List at least four methods of treatment and prevention of drug abuse.

SESSION OVERVIEW

- Definition of terms
- Burden of substance misuse
- Factors associated with drug abuse among adolescents
- Drugs that are commonly abused
- Consequences of drug abuse
- Treatment and prevention of drug abuse

METHODS

- Brainstorming
- Lecture
- Discussion
- Presentation

MATERIALS

- Slides/transparencies
- Flipchart stand and paper
- Markers
- VCR/TV/video cassette
- Computer
- Sample drugs

CONTENT

SUBSTANCE ABUSE

INTRODUCTION

Drug (Substance) abuse has become a public health problem all over the world. In resource-poor countries, the problem is of no less importance than in Western countries and exacts a tremendous toll in terms of morbidity and mortality. In Nigeria within the last two decades, adolescents and young adults have been found to be abusing licit (alcohol, tobacco) and illicit substances (Indian hemp, cocaine and heroin). The abuse of such substance has harmful effects on the individual, family and the larger society.

In addition to acute effects and disorders, substance use in children and adolescents can harm the healthy development of the body, brain, and behaviour. Also, apart from the consumption of such drugs, trafficking in illicit drugs constitutes a criminal offence. Unfortunately, male youths predominantly form the risk group at tender ages of 10-15 years. It is therefore essential for the society (Government and non-Governmental Organizations) to work out strategies (methods) of controlling drug abuse in our societies.

DEFINITIONS

- **Drug**
  A drug is a substance which affects the body to modify its functioning. Drugs which mainly affect the level of consciousness/mind, mood and behaviour are called psychoactive drugs. These psychoactive drugs have habit-forming potentials. Examples of these drugs are cigarette (nicotine), alcohol, cannabis (Indian hemp), heroin, cocaine and kola-nut.

- **Tolerance**
  This is said to have developed when a drug produces a decreased effect or when there is the need for markedly increased amounts of the substance to achieve a desired effect.

- **Substance dependence**
  This is a repetitive prolonged use of a habit forming drug to the extent that there will be an overriding desire for the drug, and tendency to increase the frequency and quantity used. There is also the development of withdrawal symptoms when attempt is made to stop the use of the drug.

- **Substance withdrawal**
  This is the manifestation of physical and / or psychological symptoms e.g. sweating, tremors or restlessness occurring when a drug is reduced in amount or stopped and usually lasts for a limited time.

- **Substance intoxication**
  This is the development of reversible substance – specific problems due to recent ingestion of (or exposure to) a substance e.g. excessive consumption of alcohol over a short period of time and usually disappears when that substance is eliminated from the body.

DRUG (SUBSTANCE) ABUSE

Substance abuse is a maladaptive recurrent pattern of use of a habit-forming drug that may lead to significant impairment or distress manifesting as:-

- Failure to fulfill major role obligations at work, school or home e.g. poor work performances, absenteeism, expulsion from school, neglect of children etc.
- Recurrent substance use in situations in which it is physically hazardous e.g. operating a machine.
- Recurrent substance related legal problems e.g. arrest for substance-related disorderly conduct.
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or made worse by the effects of the substance.

The abuse of habit-forming drugs can progress from the stage of experimentation through the stage of more frequent use to the stage of drug dependence/addiction. At this stage of physical and/or psychological dependence, there is a craving for the drug of choice, tendency to increase the dose of drug used, withdrawal signs and symptoms when the drug is stopped.

BURDEN OF SUBSTANCE ABUSE

Hazardous alcohol intake and related disorders are major public health problems. In addition to formal alcohol disorders such as dependence and harmful use, increasing attention has been paid to hazardous alcohol intake, defined as a level of consumption or pattern of drinking which, if it persists, is likely to result in harm. Hazardous alcohol intake is directly or indirectly implicated in many physical, psychological, and social problems, imposing a substantial financial burden on the drinkers and on society. Most alcohol-related problems appear in non-alcoholic dependent individuals who fall into the categories of hazardous or harmful drinkers according to the World Health Organisation (WHO) (2000) terminology.

Adolescent substance abuse is a serious concern worldwide and substance use by youth has serious health and social implications. For example, although most youths who use drugs do not commit violent crimes, there is a correlation between frequency and severity of juvenile delinquency and frequency and severity of drug use. In addition, health issues such as the long-term physical effects of tobacco use and increased risk of childhood injuries are critical concerns related to substance abuse by adolescents.

The result of the National Household Survey on Drug Abuse shows that the prevalence of alcohol use increases progressively from early adolescence o young adulthood. A review of the studies on alcohol use in Nigeria shows that there has been a rapid increase in alcohol availability and consumption in recent times with young adults in universities and colleges being those mainly concerned.

WHY ADOLESCENTS USE SUBSTANCES

Adolescents often take to drugs because of environmental influences, defects in their personality (who they are) or because such substances are easily available. Some of the most common reasons are:-

- Peer pressure i.e. influence of friends;
- Ineffective control of drug availability;
- Out of curiosity - they want to find out about it;
- To gain acceptance by friends e.g. cultism in institutions of learning;
- As a means of escaping from or relieving pressures;
- To get high;
- As a means of relaxation;
- Parental use of drugs e.g. They smoke cigarette or drink alcohol;
- Problems at home or at school;
- They work on jobs or in environment that encourages drug use e.g. as bar attendants, cigarette vendors;
- Presence of personality problems e.g. antisocial personality disorder;
- Heredity – alcohol and other drug problems tend to run in some families;
- Parental deprivations e.g. separation, divorce; death of parents;
- Advertisements: youths learn wrong information from advertisement of tobacco and alcohol;
- Social change, youths moving from rural areas to urban centres where they have no social support, unemployment.

DRUGS COMMONLY ABUSED IN NIGERIA

- Alcohol
- Tobacco
- Cannabis (Indian Hemp)
- Stimulants e.g. dexamphetamines, pemoline
- Anxiety relieving drugs e.g. valium, lexotan
- Opioids e.g. heroine
- Cocaine
- Volatile substances e.g. Solvents
- Coffee, tea, kola nuts
- Hallucinogens

EARLY WARNING SIGNS OF DRUG ABUSE

There are certain behaviours, which can help parents and care givers to suspect in good time when a person is using drugs. These are:

- Sudden change in behaviour and mood
- Sudden change and decline in attendance and performance at school or work
- Unusual temper flare-ups
- Increased borrowing of money from parents and friends
- Stealing at home, school or work place
- Unexplained long absence from home
- Unnecessary secrecy

- Changes in dressing and appearance
- Presence of paraphernalia e.g. syrups, foil paper, lighter and burnt spoon.

EFFECTS OF DRUG ABUSE

The consequences of excessive and/or prolonged drug abuse can be socio-economic, physical or psychological.

Social

- Loss of sense of responsibility
- Loss of Job
- Family disruption
- Criminal behaviour
- Delinquent acts usually in youths
- Lack of achievement
- Promiscuity
- Road traffic accidents
- Attempted suicide & suicide

Physical

- Physical dependence leading to withdrawal reactions,
- Sympathetic nervous system stimulation (restlessness, tremors) as in amphetamine or cocaine abuse,
- Depression of the central nervous system with drugs such as alcohol, barbiturates, heroin, Valium etc.,
- Damage to organs such as liver, brain, pancreas, and peripheral nerves,
- Head injury from road traffic accidents, falls, home accidents etc.,
- Damage to unborn babies, e.g. fetal alcohol syndrome in alcoholic mothers, low birth weight in chronic cigarette smokers, etc.

Psychological Complications

- Psychic dependence leading to cravings e.g. cannabis, tobacco, kolanuts,
- Mood altering resulting in mood elevation or depression e.g. drugs such as cocaine, amphetamines, cannabis, and alcohol,
- Abnormal behaviour such as psychosis with drugs like cannabis, cocaine, amphetamines,
- Psychological symptoms of withdrawal e.g. hallucinations, severe anxiety, sleep disturbance etc.,
- Dementia- Impairment of memory as in chronic alcohol use,
- Personality disintegration and loss of self-esteem,
- Lack of motivation as seen in chronic cannabis abuse,and
- Sexual disorders such as impotence and delayed ejaculation.

TABLE 6.2: SUMMARY TABLE OF COMMON DRUGS ABUSED AND THEIR EFFECTS

DRUG GROUP	EFFECTS	DANGER	EXAMPLE
STIMULANTS	• Can cause increase in energy and activity. • Can suppress hunger. • Produce a state of excitement or 'feeling good'. • Can cause one to be in a state of euphoria. The intensity of the feeling depends on the type of drug e.g. cocaine is stronger than caffeine in coffee.	• Sleeplessness • Anxiety • Irregular heartbeat • Possible heart failure • Over excitement • Hypomania • Hallucination and other forms of mental disorders; Reckless behaviour • Tolerance and psychological dependence develop quickly. Amphetamine can cause psychosis.	• Cocaine (crack) • Caffeine • Nicotine • Amphetamine
DEPRESSANTS	• Can slow down body functions. • Cause sleep or drowsiness. • Lead to fall in blood pressure, lowering of the heart rate and breathing, unconsciousness. • Can cause death: Can make a person to "feel good" at the beginning. • Can cause depression in addicts.	• Drowsiness • Uncoordinated behaviour and actions • Difficulty in operating machines • Unconsciousness and death	• Alcohol • Lexotan • Valium • Other benzodiazepines • Barbiturates
MARIJUANA	• Can alter the way people see, hear, and feel. • Can cause fear or reduce it thereby making the user bolder and more daring in taking risk. • Can cause dryness of mouth and throat. • Disorientation • Confusion	• Problem of coordination • Long term use can also decrease libido, and affect sperm production. • Like cigarette smoking, it can cause damage to the respiratory system especially the lungs. • Can reduce motivation; and • Precipitate mental disorders.	• Indian hemp, also referred to as • "Weed • "Igbo" • "Ganye".
INHALANTS	• Inhaled fumes can cause - Excitation, - Dis-inhibition. • Euphoria.	• Dizziness • Incoordination • Slurred speech • Unsteady gait • Lethargy • Tremor • Generalised muscle weakness • Blurred vision • Euphoria • Stupor or • Coma. • Facial rash	• Glue (Solution for patching shoes) • Paint thinner • Nail-polish remover • Aerosols like hair spray, and petrol.

OPIOIDS	• Can induce analgesia, drowsiness and changes in mood.	• Nausea or vomiting • Muscle aches • Watering of eyes and running of noses • Sweating • Chills • Diarrhoea • Yawning • Fever • Insomnia	• Heroin • Morphine • Codeine.

CONSEQUENCES OF USING SUBSTANCES ON REPRODUCTIVE HEALTH

Apart from the general effects of drugs on the body, drugs particularly affect reproductive health in a very serious and harmful way. Drugs cause disinhibition and may also make young people to be more daring. In this state, they take risks including:

- Sexual experimentation: Unprotected sexual activity may lead to:
  - Infection with STIs and HIV/AIDS (untreated STIs may lead to infertility)
  - Sexual abuse and rape
  - Unwanted pregnancy: (Illegal unsafe abortion may be procured to terminate unwanted pregnancy, which may lead to infection, bleeding, infertility or death).
- Prostitution in order to sustain the habit.
- Early initiation of sexual activity, which is more likely to have serious health problems in future such as cancer of the cervix.
- Poor performance at school: such school dropout falls into the low-income group where problems of unplanned families are more common.
- Unstable homes, marital disharmony, separation and divorce.

CONSEQUENCES OF USING SUBSTANCES ON THE INDIVIDUAL, FAMILY AND THE COMMUNITY

INDIVIDUAL

Drug abuse may have the following effects on the individual:

- Development of behavioural problems showing in the forms of misconduct, loss of self-control, lack of self-discipline, social irresponsibility, lack of social trust, etc.;
- Physical health problems arising from damage to important organs of the body such as chest infections, lung cancer, liver damage, poor state of nutrition; injuries arising from frequent accidents at home, school, workplace or in the traffic, and STIs/HIV/AIDS and reproductive problems;
- Psychological and mental health problems such as: slowed reflexes, inability to think clearly and understand properly, memory and perceptual disturbances, severe forms of mental illness such as psychosis;
- Poor academic performance leading to school drop-out; falling into crime, single parenthood, prostitution, imprisonment etc.

FAMILY

Drug problems in any member of the family may lead to the following:

- Increase in domestic violence and sexual abuse of some members of the family, especially the females, thereby precipitating a breakup of the family;
- Stigmatization of the family because of drug abuse, social misconduct or criminal behaviour associated with the drug use. When this happens, the family may experience shame and disappointment and will lose prestige;
- Heavy burden to tolerate the addict, support the drug behaviour and care for him or her in the hospital or other places of treatment as well as get him or her out of the many troublesome situations which he or she is likely to fall in;
- Drug addicts tend to fail in their responsibility to the family and this may lead to a breakdown of the family.

COMMUNITY

Drug problems impose burden on society in many ways, including the following:

- Economic loss arising from damage to machinery in the workplace;
- Damage to road structures;
- Pressure on public health institutions;
- Loss of work days due to ill health;
- Pressure on the legal, judicial and security services, including the prisons in the effort to combat drug trafficking and abuse. These services are also under pressure from collaborating with international agencies and other countries in combating drug abuse and trafficking;
- Drug trafficking is associated with such crimes as racketeering, conspiracy, bribery, corruption, murder, extortion, blackmail, tax evasion, money laundering, illegal possession of weapons, terrorism, etc. A country may lose prestige and international respect if ostracized by other countries because its citizens traffic drugs.

MANAGEMENT/REFERRALS

Management

Management of drug abusers is usually fraught with difficulties. Some of the difficulties encountered in managing drug addicts are due to the following characteristics:

- Some of them can become aggressive and violent under the influence of drugs.
- Majority of drug addicts tell lies and cannot be believed or trusted.
- Most of them are very manipulative, dependent on other people and crafty.
- Under the influence of drugs, addicts have a high tendency to commit suicide or harm themselves.
- Some addicts are given to the life of crime and may not have developed enough skills to survive outside the drug culture.
- They may be completely occupied with seeking out drugs and taking them to the extent that nothing else matters to them including offer to help.
- Under the influence of drugs their mood may swing unpredictably.

Main methods of treatment

- Referring the drug addict to treatment centres such as hospitals, counselling centres or rehabilitation homes for full assessment including history taking, examination, testing and treatment of all problems identified.
- If the person is having serious withdrawal symptoms, he may need to be admitted and detoxified. This is a process of getting rid of the drug in the person's body under controlled situation and monitoring. The client will be placed on medication by professionals under close observation. After the initial phase of detoxification and taking care of any existing physical problems, the person is enlisted into a drug treatment programme where psychological forms of treatment may be used to assist him or her to get out of the habit of taking drugs.
- The addict will also be assisted to develop skills that may equip him for independent economic existence when he goes back to society. This process is called rehabilitation. Rehabilitation programmes are of different types and can be set in different locations or for specific groups, such as adolescents.
- On discharge back to society, some drug addicts may be advised to attach themselves to self-help groups for further reinforcement of their determination to stay free of drugs. Self-help groups are made up of people who have similar problems in the past and have decided to come together to help and reinforce themselves so that they can continue to stay away from drugs. The most common of these groups is the AA or Alcoholic Anonymous. The group has established a set of regulations to guide their conduct, which they follow faithfully. These guidelines or rules are called the 12 steps and 12 traditions of the AA.
- Apart from these, the drug abuser/client needs constant support from the family, the community and his or her primary therapist. He needs to be counseled regularly to assist him have information to enable him make the right life choices.
- Counsellors should refer identified health problems promptly.

Treatment of health problems related to drug abuse

The main point to note in the treatment of problems related to drug abuse is that drug abuse is dangerous to health and is often a problem of young people whose lives may be ruined if adequate intervention is not made in good time. The situation should therefore always be given the seriousness it deserves.

Prevention

The main ways to prevent drug abuse are by controlling the supply of the drugs and by reducing the demand for the drugs by users. These are done through several strategies including :

- Use of mass media to increase public awareness to drug problems;
- Drug abuse preventive education in schools;
- Community and NGOs involvement in drug prevention activities;
- Provision of counselling centres in schools, mosques, churches and primary health centres etc.;
- Early identification, treatment and social reintegration of drug abusers;
- Legislation to prohibit production, distribution, advertisements, sale and use of drugs;
- Limiting the cultivation of drugs producing plants to medical and scientific purposes only;
- Providing those who grow drug producing crops like cannabis (Indian Hemp) with other economic activities so that they can stop further planting, e.g. by crop substitution;
- Establishing effective monitoring system to check drug production and distribution;

- Participating in international conventions on drug control and collaborating with other countries to control drug trafficking;
- Ensuring enforcement of drug control laws;
- Preventing drug abuse in young people through education and counselling; and
- Providing accurate information education and counselling to young people.

CASE STUDIES

Case Study 1

Boy Alinco is 17 years old and in his final year in secondary school. He had attended a secret send off party organized by his friends where he was given some powdery substance to sniff. He did this out of curiosity and felt nice about it. He however wanted advice from the counsellor because his friends had invited him to a venue where he could get more of the stuff. As a counsellor what would be your approach to him?

Strangers brought a seventeen-year-old boy to the school compound in your hometown after the school had closed and all the teachers had gone home. They found him along the road in school uniform. He could not explain himself and they decided to help by bringing him to the school. He looked frightened, very untidy, his eyes were red, his mouth was dry and was breathing very fast. His body temperature was equally high. Occasionally he mumbled something and wanted to run away. His schoolmates disclosed that he had not attended school for three days, which was strange about him.

They knew him to live with his mother and two sisters. The mother had travelled about a week earlier. The father lived in another town and was married to another lady. The boy had not passed his examinations in the last two terms and had been warned to improve or he would be asked to repeat the class. As a counsellor what would be your approach?

TIPS FOR THE COUNSELOR

During counselling sessions, the counsellor should do the following for his/her client:

- Identify the drugs abused
- Identify reasons for use
- Provide information on effects of the substance on the person
- Make appropriate referrals
- Follow up

SUMMARY

Several reasons account for why young people engage in substance use. Substance abuse results in several consequences on the individual young person, the family, and the society as a whole. As a result, it is necessary to detect the abuse of substances in a young person early by identifying early warning signs and referring for professional treatment as well as counselling. Emphasis should also be placed on drug demand reduction through various strategies which include information, education and communication (IEC), and legislation, to mention a few.

EVALUATION

- Define drug abuse.
- List 5 drugs that can be abused and their effects.
- Give 5 reasons for which young people abuse drugs.
- Give 3 reproductive health consequences of drug abuse.
- List three ways through which we can prevent drug abuse.
- Use the case studies above.

MODULE SIX: SESSION 4
INTERNET ADDICTION

TIME: 1 HOUR

LEARNER'S OBJECTIVES

By the end of this session, participants will be able to:

- Define internet addiction
- Describe the types of internet addiction
- Discuss the epidemiology of internet addiction
- Identify the consequences of internet addiction
- Discuss the management of internet addiction
- Identify preventive measures

SESSION OVERVIEW

- The scope of internet addiction adolescence.
- The types of internet addiction
- The epidemiology of internet addiction
- The consequences of internet addiction
- The management of internet addiction
- The prevention of internet addiction
- .

METHODS

- Brainstorming
- Lecture
- Discussion

MATERIALS

- OHP/OHT
- Flipchart Stand/paper
- Markers

CONTENT

INTERNET ADDICTION

INTRODUCTION

- The Internet has revolutionized the information and communication flow of people, changing the way we interact with others, gather and disseminate information, do business, express and entertain ourselves. Yet, for all its benefits, the Internet has also been identified as an accessory to issues including extra-marital affairs, pornography, and gambling. There also appears to be a growing concern, for what has been labeled “Internet addiction.”

DEFINITION OF INTERNENT ADDICTION

- An individual’s inability to control his/her use of the Internet, which eventually causes psychological, social, school, and/or work difficulties in a person’s life.
- A psychological dependence on the Internet characterized by an increasing investment of resources on Internet-related activities, unpleasant feelings when off-line, an increasing tolerance to the effects of being online, and denial of the problematic behaviors.

TYPES OF INTERNENT ADDICTION

- ***Cybersexual Addiction***: compulsive use of adult websites for cybersex and cyberporn
- ***Cyber-relationship Addiction***: over-involvement in online relationships
- ***Net Compulsions***: obsessive online gambling, shopping, or day-trading
- ***Information Overload***: compulsive web surfing or database searches
- *Computer Addiction*: obsessive computer game playing

EPIDEMIOLOGY

- A common finding is that there are significantly more males who are addicted to the Internet than females.
- Compared to non-addicts, Internet addicts tended to be students and younger in age compared to non-addicts.
- Adolescents are in the process of psychological maturation and solidifying their personalities, they are particularly vulnerable to developing addictive behaviors.

AETIOLOGY

Personality factors: Personality characteristics that have most frequently been associated with the development of Internet addiction are shyness, low self-esteem, and lack of emotional and social skills.

Social factors: There is research that suggests the importance of family factors in predicting Internet addiction. Studies validate the relationship between parenting style, family communication and Internet addiction.

Psychopathology: Disorders that have been most frequently cited as being comorbid with Internet addiction include Attention Deficit Hyperactivity Disorder, Substance Use and other addictive behaviours such as watching television and playing video games.

DIAGNOSIS

- Maladaptive pattern of Internet use, leading to clinically significant impairment or distress, occurring at any time within the same 3-month period
- Six (or more) of the following symptoms have been present:
- Preoccupation with Internet activities
- Recurrent failure to resist the impulse to use the Internet
- Tolerance: a marked increase in the duration of Internet use needed to achieve satisfaction
- Withdrawal, as manifested by either of the following:
- Symptoms of dysphoric mood, anxiety, irritability, and boredom after several days without Internet activity
- Use of Internet to relieve or avoid withdrawal symptoms
- Use of Internet for a period of time longer than intended
- Persistent desire and/or unsuccessful attempts to cut down or reduce Internet use
- Excessive time spent on Internet activities
- Excessive effort spent on activities necessary to obtain access to the Internet
- Continued heavy Internet use despite knowledge of having a persistent or recurrent physical or psychological problem likely to have been caused or exacerbated by Internet use
- Functional impairment: one (or more) of the following symptoms have been present:
- Recurrent Internet use resulting in a failure to fulfill major role obligations at school and home
- Impairment of social relationships
- Behavior violating school rules or laws due to Internet use
- The Internet addictive behavior is not better accounted for by psychotic disorder or bipolar I disorder

- These criteria, however, remain in need of widespread empirical testing and validation by other researchers.

CONSEQUENCES

- Poor dietary behaviour
- Early initiation to sexually explicit themes
- Higher likelihood of involvement with drugs
- Inability to acquire life skills
- Dangerous liaisons (paedophiles)
- Eye problems
- Low back pain

MANAGEMENT

- ***Cognitive-Behavioral Therapy***
- Many researchers have looked to Cognitive-Behavioral Therapy (CBT) to deal with Internet addiction. This method assists individuals to identify and modify the thoughts and feelings that feed their addiction
- ***Reality Therapy Group Counseling***
- Reality Therapy is based on Choice Theory, which views individuals as completely responsible for their own lives.
- **Psychopharmacology**
- SSRIs

HELPING AN ADOLESCENT WITH INTERNET ADDICTION (PARENTS)

- Encourage other interests and social activities.
- Monitor computer use and set clear limits.
- Talk to your child about underlying issues.
- Get help.

PREVENTION

- Training parents to improve their ability to communicate with their children, promoting healthy family interactions, teaching parents effective family monitoring skills, and aiding the family in reducing maladaptive family functions
- Encouraging teenagers to engage in activities in the real world rather than in cyberspace

MODULE SEVEN
CHRONIC HEALTH CONDITIONS

This module is divided into five sessions and it aims to give relevant information on some of the more common chronic health conditions faced by adolescents as well as identify the roles that family, health and educational institutions can play in alleviating the problems associated with these conditions.

SESSION 1: BURDEN OF DISEASE DUE TO CHRONIC HEALTH CONDITIONS IN ADOLESCENTS

SESSION 2: SICKLE CELL DISEASE

SESSION 3: ASTHMA

SESSION 4: DIABETES MELLITUS

SESSION 5: SEIZURE DISORDERS

CHRONIC HEALTH CONDITIONS
MODULE SEVEN: SUMMARY AND TIMING ESTIMATE

SESSION TITLE	DURATION	OBJECTIVES	METHODS	MATERIALS
BURDEN OF DISEASE FROM CHRONIC HEALTH CONDITIONS	20 Minutes	• Comment on the burden of chronic health conditions (CHC) in adolescents. • Discuss the effects of CHC on adolescents. • Identify the people or organizations that can help in providing succour for adolescents with CHC.	Lecture Discussion	Flipchart Stand/paper Markers Projector Laptop
SICKLE CELL DISEASE (SCD)	45 Minutes	• To describe some common chronic health conditions in adolescents. • To describe the clinical features of each of the conditions. • To describe the goal(s) of management and basic treatment information of each of the conditions. • To describe the problems adolescents with chronic conditions encounter. • Identify the roles of the adolescent, his family, his physician (health workers), teachers and others in the management of the particular chronic condition.	Lecture Case Studies Discussions	Flipchart Stand/paper Markers Projector Laptop
ASTHMA	45Minutes		Lecture Case Studies Brainstorming	Flipchart Stand/paper Markers Projector Laptop
DIABETES MELLITUS (DM)	45 Minutes		Lecture Case Studies Discussions	Flipchart Stand/paper Markers Projector Laptop
SEIZURE DISORDERS (EPILEPSY)	45 Minutes		Lecture Case Studies Brainstorming	Flipchart Stand/paper Markers Projector Laptop

MODULE SEVEN: SESSION 1
BURDEN OF DISEASE DUE TO CHRONIC HEALTH CONDITIONS IN ADOLESCENTS

TIME: 20 Minutes

LEARNERS' OBJECTIVES:
At the end of this session participants will be able to:

- Discuss the burden of chronic health conditions in adolescents.
- Discuss the effects of chronic health conditions on adolescents.
- Identify the people or organizations that can help in providing succour for adolescents with chronic health conditions.

METHODS
- Lecture
- Discussions

MATERIALS
- Flipchart Stand and paper
- Markers
- Slides/transparencies
- Overhead Projector
- Computer

CONTENT

BURDEN OF DISEASE DUE TO CHRONIC HEALTH CONDITIONS IN ADOLESCENTS

The adolescent period is generally a relatively healthy period. However, some adolescents experience health-related challenges with associated morbidity and mortality. Chronic health conditions represent a 'silent' but potentially lethal group of health-related challenges affecting Nigerian adolescents. However, most of these conditions have not been given the necessary proactive management that can reduce the needless associated mortality. Examples of common chronic health conditions in adolescents are Sickle Cell Disease (SCD), Diabetes Mellitus (DM), Seizure Disorders (Epilepsy), Asthma, mental health problems such as depression, Congenital Heart Disease (CHD), chronic intestinal parasitic infections such as Schistosomiasis, Cancers such as Leukaemia and other haematological conditions such as Aplastic anaemia. The first four problems would be focused on in this module.

Sickle cell anaemia has a prevalence rate of 2% in Nigeria, affecting approximately three million Nigerians, mostly children and adolescents. The prevalence of diabetes mellitus (DM) in Nigeria is low but has been increasing over time, and Type II DM is increasingly being detected in adolescents. Asthma is common in the second decade of life and about 15% of adolescents worldwide are affected by it. Although seizure disorders affect a much lower proportion of Nigerians from data collected in previous studies (about 0.005%-0.043% of the total population), the considerable

morbidity and mortality associated with epilepsy makes it a significant public health issue among adolescents. Epilepsy is a disease of the young rather than that of the old and 85% of those who are affected in Nigeria are less than 30 years old.

Adolescence is a period of cognitive and psychosocial development. One peculiar feature of most chronic health conditions in adolescents is their ability to inhibit growth and/or development. For instance, diabetes mellitus can impair pubertal development. On the other hand, puberty itself can affect the course of a chronic disease. For example, normal pubertal changes are associated with insulin resistance; therefore, blood glucose control can be difficult during pubertal years in teenagers with diabetes.

The problems faced by adolescents with chronic health conditions are not only physical but also have significant psychological components. Adolescents are usually distraught when these conditions prevent them from doing or achieving things that they would have otherwise achieved. Some of the core areas in which they may be adversely affected include their academics and their sexuality- two critical areas which affect their self-esteem and all other aspects of their lives. Many adolescents with chronic health conditions face complex emotional challenges during this important period of their lives. A holistic approach that will involve the adolescent, his or her family, attending physician and teachers is thus needed to handle these challenges. Adolescents with chronic health conditions often have need of social and psychological support from those around them and the aim of their treatment and care is to manage their illness in such a way that they are able to enjoy and achieve their full potential and make a meaningful contribution to the society.

Evidence from developed countries shows that support groups that address the various chronic health conditions play an important role in the management of adolescents with these conditions. Such groups are not common in Nigeria and there is a need to establish them so that adolescents with chronic health conditions can benefit from them. Health and educational authorities as well as civil society organizations including faith-based organizations, community-based organizations and other non-governmental organizations can spearhead the formation of support groups. Governments at various levels can also contribute their own quota by giving priority to chronic health conditions and investing more in preventing rather than curing them.

MODULE SEVEN: SESSION 2
SICKLE CELL DISEASE

TIME: 45 Minutes

LEARNERS' OBJECTIVES:
At the end of this session participants will be able to:

- Describe the clinical features of Sickle Cell Anaemia.
- Describe the goal of management and basic treatment information of Sickle Cell Anaemia.
- Identify the problems or challenges adolescents with Sickle Cell Anaemia face.
- Identify the roles of the adolescent, his family, his physician (health workers), teachers and others in the management of Sickle Cell Anaemia.

METHODS
- Lecture
- Case Studies
- Discussion

MATERIALS
- Flipchart Stand/paper
- Markers
- Projector
- Laptop

CONTENT

INTRODUCTION

Sickle Cell Disease is a group of inherited blood disorders characterized by the presence of abnormal haemoglobin (Hb). It is essentially a disease of the black race- especially common in Africans and African Americans. It is a lifelong condition and because of improved understanding about and care for the condition, many children who are affected are increasingly able to reach and even go beyond the adolescent age. Two major types have been identified- Sickle Cell Anaemia and Sickle Cell Trait (SCT).

- **Sickle Cell Anaemia (SS)** - The homozygous (two identical genes) state in which the adolescent inherits the abnormal Hb.(S) from each parent.

- **Sickle Cell Trait (AS)** – Referred to as the carrier state in which the person inherits the Hb.S gene from one parent and normal Hb.(A) from the other parent.

Table 7.1: PATHOGENESIS, CLINICAL FEATURES, DIAGNOSIS, COMPLICATIONS, MANAGEMENT AND ADOLESCENT CONCERNS IN SICKLE CELL DISEASE

PATHOGENESIS	CLINICAL FEATURES/ COMPLICATIONS	DIAGNOSIS	MANAGEMENT	SPECIAL CONSIDERATIONS
• Haemoglobin (Hb).S distorts the shape of red blood cells leading to fragile, sickle-shaped cells which deliver less oxygen to the body's tissues. • Hb.S can also clog more easily in small blood vessels, and break into pieces that disrupt healthy blood flow causing the pain in vaso-occlusive (bone pain) crisis.	• Abdominal, Chest & Bone pain. • Pallor (Anaemia). • Breathlessness. • Delayed growth & puberty. • Enlarged/ Atrophied spleen. • Fatigue. • Jaundice. • Rapid heart rate. • Leg ulcers. • Stroke. • Priapism (painful /prolonged penile erection) ± erectile dysfunction. • Gallstone formation. • Infections/ Fever. • Transfusion reaction- Iron overload, exposure to pathogens (infectious agents). • Pulmonary (Lung) hypertension. • Avascular (bloodless) necrosis (death) of bones.	• Sickling test (not diagnostic). • Peripheral Blood film. • Genotype test/HB Electrophoresis (Hallmark)	The Goal is to manage and control symptoms& to limit frequency of crises. SPECIFIC MEASURES- • Avoid temperature extremes and High altitudes. • Reduce emotional stress& demanding physical activity. • Adequate intake of fluids. • Foot care& protective shoes. • Periodic health care visits. • Educate them/ parents/ teachers. • Malaria prophylaxis. • Adequate nutrition& Folic acid supplements. • Reduced alcohol/ smoking. • Blood transfusion. • Symptomatic treatment.	• Pregnant adolescents are at increased risk of crisis and spontaneous abortion. • Support groups where members share common experiences and problems can relieve stress. • Genetic counselling: Counselling on sexual/ future marital partner plus offer of contraception to those who are sexually active.

CASE STUDY

Rachel is a 17 year old secondary school girl with Sickle Cell Anaemia (HbSS). She has had a turbulent period growing up as a child because of frequent crises that she has experienced as a result of her inherited condition, although in recent times the crises have reduced and are usually well controlled. She is the outgoing type and she is in a relationship with a 22 year old guy, George (of unknown haemoglobin status) who knows her haemoglobin status as HbSS. They have had sex together three times, the last episode was yesterday. It was just 'on the spur of the moment' and they did not use condom as they used to do. She is worried because the timing coincides with her ovulation period and she does not know what to do or who to turn to.

Learners are to -

- Identify the proactive or pre-emptive steps that could have been taken to prevent this situation.
- What preventive measures could Rachel's parents, her physician and teacher take in this situation? What measures can they take if she opens up to them? What can be done about the possibility of her getting pregnant?
- In case she eventually becomes pregnant and George's genotype is found to be AS, is marriage a viable option in this situation- Why or why not? Should Genetic Counselling be included in the school curricula? If yes, how can this be achieved?

SUMMARY

Sickle cell disease is a group of inherited conditions characterised by abnormal haemoglobin that is prevalent in the black race. There are two major types- Sickle Cell Anaemia and Sickle Cell Trait. The former is usually associated with severe morbidity and mortality. Delayed growth and puberty is one of the features of this condition in adolescents and affected adolescents need the support of their families and others.

EVALUATION

1. What are the general preventive measures that adolescents with Sickle Cell Anaemia should take so as not to aggravate their condition?
2. How will you counsel an adolescent with Sickle Cell Anaemia who is sexually active?

MODULE SEVEN: SESSION 3
ASTHMA

TIME: 45 Minutes.

LEARNERS' OBJECTIVES:
At the end of this session participants will be able to:

- Describe the clinical features of severe Asthma.
- Describe the goal of management and basic treatment information of Asthma.
- Identify the peculiarities of adolescents with Asthma.
- Identify the roles of the adolescent, his family, his physician (health workers), teachers and others in the management of Asthma.

METHODS
- Lecture
- Case Studies
- Brainstorming

MATERIALS
- Flipchart Stand/paper
- Markers
- Projector
- Laptop

CONTENT

INTRODUCTION

Asthma is an inflammatory condition of the lung airways that makes it difficult to breathe properly. It is a very common problem in adolescents often arising from childhood and sometimes in adolescence stage of life. About 10-15% of adolescents are affected worldwide. The severity of asthma is classified into four: Intermittent, Mild Persistent, Moderate Persistent, and Severe Persistent.

Table 7.2: PATHOGENESIS, CLINICAL FEATURES, DIAGNOSIS, COMPLICATIONS, MANAGEMENT AND ADOLESCENT CONCERNS IN ASTHMA

PATHOGENESIS	CLINICAL FEATURES/ COMPLICATIONS	DIAGNOSIS	MANAGEMENT	SPECIAL CONSIDERATIONS
• Exact cause- unknown. • Postulates- A blend of genetic (inherited) factors and environmental triggers (such as allergens- pollen grains, dust, smoke and infections). • Asthma tends to run in families, so adolescents whose parents have asthma are more likely to develop it themselves.	• Wheezing (audible noisy breathing). • Breathlessness (dyspnoea) - a major source of distress. • Coughing. • Chest tightness or pain. • Rapid heart rate. • Sweating.	• Clinical features • Lung function tests	The goal is to maximize long-term control of the illness with medications & other treatment, approaches leading to reduced frequency of symptoms/attacks. SPECIFIC MEASURES- • Identifying& avoiding allergens& other triggers. • Following appropriate drug treatment (Rx)- usually steroids& salbutamol (tablets, inhaler, nebullizer). • Home monitoring performed by either patient or family. • Good communication between the doctor and adolescent as well as with schoolmates& teachers. • Needed psychosocial support. • Oxygen administration. • Treatment of asthma in all environments (home, school, work). • Referral to a clinic.	• Asthma is both undertreated& under-diagnosed in this group leading to increased mortality and morbidity. • Poor compliance with treatment is common. • The concerns that they have about their illness and its Rx are often not recognised or addressed by health professionals.

CASE STUDY

Ijogbon is a 16 year old senior secondary school boy who has recently developed asthmatic attacks which are increasing in frequency and intensity. He has communicated (verbally) his health condition to his teacher, Mr. “No Nonsense” who really did not take the information given to him as a serious one. Ijogbon is a mischievous boy and he often misbehaves in class and Mr. “No Nonsense” has often warned him. Ijogbon was at it again one day and Mr. “No Nonsense” did not only beat him but

also asked him to cut the grass surrounding one of the buildings in a sandy area of the school premises. Ijogbon refused to cut the grass claiming that it could trigger an asthmatic attack in him. Expectedly, Mr. “No Nonsense” refused to ‘take this nonsense’ and they were almost exchanging blows.

1. What roles should Ijogbon, his parents as well as his doctor and school authorities have played in preventing this scenario?

2. In case Ijogbon has an attack in school, what help should be made available to him?

SUMMARY

Asthma is a condition characterised by reversible airway narrowing with associated respiratory symptoms, principally difficulty in breathing. It is quite common in adolescents and it is a significant cause of morbidity and mortality in them. The adolescent, his or her family, as well as health and education authorities and other bodies need to pay attention (take proactive steps) in the management of this condition in adolescents.

EVALUATION

1. What are the general preventive measures that should be taken to prevent asthmatic attacks in susceptible adolescents?

2. How will you know when an adolescent has asthma? How will you manage a case of acute asthmatic attack?

MODULE SEVEN: SESSION 4
DIABETES MELLITUS

TIME: 45 Minutes

LEARNERS' OBJECTIVES:
At the end of this session participants will be able to:

- Describe the clinical features of Diabetes.
- Describe the goal of management and basic treatment information of Diabetes.
- Identify the difficulties with controlling blood sugar levels in adolescents.
- Identify the roles of the adolescent, his family, his physician (health workers), teachers and others in the management of Diabetes.

METHODS
- Lecture
- Case Studies
- Discussions

MATERIALS
- Flipchart Stand/paper
- Markers
- Projector
- Laptop

CONTENT

INTRODUCTION

Diabetes Mellitus (DM) is a metabolic disease in which a person has high blood sugar (BS), either because the body does not produce enough insulin, a hormone produced in the pancreas [Type I Diabetes Mellitus, formerly known as Insulin Dependent Diabetes Mellitus (IDDM)], or because cells do not respond to the insulin that is produced [Type II Diabetes Mellitus formerly known as Non Insulin Dependent Diabetes Mellitus (NIDDM)] or Adult onset DM. Type II DM is increasingly being seen in children and adolescents probably because of transitions in their nutrition. Gestational diabetes is a type of diabetes that occurs in pregnancy and it is also of significance in adolescents.

Table 7. 3: PATHOGENESIS, CLINICAL FEATURES, DIAGNOSIS, COMPLICATIONS, MANAGEMENT AND ADOLESCENT CONCERNS IN DIABETES MELLITUS

PATHOGENESIS	CLINICAL FEATURES/ COMPLICATIONS	DIAGNOSIS	MANAGEMENT	SPECIAL CONSIDERATIONS
Type I DM- loss of the insulin-producing beta cells in the pancreas leading to insulin deficiency. Type II DM-characterized by insulin resistance. Predisposing/ Causative factors- - Idiopathic (unknown). - Family history - Pancreatic diseases, Infections- e.g. Mumps, Drugs- e.g. Thiazides	- Polyuria (excessive urination) - Nocturia (frequent night-time urination - Polydipsia (excessive thirst) - Polyphagia (huge apetite) - Weight loss. - Fatigue. - Hypoglycemia (low blood sugar). - Comas- Diabetic ketoacidosis (DKA) or non-ketotic hyperosmolar. - Cardiovascular (Heart) disease. <u>Chronic renal (kidney) failure</u>. Retinal (eye) damage. Neuropathy (nerve problems). Stunted growth. Delayed puberty.	Fasting Blood Sugar (FBS) and 2 hour post prandial BS. (Use of Glucometer) Oral Glucose Tolerance Test (GTT). Glycosylated Haemoglobin (HbA1c).	The Goal of treatment is to keep blood sugar levels close to the normal range. **SPECIFIC MEASURES-** - Regular blood sugar testing. - Patient, Family and Teachers education is essential. - Lifestyle modifications- - Dietary (Reduced fats& refined carbohydrates) - Weight loss (in obese)& - Moderate Exercise. - Oral medications. - Insulin.	Adolescents may have problems controlling their blood sugar levels because of-hormonal changes during puberty. Adolescent lifestyle: Peer pressure, erratic schedules, body image concerns, Increased activities, eating disorders etc. Experimentation with alcohol, cigarettes. Conflicts with parents, teachers etc. Poverty Peer support- very useful.

CASE STUDY

Beauty is a 16 year old girl who has had diabetes mellitus since she was six years old. Beauty's mother is a known diabetic who has greatly helped her to live with her chronic health condition. In recent times, Beauty has been very worried because her development of secondary sexual characteristics has been rather slow. She is yet to attain menarche (i.e. start menstruating) and she finds it very uncomfortable to undress when her roommates are around in the school hostel because she feels her breasts are not well developed. Some of her roommates and other friends have started 'taunting' her by 'showing off' their well developed bodies and talking about their relationships with their boyfriends. Beauty's Mum had taken her to their family doctor who just told them not to worry but that they should rather focus on the blood sugar level control instead of being distracted with 'future matters.' Beauty's performance in class has dropped significantly. Although her teacher has

noticed this, she has not found time to discuss her recent performance with her. Beauty is troubled and weighed down and she is in need of help.

1. What should Beauty do?
2. What roles should the doctor; teacher, school counselor etc play in this of situation?
3. How can school authorities identify adolescents who are down psychologically and meet their needs?
4. What roles should NGOs, FBOs and CBOs etc play in the prevention and management of chronic health conditions?

SUMMARY

Diabetes Mellitus is a chronic condition characterised by high level of sugar in the blood. It is increasingly becoming a source of concern in adolescents. There are two major types- Type I DM and Type II DM and both of them could occur in adolescents. Diabetes affects adolescent development and pubertal development can also adversely affect management of Diabetes in adolescents.

EVALUATION

- What are the challenges or special considerations of adolescents with Diabetes Mellitus?
- How can you help in alleviating these challenges?
- What are the possible features that adolescents with Diabetes may present with?

MODULE SEVEN: SESSION 5
SEIZURE DISORDERS

TIME: 45 Minutes

LEARNERS' OBJECTIVES:
At the end of this session participants will be able to:

- Describe the clinical features of Seizure Disorders.
- Describe the goal of management and basic treatment information of Seizure Disorders especially measures to take during a seizure episode.
- Identify the peculiarities of adolescents with Seizure Disorders.
- Identify the roles of the adolescent, his family, his physician (health workers), teachers and others in the management of Seizure Disorders.

METHODS
- Lecture
- Case Studies
- Brainstorming

MATERIALS
- Flipchart Stand and paper
- Markers
- Slides/transparencies
- Projector
- Computer

CONTENT

INTRODUCTION

Seizure disorders are a group of brief and usually unprovoked, stereotyped disturbance of behaviour, emotion, motor function (movement), or sensation which on clinical evidence results from abnormal excessive electrical discharge of cerebral (brain) neurons (nerve cells). Repeated seizure disorders are known as Epilepsy and are broadly divided into two-

1. Generalized seizures- affecting every part of the brain. They include Tonic-clonic (Grand mal), Absence seizures (Petit mal) & Myoclonic siezures.

2. Partial seizures- affecting a part or some parts of the brain. They include Simple partial (e.g. Jacksonian) and Complex partial (e.g. Temporal lobe epilepsy). The simple partial and complex partial are differentiated by the presence and lack of consciousness.

Most seizures in adolescents are of the "Absence" type.

Table 7.4: PATHOGENESIS, CLINICAL FEATURES, DIAGNOSIS, COMPLICATIONS, MANAGEMENT AND ADOLESCENT CONCERNS IN SEIZURE DISORDERS (SD)

PATHOGENESIS	CLINICAL FEATURES/ COMPLICATIONS	DIAGNOSIS	MANAGEMENT	SPECIAL CONSIDERATIONS
Idiopathic- No known cause usually. **Predisposing factors**- • Head injury. • Brain tumours and or surgery. • Central Nervous System (CNS) infections. • Metabolic causes. • Drug overdose / withdrawal. People with a seizure disorder are more likely to have a seizure when they are under excess physical or emotional stress or deprived of sleep. Flashing light or flickering TV screen may also provoke an attack in susceptible persons.	• Loss of consciousness (brief or prolonged) • Convulsion/ Muscle spasms that shake the body. • Loss of bladder control • Faecal Incontinence • Sudden confusion and inability to pay attention. • Seizures are preceded by unusual sensations (called aura). An eyewitness account of the episode is usually helpful to attending physician (It's important to take note of how long the seizures lasted). Two unprovoked seizures that occur at different times- suggestive of Seizure Disorders	• Clinical features • Electroence phalograph y/ EEG (to record the brain's electrical activity) • CT scan/ MRI	The Goal of emergency Rx is to maintain a patent airway & minimise harm to the adolescent. **Measures to be taken during a seizure attack:** • Protect the person from falling/ dangerous objects. • Loosen clothing around the neck. • Do not force dangerous objects e.g. spoon in the person's mouth because of increased risk of aspiration/ death • If unconscious, roll him onto one side to ease breathing. • Do not leave him alone until he is completely awake/ no longer confused, and can move about normally. • Refer (take to a clinic). • A family member, friend or teacher should be trained to help if a seizure occurs. • Drug treatment: Anticonvulsants.	Adolescence is a time of increased risk for seizure onset or changes in seizure pattern. Attitudes of others towards epilepsy often limit dating and other social interactions. Ridicule& bullying are too common in school settings with subsequent low self/ esteem& poor performance. They should refrain from activities in which a sudden loss of consciousness could lead to serious injury e.g. driving. A need to educate the school community& others on SD- It is not contagious. Adolescents with SD should avoid stress.

Note: The notion that objects such as metallic spoon should be put into the mouth of a person who is having seizures is a dangerous and needless one because more harm than good may be caused to the affected individual. For instance, in the process of attempting to put such metallic objects, the person's tooth may be accidentally removed and subsequently lodged in the respiratory tract with consequent aspiration which may result in respiratory distress and/or death. If suitable, non metallic objects such as padded wooden or plastic spatula (flat utensil with handle) are available for insertion into the person's mouth so that he/she does not bite his tongue, they can be safely used, otherwise the person should just be allowed to lie on his side.

CASE STUDY

Anayi is a 14 year old JSS 3 female student who has been living with seizure disorder (epilepsy) since childhood. She has been on anti-epileptic drugs and she has been very compliant. Seizure episodes have been a rare occurrence (less than once in two years) in her life and she is above average academically. In the last three years since pubertal changes set in, Anayi has gained an additional 15kg in weight making her weight to be 45kg. Although she sees her doctor once in every two months, the doctor has 'forgotten' to increase the dosage of her drugs. During a class lecture one fateful day, the unexpected happened and Anayi had a 'full fit episode' in front of her classmates and teacher who all left her alone and ran away.

The first person to come to her aid was the school nurse who arrived on the scene 10 minutes after, by which time Anayi had come out of the fitting state and was shamefacedly terrified. Real trouble started for Anayi when her classmates refused to sit down beside her the next day and those who spoke with her only used monosyllables. She could not concentrate in class again and she started missing classes. To make matters worse, the school proprietor asked her to leave the school after discussions with her parents because he did not want her to die or get injured in the event that she threw a fit while in school.

1. How would you rate the handling of this situation by Anayi's classmates, teacher and the school authority?
2. In an ideal situation, how should the situation have been b handled?
3. Is there a need to train teachers on the basic management of the symptoms and signs of chronic diseases?
4. Give reasons for your answer.

Chronic health conditions (CHCs) are relatively common among in-school adolescents. Can support groups for the different CHCs make a difference in the management of adolescents with CHCs? Give reasons for your answer.

1. What mechanisms can educational authorities put in place for the formation of support groups? Who should spearhead such support groups?
2. What roles can the local, state and federal governments play in the reduction of the morbidity and mortality associated with chronic health conditions in general?

SUMMARY

Seizure disorders are a group of disorders characterised by involuntary movement as a result of paroxysmal (sudden) discharge of electric signals from the brain and they are usually associated with intense emotional and psychological problems.

EVALUATION

1. What are the immediate measures that you will take in case an adolescent has an episode of seizure in your location?
2. In what ways can you offer psychosocial support to an adolescent with seizure disorder?

GLOSSARY OF TERMS:

Absence (Petit Mal) seizure: A seizure that takes the form of a staring spell. The person suddenly seems to be "absent." An absence seizure involves a brief loss of awareness, which can be accompanied by blinking or mouth twitching.

Allergy: An exaggerated response to a substance or condition produced by the release of histamine or histamine-like substances in affected cells. The substance is known as an allergen.

Anaemia: The condition of having less than the normal number of red blood cells or less than the normal quantity of hemoglobin in the blood. The oxygen-carrying capacity of the blood is, therefore, decreased.

Avascular Necrosis: Bone death resulting from poor blood supply to an area of bone.

Diabetic coma: Coma in a diabetic due to the buildup of ketones in the bloodstream. Ketones are a product of metabolizing (using) fats rather than the sugar glucose for energy.

Diabetic ketoacidosis: High blood glucose with the presence of ketones in the urine and bloodstream, often caused by taking too little insulin or during illness. See ketoacidosis.

Electrophoresis: A process by which molecules (such as proteins, DNA, or RNA fragments) can be separated according to size and electrical charge by applying an electric current to them.

Fasting Blood Sugar (FBS): The preferred method of screening for diabetes. The FBS measures a person's blood sugar level after fasting or not eating anything for at least 8 hours.

Genetic counselling: An educational counselling process for individuals and families who have a genetic disease or who are at risk for such a disease. Genetic counselling is designed to provide patients and their families with information about their condition and help them make informed decisions.

Genotype: The genetic make-up of an individual.

Glucometer: An electronic device used to measure the blood glucose level using test strips.

Glycosylated haemoglobin (HbA1C): Hemoglobin to which glucose is bound. Glycosylated hemoglobin is tested to monitor the long-term control of diabetes mellitus.

Grand mal: A form of epilepsy characterized by tonic-clonic seizures involving two phases -- the tonic phase in which the body becomes rigid, and clonic phase in which there is uncontrolled jerking.

Hemoglobin: The oxygen-carrying pigment and predominant protein in the red blood cells.

Hemoglobin Electrophoresis: A laboratory technique to determine the type of hemoglobin that an individual has.

Hyperosmolar non-ketotic coma: A coma usually caused by an infection or illness that results in blood sugar levels rising to dangerously high levels without high ketones.

Inhaler/ Metered dose inhaler (MDI): A small aerosol canister in a plastic container that releases a mist of medicine when pressed down from the top. This medicine can be breathed into the airway.

Insulin: A natural hormone made by the pancreas that controls the level of the sugar glucose in the blood. Insulin permits cells to use glucose for energy. Cells cannot utilize glucose without insulin.

Ketoacidosis: A condition often caused by an infection or other illness like dehydration, or from taking too little insulin; when the body begins to break down muscle and fat for needed energy, ketones are released into the urine and blood, leading to diabetic ketoacidosis.

Ketones: The chemical substance made by the body when there isn't enough insulin in the blood; a build-up of ketones can lead to serious illness or coma.

Myoclonic: Referring to sudden muscular contraction, or a series of these, that usually indicates a disorder of the nervous system if experienced persistently. Oral glucose tolerance test: A test to determine the body's ability to handle glucose so as to determine whether there is glucose intolerance.

2 hour Post-prandial test: A test done to determine the level of blood glucose two hours after eating, usually done after a fasting blood sugar has been done.

Pathogenesis: The development of a disease. The origin of a disease and the chain of events leading to that disease.

Nebulizer: A machine that changes liquid medicine into fine droplets (in aerosol or mist form) that are inhaled through a mouthpiece or mask.

Pancreas: A fish-shaped spongy grayish-pink organ about 6 inches (15 cm) long that stretches across the back of the abdomen, behind the stomach.

Red blood cells: The blood cells that carry oxygen. Red cells contain haemoglobin and it is the hemoglobin which permits them to transport oxygen (and carbon dioxide).

Seizure: Uncontrolled electrical activity in the brain, which may produce a physical convulsion, minor physical signs, thought disturbances, or a combination of symptoms.

Wheezing: The high-pitched whistling sound of air moving through narrowed airways.

MODULE EIGHT
ADOLESCENTS WITH OTHER SPECIAL NEEDS

This module focuses on adolescents with special needs. For the purposes of this manual, adolescents with disabilities (mental and physical) and street children will be discussed in this module.

SESSION ONE: **OVERVIEW OF ADOLESCENTS WITH SPECIAL NEEDS**

SESSION TWO: **ADOLESCENTS WITH PHYSICAL AND MENTAL DISABILITIES**

SESSION THREE: **STREET ADOLESCENTS**

SESSION FOUR: **INTERVENTIONS FOR ADOLESCENTS WITH SPECIAL NEEDS**

MODULE EIGHT: ADOLESCENTS WITH OTHER SPECIAL NEEDS
SUMMARY AND TIMING ESTIMATE

SESSION TITLE	DURATION (MINUTES)	OBJECTIVES	METHODS	MATERIALS
Overview of adolescents with special needs	1 hour	• Introduction • Define impairment, disability and handicap. • List the types of disability. • Discuss the causes of disability. • Discuss the consequences of disability.	Discussion Lecture Group-work	Flip Chart Stand/paper Chalk Board/chalk Flip chart paper/Chalk Markers DVDs Overhead projector
Adolescents with physical and mental disabilities	1 hour 30 minutes	• Introduction • Discuss magnitude of the problem. List forms of physical and mental disability. • Discuss the impact of physical and mental disabilities .	Discussion Lecture Group-work	Flip Chart Stand/paper Chalk Board/chalk Flip chart paper/Chalk Markers DVDs Overhead projector
Street adolescents	1 hour	• Introduction • List categories of street children. • Discuss factors responsible for children being on the streets. • Discuss problems of street children. • Discuss interventions for street children phenomenon.	Discussion Lecture Group-work	Flip Chart Stand/paper Chalk Board/chalk Flip chart paper/Chalk Markers DVDs Overhead projector
Interventions for adolescents with special needs	1 hour	• Introduction • Prevention of disabilities • Interventions – Education, Healthcare, Social networking, employment	Discussion Lecture Group-work	Flip Chart Stand/paper Chalk Board/chalk Flip chart paper/Chalk Markers DVDs Overhead projector

MODULE EIGHT: SESSION 1
OVERVIEW OF ADOLESCENTS WITH SPECIAL NEEDS

TIME: 1 Hour 30 Minutes

LEARNERS' OBJECTIVES

At the end of the session, participants will be able to:

- Differentiate between an impairment, disability and handicap.
- List the various types of disability.
- Discuss some challenges that adolescents with disabilities encounter.

SESSION OVERVIEW

- Introduction
- Definition of terms
- Types of disability
- Causes of disability
- Consequences of disability

METHODS

- Lecture
- Discussion
- Group work

MATERIALS

- Flip Chart Stand and paper
- Chalkboard/Chalk
- Markers
- VCR and TV
- Video tapes/CD/DVD tapes
- Computer

CONTENT

INTRODUCTION

Globally, about 180 million young people between the ages of 10-24 (years) live with a physical, sensory, intellectual or mental disability which is significant enough to make a difference in their daily lives. Most of these people (about 80%) live in developing countries (UN: 1990). They are amongst the most marginalized of all young people in the world.

Article 23 of the Charter on the Rights of Children (CRC) states that "a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community".

The adolescent years can be particularly stressful for those with disabilities because this is the period during which they undergo physical and psychological maturation and are expected to acquire some degree of independence, acquire skills, and assume a social identity so that they can fully participate in their communities. However, for adolescents with disabilities, acquiring these skills is a challenge because, they are somewhat restricted because of the disability they have. These disabilities often make them handicapped in many areas of their social lives. Adolescents with disabilities often receive less education than their able-counterparts. This reduces opportunities for gainful employment later in life. In Nigeria, the exact number of adolescents living with disabilities and types of disabilities are not known.

DEFINITION OF TERMS

Impairment – refers to physical loss of function e.g. a hearing impairment as a result of complications of measles in childhood.

Disability – the functional limitation which arises as a result of an impairment and which prevents the individual from performing appropriate tasks e.g. inability to hear as a result of hearing impairment.

Handicap –a disadvantage for the individual, resulting from impairment or disability that limits the fulfilment of a role that is normal for that individual may be in dimensions of physical independence, mobility, occupation, social integration, economic self-sufficiency, orientation, or other areas.

Mental Retardation (MR) – a condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, which contribute to the overall level of intelligence, i.e. cognitive, language, motor, and social abilities..

CLASSIFICATION OF IMPAIRMENT

- **Intrinsic**: This occurs when the functional impairment is within the individual.
- **Extrinsic**: The functional impairment is external to the individual.

TYPES OF INTRINSIC IMPAIRMENT

- Mobility
- Visual
- Auditory
- Visceral
- Others

EXAMPLES OF EXTRINSIC IMPAIRMENT

- Maternal deprivation
- Poverty

CAUSES OF DISABILITY

These are due to several causes including:

- **Genetic causes**: Sometimes disability is caused by abnormal genes inherited from parents, errors when genes combine, or other reasons. The most prevalent genetic conditions include Down syndrome, Klinefelter's syndrome, Fragile X syndrome, Neurofibromatosis, congenital hypothyroidism, Williams syndrome, Phenylketonuria (PKU), and Prader-Willi syndrome.
- **Prenatal causes**: Mental disability can result when the fetus does not develop properly. For example, there may be a problem with the way the fetus' cells divide as it grows. A woman who drinks alcohol or gets an infection like rubella during pregnancy may also have a baby with mental disability.
- **Perinatal causes:** If a baby has problems during labor and birth, such as not getting enough oxygen, he or she may have developmental disability due to brain damage.
- **Exposure to certain types of disease or toxins**. Infections such as meningitis, measles, mumps could become complicated and result in hearing impairment, visual impairments etc. Guinea worm infestation, polio, leprosy, onchocerciasis are common causes of impairment and disability in Nigeria. Onchocerciasis is reportedly responsible for blindness in over 100,000 people. Diseases like whooping cough, measles, or meningitis can cause mental disability if medical care is delayed or inadequate. Exposure to poisons like lead or mercury may also affect mental ability.
- **Nutritional deficiencies:** Iodine deficiency, affecting approximately 2 billion people worldwide, is the leading preventable cause of mental disability in areas of the developing world where iodine deficiency is endemic. Malnutrition is a common cause of reduced intelligence in parts of the world affected by famine.
- **Environmental and socio-cultural factors:** Children from socially disadvantaged environment usually face more adversity and are more predisposed to certain infections and/ or toxins. Also, under-stimulation is a recognised factor for mild mental retardation.

CONSEQUENCES OF DISABILITY

Adolescents with disabilities are first of all adolescents and they experience what their counterparts without disabilities experience during this period of their lives. In addition to adolescent concerns, they also have concerns as a result of the disability they have. Research in developed countries has shown that adolescents with disabilities generally want what all adolescents want in life – happiness, success, independence, marriage etc.

Disabilities place the individual in a more vulnerable position than his/ her counterparts. This is worse in developing countries where social security networks are poorly developed. These disabilities make them handicapped in various aspects of social life. Many of them are victims of social stigma, discrimination, exploitation and abuse. Even within their own homes, many are isolated. They are often viewed as a liability because they cannot readily contribute to the family income. Many resort to begging when they cannot obtain gainful employment since they have inadequate education and no skills.

Generally adolescents with disabilities:

- have concerns for self-esteem,
- receive less education,
- are marginalized in social activities – some experience social isolation and discrimination, and
- have fewer opportunities for gainful employment later in life compared with those who do not have disabilities.

Other problems they face include:

- Lack of support,
- Violence related issues,
- Inadequate access to appropriate programs, and
- Lack of appropriate healthcare facilities.

Socially,

- Young adults with disabilities are more likely to still be living with parents (compared with able young adults.
- They are more likely to be single.
- Studies have shown that they may be at greater risk for poor health outcomes.
- They may have strained relationship between parents.

SUMMARY

Despite growing numbers and needs, adolescents with disability have been given inadequate attention. The needs of disabled young people are similar to that of their non-disabled peers - the need for education, job training and employment, and for fostering a successful transition from childhood to adulthood through participation.

EVALUATION

- Differentiate between an impairment, disability and handicap?
- List the two main types of disability.
- List 4 causes of disability.
- Mention four challenges that adolescents with disabilities encounter.

MODULE EIGHT SESSION 2
ADOLESCENTS WITH PHYSICAL AND MENTAL DISABILITIES

TIME: 1 Hour

LEARNERS' OBJECTIVES

At the end of the session, participants will be able to:

- Discuss magnitude of the problem.
- List forms of physical and mental disability.

SESSION OVERVIEW

- Introduction
- Magnitude of the problem
- Types of physical disability
- Types of mental disability

METHODS

- Lecture
- Discussion
- Group work

MATERIALS

- Flip Chart Stand and paper
- Chalkboard/Chalk
- Markers
- VCR and TV
- Video tapes/CD/DVD

CONTENT

MAGNITUDE OF THE PROBLEM

The 1991 Census in Nigeria obtained some information on people with disabilities. Although the scope was limited to seven categories – the deaf, the dumb, the deaf and dumb, the blind, the crippled, the mentally ill and others, it however provided useful information on the magnitude of the problem of people with disabilities in Nigeria. It revealed that among children aged 0 – 14 years, the numerically most common impairment was deafness (30%), followed by those who were dumb (15%), those who were both deaf and dumb (14%).

TYPES OF PHYSICAL DISABILITY

- Mobility: This affects the individual's ability to walk, often called paralysis. This could affect one or both lower limbs. Some causes of locomotor disability include – congenital causes, trauma, and diseases like polio.

- Visual: This is due to an impairment in the eye (s). Examples include the following: refractive errors, colour blindness, blindness etc.

- Auditory: It refers to the disabilities affecting the individual's ability to hear. It could be total or partial and could affect one or both ears. Some causes of auditory impairment are: congenital problems, infectious diseases of the middle ear, other infectious diseases like measles, mumps, and meningitis.

- Speech: Affects the ability to speak. Examples include stammering, frank dumbness.

- Others: There could be a combination of disabilities in an individual. The most common is hearing and speech disability.

TYPES OF MENTAL DISABILITY

Mild mental retardation (Mild MR): (IQ 50–69) may not be obvious, and may not be identified until the child begins school. People with mild MR are capable of learning reading and mathematics skills to approximately the level of a typical child aged 9 to 12. They can learn self-care and practical skills, such as cooking or using the local mass transit system. As individuals with mild mental retardation reach adulthood, many learn to live independently and maintain gainful employment.

Moderate mental retardation (Moderate MR): (IQ 35–49) is nearly always apparent within the first years of life. Speech delays are particularly common signs of moderate MR. People with moderate mental retardation need considerable support in school, at home, and in the community in order to participate fully. While their academic potential is limited, they can learn simple health and safety skills and participate in simple activities. As adults, they may live with their parents, in a supportive group home, or even semi-independently with significant supportive services to help them, for example, manage their finances and employment in a sheltered workshop.

People with **severe** (IQ 20-34) or **profound** (IQ <20) mental retardation will need more intensive support and supervision throughout their entire lives. They may learn some activities of daily living. Some will require full-time care by an attendant.

SUMMARY

There are many causes of physical and mental disability and majority of them are preventable with simple measures such as reducing the occurrence of infections in pregnancy and childhood. To achieve this, there is need to provide adequate and safe antenatal and delivery services for pregnant women. In addition, measures to ensure that children have access to and receive appropriate preventive and curative health care are essential.

EVALUATION

- List 4 types of mental disability.
- List 4 types of physical disability.

MODULE EIGHT: SESSION 3
STREET ADOLESCENTS

TIME: 1 Hour 30 Minutes

LEARNERS' OBJECTIVES

At the end of the session, participants will be able to:

- Define street children.
- List categories of street children.
- Discuss factors responsible for children being on the streets.
- Discuss problems of street children.
- Discuss interventions for street children phenomenon.

SESSION OVERVIEW

- Introduction
- Definition
- Categories of street children
- Factors responsible for children being on the street
- Problems of street children
- Interventions

METHODS

- Lecture
- Discussion
- Brainstorming
- Film

MATERIALS

- Flip Chart Stand andpaper
- Chalkboard andChalk
- Markers
- VCR/TV/video tapes

CONTENT

INTRODUCTION

The phenomenon of street children is an offspring of the modern urban environment. It is estimated that there are about 150 million street children worldwide (United Nations, 1990; Scallon, 1998). An estimated 10 million children in Africa live without families, mostly in towns as street children (Kopoka, 2000).

DEFINITION

The United Nations defined the term 'street children' to include "any boy or girl….for whom the street in the widest sense of the word… has become his or her habitual abode and/or source of livelihood, and who is inadequately protected, supervised, or directed by responsible adults (Panter-Brick, C 2002). Although termed street children, the majority of them are adolescents. In this session, the terms 'street children' and 'street adolescents' will be used interchangeably.

CATEGORIES OF STREET CHILDREN

Four categories of street children have been described: children of the street; children on the street; children living in the street as part of afamily; and those in institutionalized care.

1. Children on the street- i.e. they work on the street. They constitute the majority of street children. They maintain strong ties with their families and have a sense of belonging to a household.
2. Children of the street (they live on the street all the time). They have no functional family ties, or at best very weak ties. They are essentially on their own although they may have some peer-support. They can be exploited by others – adults and other children.
3. Children living in the street with their families. Street families are becoming prominent in urban areas. These destitute families can be found living under bridges, near public toilets and in markets. Their children often resort to begging in order to fend for the family.
4. Abandoned children: They are similar to children of the street as they have no family ties. The main difference is that they have spent a large proportion of their lives in institutions. Children can be abandoned for various reasons. Parents who have children with disabilities may abandon them while some children are abandoned because of extreme poverty. They have no ties with their family and so they are responsible for their own material survival and emotional needs.

MAGNITUDE OF THE PROBLEM

The problem of street children is on the increase. In the early 1990s, UNICEF estimated that worldwide, there were 80 million children living or working on the streets and approximately 10 million of them were in developing countries. Currently, statistics on the prevalence of street children in Nigeria are minimal. The phenomenon of street children is further compounded by the incessant spates of armed conflict in many countries in Africa. The HIV pandemic which is still a problem in many sub-Saharan countries has also contributed to the problem. As children lose both or one parent to HIV, they are often forced to take to the streets either to supplement the family income or to fend for themselves and their younger ones.

FACTORS RESPONSIBLE FOR CHILDREN BEING ON THE STREET

Several factors are responsible for the increasing problem of street children. Broadly, these factors operate at the level of the society at large, the family and the individual level.

- Factors within the larger environment – the society include the following:
  - Increasing economic hardships in many countries: This affects government funding of education and other social amenities and families including their adolescents have to look for whatever means are available to support themselves. Some adolescents are thus constrained to drop out of school or work on the street so they can get some money to fund their education.
  - Economic hardships also push more families below the poverty line as employment opportunities for parents are inadequate thus making it imperative that children go to work on the street in order to augment the family income. Some adolescents are also constrained to leave the home to fend for themselves when the economic conditions are harsh.
  - Increasing incidents of armed conflict: This leads to the death of the family breadwinners and children are thus forced to join the labour force prematurely. The majority of them work at menial jobs because they lack appropriate skills.
  - An aftermath of disasters, especially where there are no procedures for handling post-disaster situations.

- Some factors within the family which can predispose adolescents to street life include the following:
  - Poverty
  - Conflict situations within the family (could make children seek refuge on the streets.)
  - Dysfunctional families
  - Violence within the family
  - Ill-treatment of adolescents within the home
  - Poor family connectedness (which could make adolescents seek to be with their peers on the street)
  - Death of a parent

- At the individual level:
  - Adolescents desire some degree of independence and when this is lacking in the home, some are lured by their friends onto the streets where they can have the independence they want.
  - Some adolescents seek for companionship among their peers on the street, especially if they perceive that this is lacking within the home.
  - Deviant behaviour such as stealing, among some adolescents could make them voluntarily abandon the home for street life and they could also be thrown out of the home by their parents as a result of these incessant behaviours.

TYPES OF JOBS UNDERTAKEN BY STREET CHILDREN

Street children engage in various jobs. They are limited in what they can do because:

- they are under-aged and can thus not be legally employed in stable and ‘safe’ jobs;

- they have inadequate education and skills and thus have limited opportunities for gainful employment;
- The economic situations which forced the majority of them on to the street mean that viable jobs are scarce.

Hence they often have menial jobs and work as hawkers, bus conductors, scrap pickers, porters in markets, scavengers, shoe shiners, vehicle washers etc. In addition to these, some are involved in jobs which place them in conflict with the law such as drug trafficking, burglary, prostitution.

PROBLEMS FACED BY STREET CHILDREN

Street children have a multitude of physical, psychological and social problems. Their high-risk existence leads to individual morbidity and mortality and has a negative effect on their health and that of the community at large. The kind of job they do and the place where they live (the streets) place them at many risks.

- Physical health problems of street children include:
  - Malnutrition,
  - Respiratory infections,
  - Sexually transmitted diseases, including human immuno-deficiency virus,
  - Skin infections,
  - Malaria,
  - Gastrointestinal diseases,
  - Unintentional and violence-related injuries.
- Psychological problems:
  - Low self-esteem
  - Mental illness such as depression.
- Social problems include:
  - Lack of social ties,
  - Street adolescents are an income-generating group and constitute a ready pool of individuals who can easily be conscripted for perpetrating societal violence (religious, political).
  - They can also be easily recruited into rebel groups and as child soldiers etc.
  - Lack of education leading to a perpetration of illiteracy and poverty,
  - Substance abuse and its effects,
  - Exploitation including being under-paid,
  - Stigmatization and discrimination,
  - Exposure to maltreatment and violence from their peers, adults and the police.

INTERVENTIONS TO CURB THE PHENOMENON OF STREET CHILDREN

- Primary level interventions: General interventions to improve the economic situation in the country and ensure the full implementation of Child Rights Act as it pertains to children and adolescents working on the street.

- Family level interventions to strengthen the family so that it can fulfil its roles of provision and protection of its members are important.

- Other specific interventions to cater for adolescents already entrenched in street life should be set up by government and non-governmental organizations that focus on street children. These could include the following:

  -Establishing and sustaining outreach projects run by government social workers so they can identify vulnerable families and assist them to cope with the various socio-economic conditions they are grappling with.

  -Provision of drop in centres where street children can come in to have a meal, bath and do their laundry. Such centers should also have facilities for professional counselling to be able to integrate the adolescents back to the school system. These centres should also be able to link street adolescents with those who can provide vocational training for them.

  -Establishing transitional homes to provide temporary shelter and care for an average where the children can stay. Shelter houses i.e. residential homes with sleeping accommodation, food and educational as well as recreational facilities.

  -The National Health Insurance Scheme (NHIS) should make provision for street children, especially those who no longer have ties with their parents.

  -Future national population census exercises need to capture the numbers of street children in the country in order to facilitate government planning for them.

SUMMARY

The impact of street children phenomenon on the society cannot be overemphasized. Their problems are numerous, apart from the burden on themselves and their families, the impact of their problems has direct or indirect effect on national development. The interventions then must be at multiple levels - individual, family and society to control this phenomenon and its associated challenges.

EVALUATION

- Define street children.
- List five factors responsible for children being on the street.
- List five problems of street children.
- List five interventions to address the problem of street children.

MODULE EIGHT: SESSION 4
INTERVENTIONS FOR ADOLESCENTS WITH SPECIAL NEEDS

TIME: 1 Hour

LEARNERS' OBJECTIVES

At the end of the session, participants will be able to:

- Discuss prevention of disabilities.
- Discuss interventions – Education, Healthcare, Social networking.

SESSION OVERVIEW

- Introduction
- Prevention of disabilities
- Interventions – Education, Healthcare, Social networking

METHODS

- Lecture
- Discussion
- Group work session five– Develop an intervention for meeting the recreational needs of adolescents in a school for the handicapped.

MATERIALS

- Flip Chart Stand/paper
- Chalkboard/Chalk
- Markers
- VCR/TV/video tapes

CONTENT

INTERVENTIONS TO ADDRESS THE PROBLEM OF DISABILITIES

These can be instituted at the primary, secondary and tertiary levels of prevention.

Primary prevention (prevent impairments from occurring)

- General health promotion:
  - Improved socio-economic situation in the country, access to safe water and waste disposal methods, good food, education for all,
  - Health education to prevent known causes of some impairments .
- Specific interventions such as:
  - Immunization (Measles, OPV, Vitamin A)
  - proper antenatal care,
  - discouraging the use of herbal drugs during pregnancy.
- Prevention of accidents – domestic, school, RTAs.
- Surveillance-This monitors the trends in prevalence of disabilities in the country and aid planning.
- Research will provide data for evaluating the current situation, determine the type of interventions to be instituted and give directions for other interventions; e.g. are current strategies working?

Secondary prevention (early diagnosis and prompt treatment)

- Screening in hospital, schools,
- Parents to be vigilant,
- Provision of medical and surgical care.

Tertiary prevention (Limitation of disability and rehabilitation)

- Physiotherapy
- Education
- Group therapy
- Employment opportunities

SUMMARY

General programs intended for adolescents and young adults rarely include those with disabilities. Programs for disabled populations where they do exist are not exclusively for them. More programs for this group of people need to be planned and implemented with the full support and participation of the stakeholders – the disabled population.

EVALUATION

- List the 3 levels of intervention for people with disabilities.

MODULE NINE
PRINCIPLES AND PRACTICE OF COUNSELLING

This module comprises sessions focusing on the Principles and Practice of Counselling. It gives an insight into the micro skills of communication in counselling, reflections, summarizing, verbal following and initial interview. It will equip counsellors with vital knowledge and facilitate the development of appropriate skills.

SESSION 1: OVERVIEW OF COUNSELLING

SESSION 2: THE MICRO SKILLS OF COMMUNICATION IN COUNSELLING

SESSION 3: DIFFICULT MOMENTS IN COUNSELLING

SESSION 4: INITIAL INTERVIEW WITH INDIVIDUAL /FAMILY

SESSION 5: TERMINATION AND EVALUATION OF COUNSELLING

MODULE NINE: PRINCIPLE AND PRACTICE OF COUNSELLLING
SUMMARY AND TIMING ESTIMATE

SESSION TITLE	DURATION	OBJECTIVES	METHODS	MATERIALS
Overview of Counselling	1 Hour	• Define and explain the concept of counselling . • Identify the attributes of a good counsellor. • List the general guidelines for effective counselling.	Discussion Lecture	Flip chart stand/papers, markers PowerPoint slides Computer, projector and screen. VCR, Video Cassette, TV Video tape.
Micro skills of communication in counselling	2 Hours	• Discuss the micro skills of communication in counselling. • Demonstrate the micro skills needed for communication in counselling .	Discussion Demonstration Role play	PowerPoint slides Computer, projector and screen. Flipcharts and markers Video cassette, VCR and TV set.
Initial interview with the individual and family	2 Hours	• Explain the steps and the roles of members in the initial interview with an individual. • Discuss the steps involved and the roles of members in initial interview with family. • Conduct an initial interview with individual and with family.	Brainstorming Discussion Demonstration Role play	Flip chart stand/papers PowerPoint slides Computer, projector and screen. Markers Posters.
Difficult moments in counselling	1Hour	• Identify difficult moments in counselling. • Discuss ways of handling them.	Brainstorming Demonstration Discussion Role play	Flipchart/stand/papers Markers PowerPoint slides Computer, projector and screen, Posters.
Termination and evaluation of counselling	1 Hour	• Identify when to terminate and evaluate counselling. • Explain how to evaluate counselling.	Brainstorming Role- plays Discussion Demonstration	Flipchart/stand/papers PowerPoint slides Computer, projector and screen Film VCR/TV/video cassette.

MODULE NINE: SESSION 1
OVERVIEW OF COUNSELLING

TIME: 1Hour

LEARNERS' OBJECTIVES

At the end of the session, participants will be able to:

- Define counselling.
- Explain the concept of counselling .
- Identify the attributes of a good counsellor.
- List the general guidelines for effective counselling.

SESSION OVERVIEW

- Introduction to counselling
- Definition and types of counselling
- Attributes of a good counsellor
- General guidelines for effective counselling

METHODS

- Brainstorming
- Discussion
- Lecture

MATERIALS

- Flipchart
- Markers
- Overhead projector
- Screen
- Films on counselling

CONTENT

INTRODUCTION

Most of the behaviors that lead to reproductive and sexual health problems are under the voluntary control of individuals, although there are many pressures, which influence these behaviors. Most adolescents have the potential capacity to make decisions and take action to protect their health. Most young people are fully aware of the prevailing moral and cultural norms in their societies. They generally know what adults want them to do, but they are often overwhelmed by other influences and personal needs. Counselling which contributes to their overall development will help them to clarify their feelings and thinking and enable them to take informed decisions.

In many societies, counselling is highly directive, a situation in which the counsellor tells the adolescent what to do. This type of counselling does not facilitate development nor strengthen the adolescent's capacity to address problems, which may arise in the future. It may even be counterproductive if the adolescent feels rebuked or treated as a child. A style of counselling which is non-directive and which helps young people make their own decisions is of greater value to them in the long term. It is this form of counselling that has been developed by the Adolescent Reproductive Health Program and it is advocated and described in this manual.

DEFINITION

Counselling is an interpersonal communication between two or more people in which one person (the counsellor) helps another person (the counsellee) make an informed decision and act upon it. Counselling helps to clarify feelings and thoughts.

There are two types of counselling.

- **Directive counselling**
  In directive counselling, the counsellor tells the client what to do. This type of counselling weakens the adolescents' capacity to deal with problems.

- **Non-directive counselling**
  In non-directive counselling, the counsellor helps the adolescent to explore and clarify his/ her feelings and make his/ her own informed decisions.

ATTRIBUTES OF A GOOD COUNSELLOR

The attributes of a good counsellor include the ability to:

- Establish rapport by meeting the client at his/her level.
- Express empathy, by being in tune with clients feelings.
- Elicit needed information.
- Explore clients' feelings.
- Give accurate information without being judgmental.
- Give practical assistance such as referral to appropriate services.

- Focus on the circumstances, facts and feelings, which relate to the client's problem. As a result of the counselling interactions the client emerges with increased self-confidence and ability to solve his/her problems.

GENERAL GUIDELINES FOR EFFECTIVE COUNSELLING

To be effective, the counsellor must:

- Accept the client as an individual.
- Encourage clients to talk freely about themselves.
- Help clients to explore their feelings.
- Demonstrate respect and willingness to listen.
- Believe that the client can be helped to help himself/herself.
- Help clients believe that they have some control over their own lives i.e. they can make their decisions and act on them. They can also evaluate the consequences of these decisions and the actions that follow.
- Assist the client to make informed choices.
- Adhere strictly to the concept of confidentiality, which must be made clear to the client and understood by the client.
- Provide conducive environment and proper sitting arrangement.
- Ensure adequate record keeping of counselling sessions.

OUTCOMES OF EFFECTIVE COUNSELLING

This enables the client to:

- Have more control over his/her own life.
- Feel more confident.
- Adopt healthy development and behavioural change.
- Feel good which is rewarding, in that it will encourage the client to help him/herself.
- Plan the future.

SUMMARY

Counselling is an important process in the promotion of adolescent sexual and reproductive health and the characteristics of the counsellor plays an important role in this process.

EVALUATION

- Define counselling.
- List types of counselling.
- Mention five characteristics of a good counsellor.
- Enumerate the guidelines for effective counselling.

MODULE NINE: SESSION 2
MICRO SKILLS OF COMMUNICATION IN COUNSELLING

Time: 2 Hours

LEARNERS' OBJECTIVES

At the end of the session, participants will be able to:

- Discuss the micro skills of communication in counselling.
- Demonstrate the micro skills needed for effective communication in counselling.

SESSION OVERVIEW

- Micro skills of communication in counselling
- Use of micro skills for effective communication

METHODS

- Brainstorming
- Discussion
- Demonstration
- Role Play

MATERIALS

- Flip charts/stand and papers
- Markers
- Video tapes, VCR and TV
- Overhead projector
- Transparencies

CONTENT

INTRODUCTION

The purpose of counselling in ARH programme is to help adolescents achieve three things, which are: self-exploration, self-understanding, and decision making with consequent action. In order to help the adolescents achieve these goals the counsellor uses skills of listening and expression, and these are called the micro skills of communication.

Micro skills of communication are techniques in communication that are applied to help the clients explore their feelings and arrive at their own decisions. These micro skills consist of listening and expressive skills.

LISTENING SKILLS

The listening skills consist of the following:

- Attending skills
- Use of Encouragers
- Reflections
- Summarising
- Verbal following.

ATTENDING SKILLS: These are usually employed during face-to-face counselling, where the counsellor gives the counsellee his/her full attention by paying close attention to what is being said in order to encourage the person disclose more information.

Attending skills are made up of

- Eye contact
- Body language
- Distance
- Posture
- Facial expressions
- Tone of voice
- Appearance.

- **Eye contact**

Looking into each other's eye without creating embarrassment or discomfort. This is different from staring. Good interpersonal communication requires appropriate eye contact. it is helpful for the counsellor to turn his or her face to the client as a way of indicating interest. The establishment of eye contact affirms a turning point in the first session.

- **Body language**

This is one of the most significant forms of communication; it has many components which include distance between two people, posture, facial expression, tone of the voice and appearance.

- **Distance**

Usually in a face-to-face encounter or conversation, a comfortable distance is maintained between two people in their encounter. This distance is called personal space. If the personal space is violated such that one of the two persons in the encounter steps forward and closer to the second person, the second person is likely to step backward so as to maintain the personal space.

- **Posture**

This is the posture assumed by the Counsellor, which shows the level of rapport between him/her and the counselee. In this case, if the counsellor leans forward the counselee is likely to lean forward and encourage the counselee to feel more relaxed and comfortable to talk more.. **Facial expressions**

These are expressions noticeable in a person's face. Facial expressions can express worry, fear, sadness, anxiety, happiness etc. It is helpful for a counsellor to observe these expressions and act on them.

- **Tone of the voice**

This involves the vocal quality of the person talking. Raising the volume or the pitch of one's voice is often associated with anger; speaking more quickly is associated with anxiety and anger. Lowering the loudness and speed in one's voice may indicate sadness, etc. It is important for the counsellor to also pay attention to vocal qualities of the clients' utterances.

- **Appearance**

This involves the way we dress and look. Our dressing can give information about our characteristics, mannerisms, possibly our state of mind and outlook. Some forms of dressing can indicate a rough nature, carefree attitude, being indecent, or unkempt etc. The young person who looks unkempt may be under drug influence. It is therefore important for the counsellor to take note of the client's appearance for subsequent action.

ENCOURAGERS

These are simple but powerful signals that are given to encourage the client to speak or continue speaking. Encouragers could be verbal or non-verbal . They include signals such as "a nod of the head", a sound such as "mm hm", words such as "I see", "go on" and so on. These small signals are vital indicators to the client that the counsellor is listening, interested and pleased that the client is expressing himself or herself. Encouragers exist in every language and so the counsellor should use these signals in the language understood by the client.

REFLECTIONS

This involves accurate restatement of what the clients has said, using slightly different words. It is restating the statement made by the client and building into it the meaning of what he said with regards to facts or feelings. It is a useful technique of encouraging the client to continue talking and another way of telling the client that the counsellor is interested and listening attentively. Through reflection, the counsellor mirrors the sense of what is said in a slightly different language but does not interpret what is said. Interpretation involves the expansion of the meaning of a statement. At this point in the counselling process, the counsellor is not expected to interpret the client's

statement. Reflection is a deceptively simple skill because it is not so easy to master. It requires considerable practice.

Example 1
Clients' statement*: Yesterday at school, I was asked to do some extra home work.*
Accurate reflection *"So you were asked to do additional school work at home", This is a reflection of fact.*

Example 2
Clients' statement*: Last night, my boyfriend tried to get me to do something I did not want to do. I was scared at first, but when he stopped trying I felt okay again.*
Reflection *"I understand that you were a bit frightened at first when your boy friend was pressurising you to do what you did not want to do but when he did not persist that feeling went away".*
Inaccurate reflection *"so you were annoyed with your boyfriend last night because of what he was trying to get you to do but you felt alright when he stopped.*

Reflections are valuable active listening skills in that they:

- Show that the counsellor has been listening.
- Oblige the counsellor to listen carefully.
- Enable the client to correct the counsellor's misconception.
- Encourage the client to continue talking because when the counsellor reflects what the client has expressed it indicates mutual understanding.
- Leave the choice of the topic to the client thus helping the client to understand his/her role in the counselling session and to achieve greater self-exploration and informed decision making.

SUMMARISING
This involves skilful restating of the major points that were made during the counselling session. It covers more of what has been said than durning reflections. It includes both reflections of facts and feelings. It avoids repetition and is more concise than the clients' statements. Summary must include the important points expressed and especially those emphasised by the client. It should give a clearer expression of the client's experience without moving beyond summary into interpretation. The counsellor's interpretation should come later.

VERBAL FOLLOWING
This involves repeating what the client says. This technique allows the client to guide the subject matter and it is the best way of achieving self-exploration and understanding by the client. This skill is useful in preventing direct questions from the counsellor, which may change the subject matter raised by the client.

There are some occasions however, when it is appropriate to change the subject matter especially when the client becomes repetitive or is noticeable that the client is uncomfortable to continue. A change in subject might be readily helpful. It is advisable that such change should be slight and follow a brief summary. Changing the subject by introducing summary gives the client an opportunity to correct any misunderstanding.

Effective listening is not passive but active. Good listening will show the client that the counsellor is interested, respectful, attentive and able to understand. Effective listening is not intrusive. It does not take control of the agenda for discussion away from the client, and does not stop or change the topic the client has chosen to discuss.

EXPRESSIVE SKILLS

These are verbal expressions that are used to help clients in self-exploration. These expressions are in form of questions'f in statements made by the counsellor. Questions are the most common form of aiding active listening. Sometimes the way questions are used may run contrary to what is needed in the counselling setting.

There are two types of questions which are "open" and "closed" questions.

- **Open question**

An open question is one which permits a broad range of responses. Such questions frequently start with words like "what", "Could", "would", "How". "How do you spend your leisure time?" "Could you tell me about your family".

- **Closed question**

A closed question usually calls for a single word response such as "yes" or "no" or a number.

The difference between the two types of question is defined by the extent of freedom the person responding has in choosing a response. The open question allows the client to exercise some control over the direction of the conversation while the closed question narrows the direction of conversation to the counsellors' choice. In an open question, the client can choose how to answer the question from a wide array of responses. An open question will help the counsellor to help the client. It gives a signal to the client that s/he is free to make choices about what they will discuss.

Closed question often starts with words such as Is? Are? Do? Did? How many? e.g. "Did you tell your girlfriend what happened?" "How many brothers and sisters do you have?", etc. Closed questions are commonly used in medical settings when the health care worker obtains information needed to make decisions about treatment to be provided. In a counselling setting, this is not appropriate because it will not meet the felt need of the client. The felt need of the client is self-exploration which means that the client must exercise the choice of what to express and the decision for action is in the client's hand. This can only be achieved through "open question".

Closed question also contributes to a more authoritarian atmosphere of the type present in situations when a teacher questions a student or when a doctor questions a patient or a parent questions a son/daughter. It leaves the authority and the responsibility with the person asking the question. Closed questions can also be misleading as they may take the client in an inappropriate direction based on mistaken assumptions on the part of the counsellor.

There is a third type of question, which usually starts with why? While "why" questions appear to be open, they are often closed in disguise. This is because they are not real questions but implicit accusations. In principle, the response to a "why" question can be chosen from a wide range of

answers. It thus makes it an open question that in practice is often difficult to answer and sometimes it is used in an accusatory manner. For example, “why didn’t you tell your mother what happened at the party?” It could be taken that the person could have done so.

It should be noted however that whichever questions are asked, the principle of verbal following should be maintained. Questions should not be used to change the subject unless a summary has been provided first, and checked for accuracy from the client. If a question is to be used to start a new subject matter, it is important that it should be an open-ended question.

FOCUS AND TENSE OF COUNSELLOR’S STATEMENTS

FOCUS

The focus of a statement can be divided into five categories indicated by the following pronouns:

- “you” – focus on the client
- “I”- focus on the counsellor
- “We” – focus on client and counsellor
- “They”/ “them” – focus on others
- “It” – focus on the main theme

For Example,

- “I wonder how you are feeling at the moment?”- reflects focus on the client.
- “ I am sorry, I’m afraid, I’d forgotten you told me you had another brother.”- reflects focus on the counsellor.
- “ I’m glad that we’ve been able to talk together about things that are important to you” – reflects focus on the client and counsellor.
- “ John, you have told me about your father and mother, is there anything more you’ll like to tell me about them?” reflects focus on others.
- “As far as we know, it is common for a boy to stroke his penis for a sexual release, what we call masturbation” – reflects focus on the main theme.

TENSE

This refers to whether the statement made by the counsellor is in the present, past or future tense.
e.g. “How are you feeling now?” – reflects present tense.
“How did you react when your boy friend told you what happened?” – reflects past tense.
“Have you thought about how you will break the news to your mother?”- reflects future tense.

Choice of tense reflects the emphasis of the discussion. The past tense is used to help the client explore how s/he came to have problems. The present tense focuses on what is happening in the counselling session. The future tense is used when the clients are beginning to think ahead as to how they will resolve their problem or difficulty. It is important to add that these focus and tense skills should be used as appropriate by the counsellor to promote effective counselling.

THE ART OF ASKING QUESTIONS

In counseling, questions are asked for the following reasons:

- To know why the client has come,
- To help the client express needs and wants,
- To help the client to express feelings and attitudes that allow the counsellor to know how the client feels,
- To help the client think clearly about choices,
- To show the client that the counsellor cares,
- To learn the client's knowledge of the subject matter, and
- To learn about situations affecting the client.

HOW TO QUESTION EFFECTIVELY

- Use a tone that shows interest, concern and friendliness.
- Use words that the client understands.
- Ask one question at a time and wait with interest for the answer
- Ask questions that encourage clients to express their needs e.g. 'May I ask you about your school and family?'
- Use words such as 'then' 'Oh'. These words encourage clients to continue speaking.
- Avoid starting a question with 'why' - it sounds like one is finding fault.
- When asking a delicate question, explain why e.g. asking about number and sex partners to find out about STI/HIV risk.
- Ask the same question in other ways if the client has not understood.

SUMMARY

Micro skills are very important tools for the counsellor in helping the clients to achieve self exploration, self understanding , decision making and problem solving skills which together will increase the clients' self-development. It is crucial that the counsellor acquires these skills for effective and successful counselling.

EVALUATION

- Define micro skills of communication.
- Differentiate between reflection and summarising.
- Describe two attending skills.
- Describe the difference between 'open' and 'closed' questions.

MODULE NINE: SESSION 3
DIFFICULT MOMENTS IN COUNSELLING

TIME: 1 Hour

LEARNERS' OBJECTIVES

At the end of the session, participants will be able to:

- Define and explain difficult moments in counselling.
- Identify difficult moments in counselling.
- Demonstrate how to deal with difficult moments of counselling.

SESSION OVERVIEW

- Description of difficult moments in counselling.
- How to deal with difficult moments in counselling.

METHODS

- Brainstorming
- Discussion
- Demonstrations
- Role play

MATERIALS

- Flip chart stand/paper
- Markers
- Volunteers for role play
- VCR/TV/Video cassette

CONTENT

During the process of counselling there may be some moments that are particularly difficult for the counsellor to handle. Such moments are called difficult moments in counselling.

SOME TYPICAL DIFFICULT MOMENTS

- **Silence**

This is when a client is unwilling or unable to speak for some time. This may be common to an adolescent who is anxious or angry probably because he/she is sent to see the counsellor against his/her will.

Sometimes, silence may occur in the middle of a session. In such cases it is important to note the context and the counsellor will need to judge why it has occurred. It may be because the adolescent is finding it hard to admit a secret or may not like how the counsellor has just reacted to something, knowing this will help the counsellor in dealing with the "silence".

- **How to deal with silence**:

If it occurs at the beginning of the session, the counsellor should wait a little while and then gently call attention to it by saying e.g. "I can see that it is a bit difficult to talk. It's often like that when someone first comes to see me". This should be followed by another period of silence with the counsellor looking at the adolescent and maintaining body language that indicates an empathic interest. If it occurs at the middle of a session, the counsellor should wait and allow the person to make efforts to express his or her feeling or thoughts. The waiting may be initially uncomfortable for the counsellor but there is need for patience on the part of the counsellor. The counsellor should also find out why the silence occurred to prevent future occurrences.

- **The client cries**

A client may start to cry or sob. Crying may occur for different reasons. For some people it is a helpful way of releasing emotion. Some use it to elicit sympathy or stop any further exploration. It may be a way of manipulating a counsellor as it is probably used by the client to manipulate other people in some situations.

A natural response will be to try and stop the crying by comforting the client, but this may not be the best in a counselling situation. The best thing will be to allow the client to cry for a while to indicate that although the counsellor is sorry that they feel sad it is a good thing to express their emotions. The counsellor can say "it is alright to cry, it is a natural reaction when one is sad". If however the client is being manipulative, it will soon come to an end, the manipulator will discover that s/he cannot manipulate the counsellor. It is not also advisable for counsellor to touch their client especially those of the opposite sex.

- **The counsellor believes there is no solution**

This may occur when the counsellor is anxious and may get "stuck". In such cases it is important to remember that the primary focus of the counselling is on the person and not the problem. It is also helpful to let the client who insists on a solution to know that while it may not be possible to change

some things, getting to know the client better is always helpful and may bring about change in perspectives on things.

- **The client threatens suicide**

This may be anxiety provoking for the counsellor. Usually most young people who threaten suicide do not commit suicide but they are desperate enough to cry out for attention in this way.

The appropriate things to say will be that while no one can stop a person from taking his or her own life, the counsellor will feel terribly sad if that were to happen; that the counsellor and the client are just getting to know each other and there may be things the counsellor like and admire in the counsellee. This lifeline thrown to the client by the counsellor may give the client sufficient hope to continue. Thus a comment indicating positive feelings about the client is the most valuable approach.

- **The counsellor makes a mistake**

The counsellor may make a factual error about what the client said or provide incorrect information or be inappropriately embarrassed, angry etc. The single most important rule with the client is to be honest. Basic respect for the client is one of the key principles of counselling. That respect and confidence is best demonstrated by admitting that the counsellor made a mistake. An apology from the counsellor is appropriate in this case.

- **The counsellor does not know the answer to a factual question**

This may be a common anxiety expressed by counsellors. They may not be able to provide immediate answers to their clients' question. It is quite appropriate in this case to say so and that information on the subject will be sought and provided later. Or the counsellor can identify another source of information and refer the client to that source.

- **The client refuses help**

Some situations may arise when the client refuses to be helped especially when they are sent for help against their will. In this case the counsellor may need to probe to find out the reason.

Helping the young person say why they have come to the counselling session usually opens up the subject. If however the adolescent is completely unwilling to talk, the counsellor should stress the positive aspect that, at least he or she came and now that the two of them have met the client might like to reconsider his/her stand. Another appointment may be suggested and left open. By this the client has the green light to return if s/he so desires.

SUMMARY

In counselling, difficult moments can be encountered by the counsellor. It is important for the counsellor to master ways of handling such situations using effective counselling skills and the attributes of an effective counsellor.

EVALUATION

- List four possible difficult moments in counselling.
- Describe how to handle two of these difficult moments.

MODULE NINE: SESSION 4
THE INITIAL INTERVIEW WITH INDIVIDUAL AND FAMILY

TIME: 2 Hours

LEARNERS' OBJECTIVES

At the end of the session, participants will be able to:

- Mention the essential components of counselling.
- List the steps involved and the roles of members in initial interview with family.
- Conduct an initial interview.

SESSION OVERVIEW

- Describing steps involved in initial interview

METHODS

- Brainstorming
- Discussion
- Role Play
- Demonstration

MATERIALS

- Flipchart stand/papers
- Markers
- Volunteers for role play
- Posters
- Overhead Projector
- Screen
- Transparencies

CONTENT

THE INITIAL INTERVIEW

The Initial Interview is the first encounter an adolescent has with the counsellor. This first encounter is important for many reasons. The adolescent is likely to be sensitive to the counsellor's manner and try to find out if the counsellor is friendly and non-judgemental. The first meeting will also set the style and tone for the nature of interactions that will follow thereafter.

It is important for both counsellor and client to understand that they are entering into a professional relationship, which is different from a social one. Such professional relationship would require the enforcement of respect for the client regardless of whether the counsellor likes or dislikes the client's behaviour. The atmosphere created must be one that allows the young person to feel free to talk about the most sensitive issues. This will allow for self-exploration by the client.

ESSENTIAL COMPONENTS OF COUNSELLING

- **Timing**

In a counselling relationship, keeping to time and providing a "safe" environment for the client are very important. When possible, it is best to make an appointment for a specific time with young persons. If this is not possible, an approximate time will do. Telling an adolescent that he/she will be seen between "9 and 10am" is better than "sometime in the morning". Keeping an adolescent waiting generates anxiety, impatience and anger in them. Some may not be able to tolerate this and will leave before they can be seen. If they must be kept waiting it is helpful to let them know. Adolescents should also be informed about how long the session will last before it starts. Equally ending a session "on time" is important and it is necessary to comment on the importance of what the client has said and make arrangement for subsequent meetings.

- **Client's Comfort**

The adolescent is likely to be anxious about the first meeting. As such, it is important to show respect and cordiality from the start. The seating arrangement should be conducive, such as sitting on similar chairs without a table in between so as to de-emphasize difference in status. Some measure of privacy should also be maintained either by making sure no one else is in the room or using some dividers where the former situation is not possible.

- **Opening the Session**

In a counselling session, it is best to begin by asking the clients why they have come. The opening question is necessary to make it easier for the clients to reply and say how they feel about coming to the counsellor. It is not appropriate to say: "Tell me what your question is". It should be noted that the purpose of counselling is to deal primarily with the person and not the problem especially since the problem may require indirect handling to ensure that the underlying cause is addressed.

- **The Client's Demeanour**

One of the most important tasks of the counsellor is to be aware of the manner and emotions of the client and what provokes a change. This is important especially at the beginning of the first session when rapport is established. Adolescents may come to a session with some degree of anxiety, anger

or unseriousness or they may be expressionless. It is the task of the counsellor to reduce the extent to which these feelings hamper self expression. The counsellor can gently call attention to the mood of the client and ask whether that is the case. Commenting on the adolescents' feelings and helping them to acknowledge them help to reduce their level of tension, show the acceptability of their emotions to the counsellor and help them to acknowledge their own feelings.

- **Silence**

Unaccustomed silence can be uncomfortable to both the client and the counsellor, but some measure of silence in the first session is valuable. Sometimes, some clients may not want to talk because they are frightened and need time to trust the counsellor. Such clients should be thanked for taking the first step and another meeting should be suggested.

- **Appropriateness of Question and Reply**

Sometimes a question asked by a client may not be appropriate. Such a client should be told why the question is not appropriate, rather than evade the question. The principle of being honest is the clearest way to show respect and establish trust in a counselling relationship.

- **Ending the Session**

As a counselling session comes to an end, it is useful to make a brief summary of the session pointing out the positive achievements made by the client and the value the counsellor places on the client's willingness to work out his/ her difficulties. A further appointment if necessary should be arranged.

THINGS TO NOTE IN FAMILY COUNSELLING

It is important for the counsellor to:

- Find out who made the decision to come, how it was made and why.
- Emphasize at the outset that his/her task is to clarify the situation and help the family reach their decisions.
- Notice how the family members arranged themselves. The sitting arrangement may indicate the relationship between family members.
- Allow the family members to come together initially, introduce themselves and inform them that they will be seen separately. Thereafter they should be brought together and should not be separated again.
- Help the family members to listen to each other.
- Note the changes in each member of the family as they listen to each other.
- Ensure his/her neutrality in the counselling sessions.
- Help the family to readjust to the changes in the adolescent in the family, which will require consultation with the adolescent in matters concerning him/her.
- Ensure that he/she does not usurp the authority within the family.
- Let the family members know that adolescents are sensitive to fairness and this should be imbibed by the family.
- Let the father know that he/she recognises and appreciates the headship of the father and that the father is still in firm control and thank him for allowing the counsellor to help the family.
-

- Allow arguments during the session as a way of helping the family members clarify their feelings, but the argument should not go on indefinitely.
- Bring the session to a close appropriately.

SUMMARY

The initial interview is very crucial to the development of an effective counselling relationship, which is tangential to a successful counselling process.

EVALUATION

- Define initial interview.
- Explain the components of an initial interview.
- Describe the features that differentiate individual interview from family interview.

MODULE NINE: SESSION 5
TERMINATION AND EVALUATION OF COUNSELLING

TIME: 30 Minutes

LEARNERS' OBJECTIVES

By the end of the session, participants will be able to:

- Identify when and how to terminate counselling.
- Explain how to evaluate a counselling session.

SESSION OVERVIEW

- Identification of criteria for evaluating counselling

METHODS

- Brainstorming
- Discussion
- Role play
- Demonstration

MATERIALS

- Flip charts stand/papers
- Markers
- Overhead Projector/Screen/Transparencies
- VCR/TV/Video cassette
- Case studies

CONTENT

TERMINATION OF COUNSELLING

This is a situation in which a final end is brought to the counselling sessions and an agreement is reached by both counsellor and client that they do not see each other again regularly.

It is best that counselling is terminated by mutual agreement between the two people concerned. Counselling should not be ended abruptly. It is more helpful to discuss the termination in advance. Some counsellors find it useful to agree on the number of sessions at the beginning of the counselling session. At the penultimate session, the termination should be discussed. If both the counsellor and the client feel that more sessions are needed, this should be discussed and reasons for extension reviewed.

If a client terminates counselling by not returning, efforts should be made by the counsellor/ service provider to get in touch with the client without violating confidentiality and the client should be informed that the counselling session should be terminated by mutual agreement. An appointment should then be suggested so that the counselling process can be mutually terminated.

EVALUATION OF COUNSELLING

Evaluation of counselling involves determining whether a counselling process has achieved its set objectives. Counselling is evaluated using the following criteria:

- Self-exploration and self understanding - To what extent has this been achieved.

- Termination of counselling - Did the counselling come to an end by mutual agreement between the people concerned? If not why?

- Action by Client - Did the adolescent make some changes in his/her behaviour as a result of better self-understanding and relationships with other key people.

- Changes in relationships - Does the adolescent see himself/herself differently now? Are these changes likely to endure? Does the client behave in a more matured way?

- Client Satisfaction - Is the client satisfied with the outcome of counselling? Has the issue that brought about the counselling been resolved?

- Satisfaction of Reference - If the client was referred, to what extent were those who referred the client satisfied with the outcome?

- Future State - Is it likely that the client will be able to avoid such difficulties in future? Or deal with them in a healthy way should the need arise? Has the client left with positive feelings towards the counsellor? This will determine future contact if necessary.

Since the emphasis in counselling is on the client becoming more matured in handling future situations, evaluation of counselling focuses on the client. If therefore most of the responses to the criteria enumerated above are affirmative, the counselling will be judged successful.

SUMMARY

In counselling, it is essential that its termination should be by mutual agreement between the counsellor and the client. It is equally important to evaluate the success of counselling by determining the level to which the set objectives have been met.

EVALUATION

- Define termination of counselling.
- Explain how to terminate a counselling process.
- Describe the criteria necessary for evaluating a counselling process.

MODULE TEN
COUNSELLING PRACTICES ON SELECTED HEALTH ISSUES OF YOUNG PEOPLE

This module builds on the earlier module on counseling, which covers the "principles and practices of counseling". In particular, this module directs attention to youth-related counseling practices; it introduces the concept of adolescent/youth-centered counseling and provides information on how five selected adolescent health issues – which are fairly common or particularly sensitive – can be dealt with in terms of counseling approach.

SESSION ONE: **THE CONCEPT OF ADOLESCENT AND YOUTH-CENTERED COUNSELING**

SESSION TWO: **BASIC PRINCIPLES OF ADOLESCENT AND YOUTH-CENTERED COUNSELLING**

SESSION THREE: **PROCESS OF ADOLESCENT AND YOUTH-CENTERED COUNSELLING**

SESSION FOUR: **COUNSELLLING ADOLESCENTS ABOUT STIS, INCLUDING HIV AND AIDS**

SESSION FIVE: **COUNSELLLING PREGNANT ADOLESCENTS**

SESSION SIX: **COUNSELLLING ADOLESCENT VICTIMS OF SEXUAL VIOLENCE (RAPE AND ABUSE)**

SESSION SEVEN: **COUNSELLLING PHYSICALLY AND MENTALLY CHALLENGED ADOLESCENTS**

SESSION EIGHT: **COUNSELLLING ADOLESCENTS UNDER THE INFLUENCE OF DRUG**

MODULE TEN: SPECIAL ISSUES IN COUNSELLING ADOLESCENTS
SUMMARY AND TIMING ESTIIMATES

SESSION	DURATION	OBJECTIVE	METHODS	MATERIALS
Concepts of Adolescent and Youth Centered Counselling	1 Hour	• Explain the concept of adolescent/youth centered counselling. • Discuss the basic principles of adolescent /youth centered counselling. • Discuss the skills required by an adolescent/youth-centered counsellor. •	Presentation Discussion	Flipchart stand/papers Markers Overhead Projector Screen Transparencies
Adolescent/Youth Centered Counselling Process	1Hour 30 Minutes	• Discuss the characteristics and associated strategies of an adolescent and youth-centered • Discuss the concept of motivational interviewing and its role in adolescent and youth-centered counselling • Explain the steps involved in adolescent and youth-centered counseling process.	Discussion Presentation Lectures	Flipchart stand/papers Markers Overhead Projector Screen
Counselling adolescents about STIs and HIV and AIDS	2 Hours	• Explain important issues in HIV and AIDS counselling. • Discuss the two types of counselling (pre and post test counselling). • Discuss pre- test counselling. • Discuss post- test counselling. • List steps in preventive counseling.	Brainstorming Presentation Role Play	Flip charts and papers Chalkboard/ chalk Markers
Counselling pregnant adolescents	1 Hour 30 Minutes	• List options available to pregnant adolescents. • Discuss the challenges faced by pregnant adolescents. • Discuss consequences of abortion. • Explain post abortion care. • Explain parental consent in abortion.	Brainstorming Presentation Role Play	Flip charts and papers Chalkboard/ chalk Markers
Counselling adolescent victims of sexual violence (rape and abuse)	1 Hour 30 Minutes	• Discuss the effects of sexual violence. • List steps to take in assisting adolescents to deal with sexual violence. • List possible referral options.	Brainstorming Presentation Role Play Case study	Flip charts and papers Chalkboard/ chalk Markers
Counselling physically and mentally challenged adolescents.	1 Hour 30 Minutes	• Discuss the challenges faced by the physically and mentally challenged adolescents. • Highlight the skills needed to counsel the physically and the mentally. challenged adolescents	Brainstorming Plenary Presentation Role Play	Flip charts and papers Markers Chalkboard/ chalk Scenarios for

		• Discuss ways of increasing the self-esteem of physically and mentally challenged adolescents.		role-plays
Counselling adolescents under the influence of drugs	1 Hour 30 Minutes	• Describe the consequences of using drugs/substances on the adolescent abusing substance. • Describe the consequences of using drugs/substances on the adolescent abusing substance. • Describe the methods to be used in dealing with physical and psychological dependence.	Brainstorming Presentation Role Play	Flip charts and papers Chalk board and chalk Markers
Counselling practices using selected case studies on adolescent health issues.	2 Hours	• Improve their counselling skills after participating in the practice counselling scenarios.	Role-play Discussion Demonstration Film on counselling	Flip charts stand/paper Markers Overhead projector /screen/transparencies VCR/TV/video cassette e.g. Gather PPFN

MODULE TEN: SESSION 1
CONCEPTS OF ADOLESCENT AND YOUTH CENTERED COUNSELLING

TIME: 1 Hour

LEARNERS' OBJECTIVES

At the end of this session, participants will be able to:

- Explain the concept of adolescent/youth-centered counselling.
- Discuss the basic principles of adolescent/youth-centered counselling.
- Discuss the skills required by an adolescent/youth-centered counsellor.

METHODS

- Lecture
- Discussion

MATERIALS

- Flipchart stand/papers
- Markers
- Overhead Projector
- Screen
- Slides/Transparencies

CONTENT

CONCEPT OF ADOLESCENT AND YOUTH CENTERED COUNSELLING

In the context of adolescent and youth health issues, counselling is conceptualised as an encounter in which a provider acts as a facilitator and helps the young person to solve a problem in an understanding and nurturing atmosphere that supports self-disclosure. The counselling process is based on cognitive behavioral approach where the provider helps the young client to understand his/her unhealthy behavior and replace them with learning new behaviors in order to address common health issues such as preventing HIV/STI and unwanted pregnancy.

Counsellors have an important role to play in encouraging and supporting adolescent and youths through simple but important techniques such as empathetic listening and facilitating self-disclosure while they reflect on and change their thoughts and behavior. Furthermore, counselling can help a young client cope with a crisis (for example, how to deal with loss, such as death of a family member, unexpected pregnancy, a new HIV diagnosis, relationship break-up, loss of a home) and develop personal insight and knowledge. Through the decision making process, counselling can help young people alleviate a situational problem or challenge, expand their skills, restore a sense of well-being and correct some self destructive behavior.

BASIC PRINCIPLES OF ADOLESCENT AND YOUTH CENTERED COUNSELLING

- **It is centered on the young people's needs and wants and is responsive to their sexual identity and developmental stage.** Counsellors get to know the young person coming to see them in a more personalized and individualised manner on order to develop trust and rapport. Many young people avoid coming to health clinics for health care services simply because they are often seen as just "cases" or "numbers". Young people will not disclose information if they are not respected, if they do not feel that they will truly be heard.

- **Health is universally acknowledged as a fundamental human rights and sexual and reproductive health is an integral component of overall health**. Adolescent sexuality and sexual wellbeing are integral components of adolescent health and development. Effective youth centered counsellors acknowledge that young people are sexual beings and that because they will have sexual experiences they need to have precise and updated knowledge, clear values and healthy attitudes.

- **Providers practicing youth-centered counselling respect and accept young people for who they are, not for what they do.** Through their language and non-verbal communications, providers should express their unconditional positive regard for the young person.

- **Youth-centered counseling uses a non-directive style.** Providers must understand and appreciate that behavior change is facilitated when the young client participates in the selection of possible options to solve their own problems. Providers should not underestimate their young clients' knowledge and capacity for self-understanding and making informed decisions.

- **Adolescent and youth-centered counsellors acknowledge and use the young client's strength,** internal and external resources skills and coping strategies to solve challenges and problematic situations. Counsellor needs to acknowledge the client as a whole human being rather than focusing on addressing pathologies and fixing dysfunctions.

- **Adolescent and youth-centered counsellors focus on their young client's subjective reasons for doing things and are interested in exploring the meaning the young person ascribes to the situation**. The counselors should ask open ended questions in order to explore the intricate meanings behind their behavior.

- **Adolescent and youth centered counsellors pay attention to the young client's unique story and perspective of the situation**. While problems and opportunities for change may be similar from one young client to another, the youth-centered counsellor appreciates the uniqueness and individual perspective and meaning of each young person in counselling.

- **Adolescent and youth-centered counsellors set specific and realistic goals that are appropriate to the gender and age of the young person.** The counseling relationship is bounded by setting achievable goals, is limited and makes use of brief interventions that motivate change.

- **Adolescent and youth-centered counsellors provide pertinent and precise information about sexuality and sexual and reproductive health issues.** The counseling takes on an important role to demystify sexual myths, provide accurate and precise science-based information on sexuality and other adolescent/youth health health and development issues and provide practical strategies for the young person to act on the new information and skills learned.

- **Adolescents and youths require a full range of confidential health services tailored specifically for them.** Adolescent/youth-centered counselors have the responsibility to find out the policies regarding the provision of health services to young people and the availability of health and social services that young people can effectively access to promote their health, well-being and development.

- **Adolescent and youth-centered counsellors work in partnership with the young person and accompany them through the process of change**. The counsellors do *not* work on the youth but *with* the youth.

- **An adolescent/ youth-centered counsellor is critically aware of the power relationship between the young person and the counselor and tries to minimize that power through concrete actions**. The Counsellor, for example may attend youth activities, mixes with young people, and is interested in their world and advocates for their concerns.

COMPETENCIES OF A YOUTH-CENTERED COUNSELLOR

- **Knowledge of adolescent health and development:** Up-to-date information and facts about the process of development, health-related concerns, behavioural issues, and health challenges of adolescents and other young people.

- **Communication Skills**: kKnowledge and comfort in verbal exchanges and talking openly and unashamedly about sexuality, sexual and reproductive health issues in adolescence.

- **Interviewing Skills**: Active listening, listening to the adolescent's needs and wants, expressing empathy, keen observation of non-verbal behavior, prompts for relevant sexual health questions, reflection of young people client's personal situation.

- **Assessment Skills**: Ability to make sense of data collected during the counseling interview. Ability to understand the problems and opportunities for change of behavior and young people's perspective.

- **Intervening Skills**: Ability to conceptualise the problematic situation or challenge, identity change opportunities, work closely with young people to develop options and realistic age-appropriate goals, motivate and encourage the young person, appropriately and respectfully challenge the young person in his/her views, and being a role model for positive healthy behaviour.

- **Abiding by professional code of ethics**: Knowledge of and practice of ethical principles within the health and counselling professions. Whenever confronted with ethical dilemmas, the counsellor consults with supervisors or colleagues while maintaining the confidentiality of the young client.

- **Self awareness and self-knowledge**: Develop a keen knowledge and awareness of self in terms of one's own limitations, biases, prejudices religious and cultural beliefs and internal conflicts.

- **Self-reflection and evaluation Skills**: Providers must be able to ask critical questions of themselves in order to improve their knowledge, skills, attitudes and effectiveness as an adolescent/youth centered counsellors.

What Adolescent/Youth Centered Counseling is NOT.

While counseling in adolescent health and development issues may include imparting of knowledge and information or engaging in some educational activities, it is different from education. Counselling addresses the effective dimensions (feelings and emotions) and practical concerns that often interfere with young people using and internalizing the facts and information available through education . The following section describes what adolescent/youth-centered Counseling is NOT.

- **Psychoanalysis: Adolescent and y**outh-centered counseling focuses on changing the young person's maladaptive or unhealthy behaviours or attitudes in order to help him make more informed healthy decisions and choices about his sexual and reproductive health. It does not interpret clients' past childhood histories or experiences, and dreams.
- **Advice-giving**: While adolescent and youth–centered counsellors can help develop or provide suggestions or alternative options for discussion with their young clients, they do not give

advice or direct clients to one alternative. Rather, youth centered counseling aims to help young people analyse their own situation and solve their own problems.

- **Treatment for severe mental illness**: When adolescent and youth-centered counsellors believe they are dealing with a young person who might need more specialized care, they can make the appropriate referrals. Adolescent and youth-centered counselling focuses specifically on normal development issues related to health and not psychological or psychiatric treatments for mental illness or disorders.

- **Dealing with deep seated or clinical problems/conflicts**: Adolescent and youth-centered counselling is distinct from provision of clinical interventions or dealing with issues needing other specialist interventions. For example, counselling on adolescent sexual issues is not the same as sex or sexological therapy where clinicians deal with such problems as compulsive sexual behaviours, erectile problems or inability to achieve orgasms.

SUMMARY

Youth-centered counseling is conceptualised as an encounter in which a provider acts as a facilitator and helps the young person to solve a problem in an understanding and nurturing atmosphere that supports self disclosure. Counsellors have an important role to play in encouraging and supporting youths through simple but important techniques such as empathetic listening and facilitating self-disclosure while they reflect on and change their thoughts and behavior. Among others the skills needed by a youth-centered counsellor include communication skills, interviewing skills, and assessment skills.

EVALUATION

- What is youth-centered counselling?
- Discuss five basic principles of youth-centered counselling.
- List five competencies of a youth-centered counsellor.

MODULE TEN: SESSION 2
ADOLESCENT AND YOUTH CENTERED COUNSELLING PROCESS

TIME: 1 Hour 30 Minutes

LEARNER'S OBJECTIVES

At the end of this session, participants will be able to:

- Discuss the characteristics and associated strategies of an adolescent and youth-centered
- Discuss the concept of motivational interviewing and its role in adolescent and youth-centered counselling
- Explain the steps involved in adolescent and youth-centered counseling process.

METHODS

- Discussion
- Presentation
- Lectures

MATERIALS

- Flipchart stand/papers
- Markers
- Overhead Projector
- Screen

CONTENT

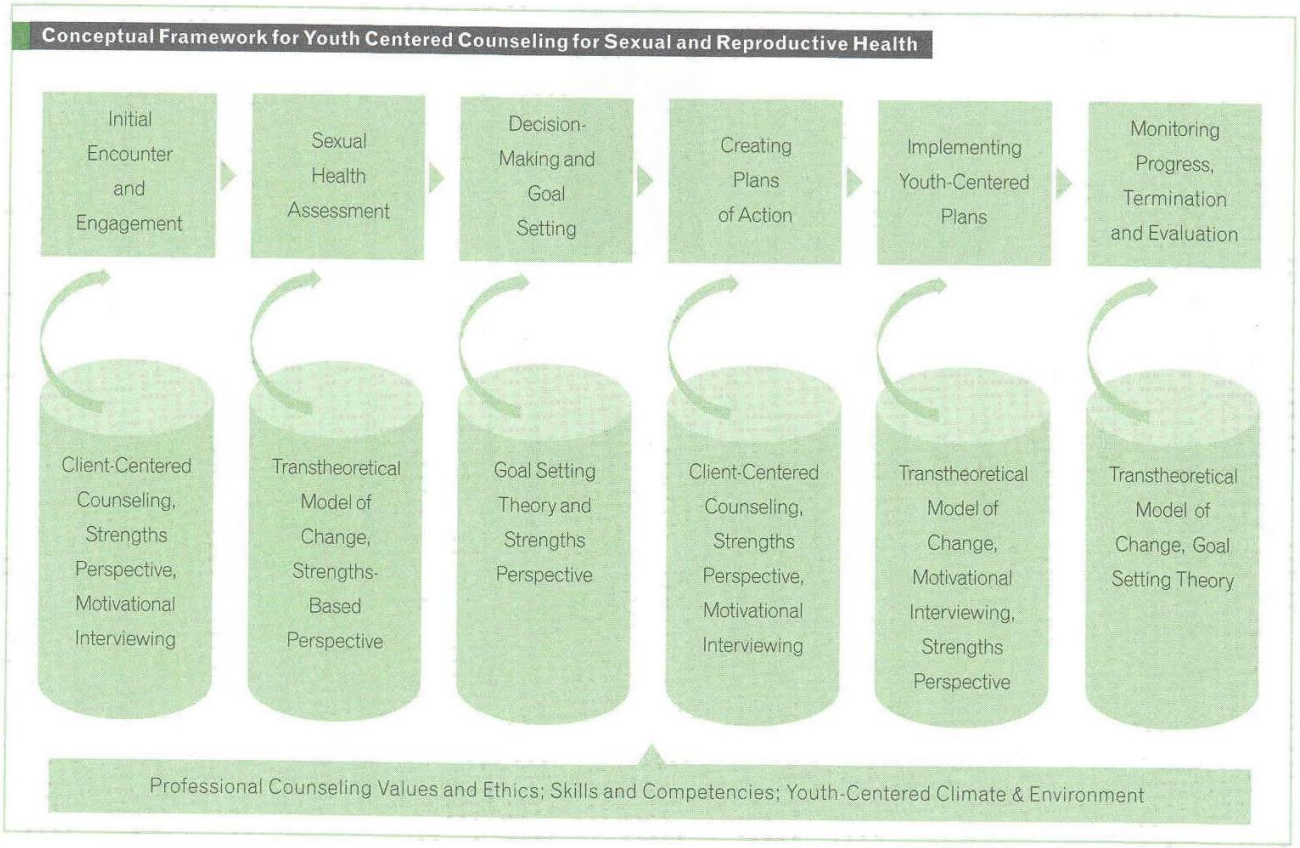
INTRODUCTION

Youth-centered counseling is conceptualised as a possibility-focused process consisting of a six step model that include:

- Initial encounter and engagement,
- Assessment or exploration of the health situation or problem,
- Decision-making and setting age appropriate goals,
- Creating plans of action,
- Implementing plans, and
- Monitoring progress and evaluation.

These six steps are supported by several counseling theories, models and conceptual frameworks. Among others, a conceptual framework based on the Transtheoretical Model of Change, Goal Setting Theory, Client-Centered Counseling, Motivational Interviewing and Strength-based approach can help counsellor engage in counseling that responds to the needs and wants of youth (PAHO, 2005). It is sensitive to the stage of development that a young person youth is in and provides a safe and non-judgmental atmosphere for the discussion of sensitive issues. The following diagram illustrates the six counselling phase of the Youth-Centered Counseling, drawing from the example of sexual and reproductive health (PAHO, 2005). Each counseling phase is underpinned by one or more of the theoretical approaches.

Figure 10.1 : Conceptual Framework for Youth-Centered Counseling



STEP 1: INITIAL ENCOUNTER AND ENGAGEMENT

Clients Centered Counseling

Client centered counseling is a process that allows an individual to express his/her problems and resolve difficulties with a minimum of direction being provided by the counselor. This approach reduces resistance from clients by allowing them to control the content and pace of counselling. Furthermore, it provides a space in which the client can "just be" without expectations of being judged, corrected, interpreted and directed. To be successful in client-centred counselling, providers need to exhibit certain characteristics. These characteristics and the associated strategies to achieve them are discussed below.

Characteristics of a Client-Centered Counsellor

- **Genuineness, Realness or Congruence**
  The counselor does not present any professional or personal façade in an attempt to increase the likelihood that the young client will cooperate and respond. This means the counsellor must be themselves .

- **Empathic understanding**
  This requires that the counsellor put himself/herself in the young client's situation, acquire as great an understanding of the young person as possible and be sensitive to how the youth feels about the situation confronting him/her.

- **Ability to learn from the young client**
  This implies that the youth is an expert when it comes to himself; the counsellor has competences only in maintaining the attitudinal conditions in the relationship with the young client so that the clients can express freely without fear of judgment.

- **Unconditional positive regards for the youth**
  The counselor is positive, non-judgemental, and accepting the youth as a person, even when the counsellor does not approve of the young client's behavior.

strategies For Client-Centered Counselling

- **Be genuinely interested in your client**
  Counsellors begin the counselling relationship with the aim to understand who the young person is as a "whole" human being and what is bringing him/her to counseling. The counsellors develop rapport and build trust by being caring, open, transparent, real and friendly.

- **Be aware of your non verbal communication**
  Non verbal communication is a powerful form of communication. Non-verbal communication gives clues to how a person is feeling, mood she is in or level of affection (How is the young

person sitting? What is the young person looking /staring at? What is his body language saying to you?).

- **Clarify your role as a counselor, the client's role and set boundaries for the counselling relationship.**
  One way to introduce young person to the counselling process is to briefly explain the counsellor's role and the professional boundaries of the counselling relationship. Boundary clarification and distinction includes being aware of your thought feelings, values and actions. To begin the process of setting clear client-counsellor relationships, counselors can share very succinctly what they do, the range of clients they work with and the types of issues they attend to. In this way, the young person does not feel as if he is the only one ever to receive counselling.

- **Tone of voice**
  Tone of voice is the quality of a person's voice. A counsellor's voice communicates a lot of the information that is not readily apparent. It i is not only what counsellors are saying or the language they use that young people listen to but also the manner in which they say it.

- **Engaging questions**
  There are several ways counsellors can relate to youth about issues of interest. The counsellor can initiate the discussion on health and well-being by asking some general non-threatening questions inquiring about the young person's needs, interest, wants, likes, and dislikes and paying particular attention to their age and gender. They should provide the opportunity for developing a trusting relationship between the youth and the counselor.

  Examples of engaging questions include:

  "I am interested in getting to know you. Do you think you could share with me…?"
  "What do you most enjoy doing?"
  "What are you interested in?"
  "How do you pass your free time?"
  "What do you do when you have time to hang out?"
  "What annoys you the most?"
  "Tell me about the friends you hang out with?"

  If the young person starts talking, follow his leads, inquiring and clarifying what he knows. If not give him choices through such questions such as:

  "Do you want to talk about being attracted to somebody?"
  "Do you want to talk about the changes in your body?"

  Providing options for them to choose what they would like to discuss in the beginning of the session gives them some sense of control over the interaction of the counselling process and young people enjoy feeling a sense of control, especially when they have been referred to counselling by someone else who may be in authority.

- **Motivational Interviewing**

Motivational interviewing provides a framework that can help youth–centered counsellors facilitate the process of change. It has been defined as a "directive, client-centered counselling style for eliciting behavior change by helping clients to explore and resolve ambivalence" (Rollnick & Miller, 1995).

Motivational interviewing comprises two equally important phases:

- Phase I: *building the therapeutic rapport and commitment with the youth,* and
- Phase II: *facilitating the process of change through decision making skills and analysis and behavior change.*

Another technique used in motivational interviewing is called "developing discrepancies," where counsellors facilitate client's awareness of the consequences of their behavior and identifying incongruence using a non- judgmental tone. For example, applying this to HIV related counselling, a counsellor might say*, "You say you want to be happy, but you are engaging in unprotected sex and this makes you feel very unhappy… help me to understand that…"*

Collaboration between the counselor and the client is a central part of motivational interviewing; providing the clients with a sense of control and respect in the counseling process, such as developing mutually negotiated options and solutions instead of imposing interpretations, advice or treatment plans. It is important to help young clients see that they are in control of their lives.

Rather than just a set of techniques or activities that counsellors use with or do to clients, it is important to understand that *motivational interviewing is a way of being with people.* The following key points have been put forward as reflecting the spirit of motivational interviewing (Rollnick & Miller, 1995).

1. Motivation to change is elicited from the client, and not imposed from without. Emphasis on coercion, persuasion, constructive confrontation and the use of external contingencies go against the spirit of motivational interviewing.

2. It is the client's task, not the counsellor's, to articulate and resolve his or her ambivalence. They describe ambivalence as a conflict between two courses of action. The counsellor's task is to facilitate expression of both sides of the ambivalence impasse, and guide the client toward an acceptable resolution that leads to behaviour change.

3. Direct persuasion is not an effective method for resolving ambivalence. While tempting to be helpful by offering persuasive arguments for change, counsellors usually create resistance to change in their clients.

4. The counselling style is generally a quiet and eliciting one. To a counsellor accustomed to confronting and giving advice, motivational interviewing can appear to be a hopelessly slow and passive process.

5. The counsellor is directive in helping the client to examine and resolve ambivalence. The operational assumption in motivational interviewing is that ambivalence or lack of resolve is the principal obstacle to be overcome in triggering change. Once that has been accomplished, there may or may not be a

need for further intervention, such as skill training.

6. Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction. Resistance and 'denial' are seen not as client traits, but as feedback regarding therapist behaviour. Client resistance is often a signal that the counsellor is assuming greater readiness to change than is the case.

7. The therapeutic relationship is more like a partnership or companionship than expert/recipient roles. The counsellor respects the client's right to make choices about behaviour and consequences of the chosen behaviour.

STEP 2: COUNSELLING ASSESSMENT

After establishing a warm and comfortable atmosphere where the youth feels safe and secure to talk about his health and other behavioural issues, the counsellor begins to assess the client's health situation. Assessment provides information at each step of the counseling process and is integral to providing relevant and meaningful interventions to young people.

Each young person must be approached on an individual basis in the counseling assessment process. The age or the developmental stage of the young person, gender, sexual orientation, culture and values of the clients are important characteristics that should be considered in the counselling assessment process.

STEP 3: SETTING AGE-APPROPRIATE GOALS

Facilitating personal goals is an important element of adolescent identity development; it entails helping young clients to picture , model and evaluate themselves in the future instead of responding only to the needs of the moments. Goal setting leads to better performance because people with goals exert themselves more, persevere in their tasks, concentrate more and if necessary, develop strategies for carrying out their intended behavior.

It is important to note, however, that setting a goal does not automatically instill motivation and may even be counterproductive, particularly if the goals conflict with other goals. Breaking a goal into a series of tasks or sub-goals can help to prevent hesitation or postponement of goal related activities.

To set goals, the following recommendations are useful:

- Conduct a careful and thoughtful analysis of the situation.
- Determine the young person's commitment to addressing the situation.
- Explore the young person's ambivalence or resistance and feelings about the goals.
- Analyse the tasks required to address the situation and corresponding feelings and thoughts about what needs to be done.
- Develop specific sub goals or smaller goals for larger goals.
- Explore with the young person his/her underlying reasons (hidden meanings ascribed) for engaging in particular behaviour or health-related practices, and.
- Determie the young individual's self-efficacy for performing the behavior. Self-efficacy is the belief that one can change a behavior or achieve a goal.

STEP 4: CREATING PLANS OF ACTION

It is more effective to collaborate with the young person rather than prescribing an intervention in the planning for behavioural change. By involving the young person in creating a plan of action, the adolescent/youth-centered counsellor is able to personalise the intervention to increase its relevance. Adolescent and youth-centered counsellors can help their clients achieve their health goals by brainstorming on activities and practical strategies that can help them take "small steps" towards change. Small and realistic steps that are easy to achieve create opportunities for small successes for the young client.

Counsellors need to be aware that changing behaviour is not an event, but a process a. The Transtheoretical Model of Change is a well-known theory that is useful to understanding change in human behaviour.

Transtheoretical Model (TTM) of Change

There are two main constructs in TTM:

- Stages of Change
- Processes of Change

The transition from one stage to the next is mediated by the use of the processes of change, defined as strategies individuals use to modify problem behaviors.

- **Stages of Change**

The stages of change consist of five stages along a continuum that depicts a person's motivation and interest in altering a current behavior viz:

- **Precontemplation**: The stage in which the young person does not recognize that there is a problem or is unwilling to change a problematic behavior.
- **Contemplation**: The stage in which the young person is considering changing her behavior and often is in a decision making process and dealing with ambivalence and resistance.
- **Preparation:** The stage in which the young person has determined that the adverse consequences of maintaining her current problematic behavior outweigh the benefits.
- **Action Stage**: The stage when individual activity changes or the individual modifies his/her behaviour.
- **Maintenance Stage**: This stage applies about 6 months after the new behaviour has been implemented and consists of lifestyle modification so that the new behaviours are stabilised.

The Stages of Change Model has been applied to a variety of individual behaviors; while, in general, all individuals go through the same stages of change, the manner in which they pass through these stages may vary depending on the type of behavior change. The Model is circular, not linear as people do not systematically progress from one stage to the next, ultimately "graduating" from the behavior change process. Instead, they may enter the change process at any stage, relapse to an earlier stage, and begin the process once more. They may cycle through this process repeatedly, and the process can truncate at any point.

Process of Change

Ten processes of change have been identified as being responsible for the movement from one stage of change to another. These processes are broadly classified into two:

- **Cognitive and Experimental processes:**
  - **Consciousness raising** which consists of encouraging young clients to increase their level of awareness, seek information or gain an understanding about their problem.
  - **Dramatic relief** is the experiencing and expressing of feelings and emotions about one's problems.
  - **Environmental evaluation** consists of examining how one's problems affect the physical environment especially other people.
  - **Social liberation** consists of increasing alternatives and listing options for problematic behavior such as recognizing that safer sex methods are "cool" and they contribute to sexual well-being and overall wellness.
  - **Self-reevaluation** consists of assessing how one feels and thinks about herself in relationship to a problem.
- **Behaviour Processes:**
  - **Counter-conditioning** entails substituting alternative behaviours for problematic behaviours (for example exercising to relieve anxiety, a teenager deciding to engage in non-sexual romantic behaviour rather than having penetrative sexual intercourse).
  - **Helping relationships** are defined as those relationships that provide unconditional positive regard, acceptance and support for the client.
  - **Reinforcement management -** the use of positive reinforcements and appropriate goal setting.
  - **Stimulus control** refers to restructuring the environment so that the stimuli or triggers for the undesired behaviour are controlled.
  - **Self liberation –** defined as making a firm commitment to change and therefore deciding to abstain from a specific behaviour can be a meaningful and self liberating decision**.**

STEP 5: IMPLEMENTING ADOLESCENT AND YOUTH-CENTERED PLANS

After the intervention has been selected, the next stage is implementation. This stage may occur in several ways: (a) immediately following the design of the intervention, within the same session; (b) as a homework assignment for the young client to implement between sessions; (c) as a step-by-step implementation, in which a segment of the intervention is worked on, followed by additional steps after successful completion of the first; and (d) a combination of all three.

In working with younger clients, , because their sense of time is so immediate, it may be necessary to identify one aspect of a problem, design an intervention and move directly to implementation in a short period of time.

STEP 6: MONTORING PROGRESS AND EVALUATING CHANGE

The main question to ask during an evaluation stage is "how do we know if the intervention worked?" Ongoing evaluation and gradual termination are recommended when the counsellor sees little or no improvement or when goals have been achieved. When appropriate, involving significant others (such as parents and partners) in the evaluation process can provide key insight into whether things are improving outside of the counselling room (and with client's permission). A short evaluation session could provide critical information of what has worked and what issues need to be addressed. Based on the evaluation, it may be necessary to return to the planning stage and design and implement new strategies to address various aspects of the problem.

SUMMARY

Adolescents and youth-centered counselling process is an evidence-based approach, which can be viewed in the context of a conceptual frameworks, with grounding in well-known counseling theories and models such as Transtheoretical Model of Change, Goal Setting Theory, and Motivational Interviewing. The process entails six steps: initial encounter and engagement; assessment or exploration of the health situation or problem; decision-making and setting age appropriate goals; creating plans of action; implementing plans; and, monitoring progress and evaluation. The process can help counsellor engage in counseling that responds to the needs and wants of young people. It is sensitive to the stage of development of the young person and provides a safe and non-judgmental atmosphere for the discussion of sensitive issues. Adolescent and youth-centered counsellors should see themselves as partners with the young client in addressing his/her individual problems rather than offering them readymade solutions.

EVALUATION

- List some strategies that are important for the counsellor to be effective in adolescent and youth-centered counselling practice.
- Explain the six steps involved in adolescent and youth-centred counselling process.
- Explain the role of motivational interviewing in adolescent and youth-centered counselling.

MODULE TEN: SESSION 3
COUNSELLING ADOLESCENTS WITH STIs, INCLUDING HIV AND AIDS

TIME: 2 Hours

LEARNERS' OBJECTIVES

At the end of this session, participants will be able to:

- Explain important issues in STIs/HIV/AIDS counselling.
- Discuss common types of counselling.
- Discuss pre- test counselling.
- Discuss post- test counselling.
- Discuss the steps involved in preventive counselling.

SESSION OVERVIEW

- Important issues in HIV/AIDS counselling
- Discuss the common types of counselling

METHODS

- Brainstorming
- Presentation
- Role Play

MATERIALS

- Flipcharts
- Chalkboard
- Markers

CONTENT

IMPORTANT ISSUES IN ADOLESCENT HIV/AIDS COUNSELLING

HIV/AIDS is given special focus in counselling because it places enormous stress on infected individuals and their families who are often faced with stigmatization, demands of caring for the seriously ill and with the trauma of death. They also face the economic burdens of health care, financial costs and loss of income especially when breadwinners become ill. There is a lot of stigmatization associated with HIV/AIDS. People can be victims of stigmatization at home, in their workplaces, and the community. Often, the death of an adult can have a dramatic impact on family structure and function. Children, the elderly or single parents may be left to run households with serious implications for those concerned.

Adolescents rarely perceive themselves as being at the risk of HIV infection, despite the fact that statistics show that they often engage in high-risk activities. For many young people, especially those in early adolescence, a disease with a long latency period neither appears personally threatening nor provides much motivation for behaviour change.

HIV counselling and testing are an important vehicle for providing risk reduction education and counselling to youths. The HIV counselling and testing process should include risk reduction education. However, it should not be used as a primary vehicle for providing such information or as a substitute for on-going outreach, education and risk reduction skills building for adolescents.

BACKGROUND INFORMATION ON HIV TESTING

Testing for HIV infection presents serious medical, legal, ethical and psychological implications in the health care setting. Health care workers attach significance to the outcome of an HIV test, especially a positive diagnosis because of its life threatening condition. HIV testing is the 100% effective way for people to know if they are infected with the HIV virus. The underlying principle of HIV testing is the detection of antibodies produced against the Human Immunodeficiency virus in the blood.

Antibodies are chemicals produced by the body that fight diseases in the body. HIV test does not test AIDS. Only a trained medical person can make a diagnosis of AIDS. It is important that counsellors have the basic knowledge about HIV testing and its results as young people may consult them.

- **Window Period**

This is the time between when the person is just infected with HIV and the development of antibodies in the person's body. During this period, the HIV test may be falsely negative because the antibodies cannot be detected in the blood.

- **HIV positive result**

This means that the person has become infected with HIV and can infect. All positive results are confirmed with another test (confirmatory test). It is unlikely that a positive result from a certified centre will be false.

- **HIV negative result**

A negative result can mean two things: -

- The person has not been infected with the HIV virus; or
- The person has been infected in the last three to six months and the body has not developed antibodies. If this is the case, the person needs to be retested again in another three months. However, they should be counseled on reducing their risks and risks of others to HIV infection.

An indeterminate result means that it was not possible to tell if the person has been infected based on the test results. The results are found to be inconclusive. This does not happen often but can occur in people with certain health diseases/conditions e.g. multiple pregnancies or miscarriages, multiple blood transfusions, recent organ transplant, autoimmune diseases (when the body immune system begins to fight itself) people on dialysis treatment, liver disorders and some types of cancer. Where such people engage in HIV risk behaviour, they should be retested after 3 months.

HIV/AIDS COUNSELLING

Providing HIV/AIDS counseling requires specialized training. Considering that the HIV/AIDS epidemic has reached alarming proportions nationwide, it requires a concerted effort by all to stem the rise of the infection. The role of the counselor is to understand the underlying principles of HIV/AIDS counselling and be able to offer assistance to young people when necessary. However, it is important that counsellors realize their limitations and know when to refer young people that require special attention.

- **Types of HIV counselling**
  - Risk reduction counselling
  - Pre Test counselling
  - Post Test counselling

- **Risk reduction/Preventive counselling**

This is generally aimed at prevention of infection. This can be primary or secondary prevention. Primary preventive counselling is targeted at non-infected individuals in order to encourage them to continue risk avoidance behaviour. Secondary prevention is often referred to as risk reduction counselling. Generally prevention counselling involves the counsellor giving full and accurate information on HIV/AIDS, mode of transmission, stages of infection and its implications and means of prevention.

- **Pre- Test counselling**

Pre test counselling provides information to enable an individual make an informed decision to go for the HIV test. It helps prepare a client for the HIV test. It provides background information on the test itself, implications of different test results and explores ways of coping with one's HIV status whether positive or negative. It also explores issues of sexuality, risk behaviours, safer sex practices and STIs/HIV. It further provides an opportunity to explore potential support from family and friends whilst ensuring the confidentiality of the test. During pre-test counselling, the counsellor needs to also explain the types of services, and care available to HIV positive people to help them live longer.

The counsellor should use the following in assessing the client:

- Client's reason for requesting screening;
- Exploration of client's knowledge about HIV/AIDS;
- Assessment of risk behaviour;
- History of past and present high risk behaviour such as drug injection, prostitution, homosexuality, bisexuality and multiple sexual partners;
- History of blood transfusion;
- Skin cutting and piercing procedures such as tattooing, circumcision and scarification; and
- Client's medical history with respect to sexually transmitted infections.

It is important not to rush through pre test counselling. Therefore, the client must be psychologically ready before taking the test.

Pre -Test Discussion

The following should be covered in the pre- test discussion:

- Establish a rapport with the clientt : who you are, purpose, and time.
- Why are they considering the test?: voluntary, "sent".
- Identify the risk activities: check knowledge about HIV transmission, STIs, drugs and alcohol use and sexual activities.
- The test: what it is and is not, window period.
- Personal implications: positive or negative result.
- Practical implications: work, relationships, medical.
- Risk reduction: What actions the client needs to take and how it will be done ?
- The procedure: how, when, where and results.
- Informed consent: Provide all the information above and support the client to make informed decision about testing.

- **Post-Test Counselling**

It is important that post test counselling is available to all clients irrespective of their HIV test results.

Reasons for Post- Test Counselling for HIV Positive Clients

Counselling after test is important for the following reasons:

- To convince the client about the reality and seriousness of the situation. It is often difficult for people to accept and believe that they are HIV positive based on the results of a blood test, especially if they are feeling healthy and strong.
- To ensure that the client understands the meaning of the test result.
- To help the client cope with the result, especially in the days and weeks to follow.
- To make a plan for ongoing medical care.
- To provide information about the dangers of spreading HIV and how to prevent spreading it to others (e.g. through proper condom use).
- To understand the need for careful consideration about having children.
- To help the client develop a plan for informing family members and friends.
- To refer the client to other psychological and support services. Many HIV positive people suffer from depression, anger and guilt – some people have even committed suicide after learning that their HIV test was positive.

Post-test counselling for HIV negative clients

For those who have negative results, it is necessary for the counsellor to reaffirm information on modes of transmission of infection and emphasize the need to avoid high-risk behaviour and how to ensure this. The counsellor should also explain to the client the issue of 'window period' and encourage the client to repeat the test in the nearest future, (3-6 months time).

Indeterminate

Counselling after test is important for the following reasons:

- To explain the need for re-testing and the reasons that the result could have been indeterminate.
- To help the client develop a plan for protecting him/herself from HIV.

- **Breaking the positive test result:** This is easier to do if pre-test counselling was done. This involves breaking the positive test result to the client. It is usually a very difficult task for the counsellor but in breaking the positive screening result to the client the counsellor must be prepared to expect some or all of the following reactions from the client.

- ***Shock***

  Confusion and bewilderment are typical. Some react courageously while others lose emotional control.

- ***Denial***

  The client may deny the situation. S/he feels the result of the test is not true or a mistake. S/he feels it cannot be happening to her/him and may exclaim aloud, 'it cannot be happening to me'.

- ***Anger***:

  The third reaction may be anger. Anger may be directed at close associates. The counsellor deals with this by helping the close associates and client to understand that anger is one way of trying to cope with the situation. The counsellor helps clients to redirect anger over the illness and motivates them to respond constructively to the challenges that the illness presents.

- ***Depression and fear of illness or death***

  Some dramatic incidents are to be expected, as natural reactions to a frightening and life-threatening illness like AIDS. Relative cheerfulness can give way to continued hopelessness, sadness, fatigue, apathy, bouts of depression, changes in sleeping patterns or eating habits, feeling of self blame, guilt and helplessness. There may be a need to refer a client with prolonged depression for psychological support.

- ***Acceptance and coming to term with the situation***

  With proper pre and post test counselling and support from other care givers, most HIV positive clients will eventually accept the situation. During this stage they are able to return gradually back to their normal life, seek health care and adhere to treatment regimen. It is always beneficial to link the client to a support group.

Counsellors must come to terms with their own fears and feelings about the life-threatening situation and learn to deal unemotionally with the subject.

SUMMARY

It is very important that pretest and post test counselling are carried out on all clients wanting to do HIV test. Breaking the news of the positive test result should be done carefully and the counsellor must be able to deal with the issue unemotionally.

EVALUATION

- Name the types of counselling in HIV/AIDS.
- Explain three possible types of reactions of clients to HIV positive screening report.

MODULE TEN: SESSION 4
COUNSELLING PREGNANT ADOLESCENT

TIME: 1 Hour 30 Minutes

LEARNER'S OBJECTIVES

At the end of this session, participants will be able to:

- Highlight options available to pregnant adolescents.
- Discuss the needs of pregnant adolescents.
- Discuss consequences of abortion.
- Explain post abortion care.
- Explain parental consent in abortion.

SESSION OVERVIEW

- Needs of pregnant adolescents
- Consequences of abortion
- Post abortion care
- Parental consent in abortion

METHODS

- Brainstorming
- Presentation
- Role Play

MATERIALS

- Flip charts stand/papers
- Chalk board/chalk
- Markers

CONTENT

The counsellor needs to give adequate information to the adolescent on the physical, social and emotional effects of pregnancy and abortion.

CHALLENGES OF ADOLESCENT PREGNANCY

The health challenges include**:**

- Malnutrition/Anaemia
- Greater severity of malaria fever
- Hypertensive diseases of pregnancy
- Premature labour and delivery
- Dangers of prolonged labour

The counsellor should emphasize the need for Focused Antenatal Care to forestall most of the above mentioned challenges. The counsellor should also provide specific information on nutritional needs and support during pregnancy.

- The emotional and psychological challenges for unmarried adolescent include:

- Guilt, regret, shame, disappointment and self-hatred
- Fear and embarrassment
- Reduction of self-esteem
- Feelings of insecurity

The counsellor should encourage the pregnant adolescent and help in lifting up her morale. S/he should use known examples to allay her fears of the immediate and the future consequences.

- The socio-economic challenges include:

- Expulsion from school
- Future low economic status where she lacks opportunities for further training
- Dependence on parents/guardians for self and baby
- Rejection by parents and relatives

The counsellor should educate the adolescent on options available to her that would ensure her child receives proper care. Where she lacks the support necessary for her to adequately meet the demands of motherhood, option of adoption and foster care should be discussed. The counsellor should make the necessary referrals where this is needed.

CONSEQUENCES OF ABORTION

By Nigerian law, pregnancy can only be terminated when the life of the woman is at risk. Abortion carries a number of risks especially when done by non-specialists. These risks include:

- Medical complications – bleeding, perforation of the uterus or infection,
- Anxiety over possible inability to get pregnant in future,
- Guilt,
- Ridicule by others,
- Depression,
- Complete loss of uterus, and
- Child born dead

POST ABORTION CARE

Counselling is one of the three components of post abortion care. The others are emergency health care services (treatment of complications), and referral services given to a woman or an adolescent after either an induced or spontaneous abortion. Many adolescents suffer short or long term illnesses as a result of unsafe abortion or abortion complications. Hence, the need for post abortion care (See Module 2 session 2).

- **Counselling:** This is to help clarify feelings and thinking. The counsellor can help the adolescent to get over the feeling of shame and guilt. During counselling, education is given to the adolescents to help minimize the emotional and physical effects of abortion. The counselling session is also an opportunity to discuss pregnancy prevention with adolescents.

- **Contraceptives**: The counsellor will use this opportunity to provide information and counselling on family planning options available to forestall future occurrences. The counsellor can encourage the client to commence a method. Since they are young people, the following contraceptive methods can be used: condoms, foaming tablets and oral pills including emergency contraceptive pills and abstinence.

- **Referral Services:** Referral is for family planning and treatment of complications from abortion. In the case of induced abortion, the client can have an incomplete abortion, which will result in infection, bleeding and physical trauma. The adolescent will need medical referral for emergency treatment for these complications. The counsellor should refer such cases to appropriate places or health institutions.

SUMMARY

The facilitator should collate discussion after the role plays and end by summarising the major counselling tips for counselling pregnant adolescents and those that had abortion.

EVALUATION

- Describe the major steps involved in counselling pregnant adolescents.
- What are the consequences of abortion?
- Describe the nature of post abortion care.

MODULE TEN: SESSION 5
COUNSELLING ADOLESCENT VICTIMS OF SEXUAL VIOLENCE (RAPE AND ABUSE)

TIME: 1 Hour 30 Minutes

LEARNER'S OBJECTIVES

At the end of this session, participants will be able to:

- Discuss the effects of sexual violence.
- List steps to take in assisting adolescents to deal with sexual violence.
- List possible referral options.

SESSION OVERVIEW

- Effects of sexual violence
- Steps in assisting the adolescents to deal with sexual violence
- Referral options

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METHODS

- Brainstorming
- Presentation
- Role Play
- Case study

MATERIALS

- Flipcharts stand/papers
- Markers
- Chalkboard/chalk
- Scenarios for role-play

CONTENT

EFFECTS OF SEXUAL VIOLENCE AND ABUSE ON VICTIMS

Victims of sexual assault suffer in many ways. Their experiences are always traumatic. The victims suffer physically, emotionally and psychologically. Physically, the victims may have their vagina and pelvic tissues damaged. Besides the physical damage, which they experience, they also go through tremendous emotional stress. The emotional effect is reflected in their reactions to the situation, which in some cases may last for just a few hours to days, weeks or longer. In some cases, they may have intermittent re-occurrence of the reactions.

The reactions to sexual assault include the following:

- Emotional shock, disbelief and despair;
- Withdrawal and isolation;
- Self blame and feelings of guilt;
- Fear, terror and feeling unsafe;
- Anger and rage, anger turned inward;
- Grief and feelings of loss;
- Loss of control and feelings of powerlessness;
- Flashbacks and nightmares;
- Triggers, which involve seasons, smells and circumstances that are similar to those that occurred during the violent experience and these bring up feelings related to the violent experience;
- Changes in sexuality and intimacy (This may be in terms of developing aversion to sex and intimacy or going to the whole length for promiscuous sexual experiences.);
- Spiritual crisis (This may be in terms of feeling angry at God or losing faith in God completely; This may even create a crisis of self at a personal level.)
- Somatic complaints and sleeping problems;
- Depression, destructive behaviour and other behavioural disorders; and
- Feelings of betrayal if the rapist is known to the victim.

STEPS IN ASSISTING THE ADOLESCENT TO DEAL WITH SEXUAL VIOLENCE

During process of counseling, it is very important that the counsellor ensures that s/he:

- Validates and believes the victim by reassuring him/her that the sexual assault was not his/her fault and that his/her feelings are normal.
- Helps to create a safe place for the victims.
- Allows the victim to express a full range of feelings.
- Offers options and not advice.
- Dispels myths about rape.
- Encourages the victim to believe in the possibility of healing.
- Facilitates the process of healing.
- Offers support, referral and follow up services.

REFER

The counsellor should refer the client for appropriate medical, legal and social support. In all cases, s/he should refer for:

- Treatment of physical injuries;
- Emergency contraception;
- STI diagnosis and treatment;
- Confirmation of assault through collection of sperm;
- Counsel and test for HIV (or refer for such services); and
- Post exposure prophylaxis for HIV.

Where desired, referral should be made to a legal practitioner for legal advice and support for prosecution. He/she can also be referred for social support to government welfare agencies and non-governmental organisations that address the problem of violence.

SUMMARY

The facilitator is to harmonize reactions to the role plays and then summarize the counselling tips for adolescent victims of sexual violence and abuse.

EVALUATION

- Explain the basic steps involved in counselling adolescent victims of sexual violence and abuse.
- Why is post trauma care necessary for such victims?

MODULE TEN: SESSION 6
COUNSELLING PHYSICALLY AND MENTALLY CHALLENGED ADOLESCENTS

TIME: 1 Hour 30 Minutes

LEARNERS' OBJECTIVES

At the end of this session, participants will be able to:

- Mention the challenges faced by the physically and mentally challenged adolescents.
- Highlight the skills needed to counsel the physically and the mentally challenged adolescents.
- Explain ways of increasing the self-esteem of the physically and mentally challenged adolescents.

SESSION OVERVIEW

- Challenges faced by the physically and mentally challenged adolescents
- Skills needed to counsel the physically and mentally challenged adolescents
- Increasing the self-esteem of the physically and mentally challenged adolescents.

METHODS

- Brainstorming
- Plenary
- Presentation
- Role Play

MATERIALS

- Flipchart stand/papers
- Markers
- Chalkboard/chalk
- Scenarios for role-plays

CONTENT

CHALLENGES FACED BY PHYSICALLY AND MENTALLY CHALLENGED ADOLESCENTS

The physically and mentally challenged adolescents are a disadvantaged group. This group is disadvantaged because of the way people perceive their disability. Due to this disability, many of them are limited in their day-to-day activities when compared to their able-bodied counterparts. The disability usually elicits discouraging reactions from the society in general. This challenged group lacks some developmental skills. Some of the problems they encounter include:

- They are not perceived as sexual beings.
- They are not socialized like their non disabled counterparts.
- They are not exposed to reproductive and sexual health information, education and services.
- Many families hide them away from public glare because they are ashamed of them and see them as liabilities.
- They lack life coping skills.
- They experience a deep feeling of rejection, shame and guilt due to the treatment they receive from others around them including their family.
- They have very low self esteem.
- They feel unloved and abandoned with no hope of companionship.
- They suffer sexual exploitation abuse and molestation.
- They are not mainstreamed in the planning and implementation of reproductive health and sexual interventions.

THE NEEDS OF PHYSICALLY AND MENTALLY CHALLENGED

The needs of the physically and mentally challenged stem from the problems enumerated above. In addition to the general needs of adolescents, physically and mentally challenged adolescents require these specific needs:

- to be loved and accepted;
- to recognize and respect their sexuality;
- to be provided with sexual and reproductive health information, education and services (Such sexual and reproductive health information, education and services must be presented to them at their own level of comprehension and understanding);
- to be linked to Vocational/Skill acquisition centers.

SKILLS NEEDED TO COUNSEL THE PHYSICALLY AND MENTALLY CHALLENGED ADOLESCENTS

In the process of counselling physically and mentally challenged adolescents, the following have to be taken into consideration:

- The counsellor must demonstrate a lot of patience, understanding and empathy.
- The counsellor must be ready to give them emotional support and encouragement that may neutralize some of the negative feelings they harbour.
- The counsellor may need to make referral if and when necessary.

INCREASING THE SELF-ESTEEM OF PHYSICALLY AND MENTALLY CHALLENGED ADOLESCENTS

Due to ignorance, the society's level of acceptance of people with disability is distorted. It is important for adolescents who have disabilities to know that they have the potential to contribute to the society. The counselor thus needs to reinforce this.

- The counsellor should explore and highlight the capabilities in the client.
- The counsellor should assure the clients that they are loved although the society is haunted by cultural norms which influence their expressing this love (especially the verbal expression of love towards them).
- The counsellor should explore the kind of care and support provided for the client (e. g. what happens when they are sick, who buy clothes for them etc.).
- The clients need to know that they have equal fundamental human rights as their able bodied counterparts.
- The client has the right to request for things they need such as information, services, food etc without feeling guilty or indebted.
- They have the right to be assertive and reject sexual advances they are not comfortable with and report same to a responsible adult around them.

SUMMARY

Summarize the participants' reactions to the role-plays. Also summarize skills for counselling the physically and mentally challenged.

EVALUATION

- Describe the needs of the physically and mentally challenged adolescents.
- List the skills for counselling the physically and mentally challenged adolescents.

MODULE TEN: SESSION 7
COUNSELLING ADOLESCENTS UNDER THE INFLUENCE OF DRUG USE

TIME: 1 Hour 30 Minutes

LEARNERS' OBJECTIVES

At the end of this session, participants will be able to:

- Describe the consequences of using drugs/substances on the adolescent abusing substance.
- Describe the methods to be used in dealing with physical and psychological dependence.
- Identify referral sites for management of drug abuse problems.

SESSION OVERVIEW

- Consequences of using drugs/substances on the adolescent
- Methods used in dealing with physical and psychological dependence
- Referrals in management of adolescents with drug abuse

METHODS

- Brainstorming
- Presentation
- Role Play

MATERIALS

- Flip charts stand/papers
- Markers
- Chalkboard/chalk
- Scenarios

CONTENT

CONSEQUENCES OF DRUG/SUBSTANCE USE ON THE ADOLESCENTS

Drug abuse may have the following effects on the adolescents' health and development:

- Behavioural problems manifesting as misconduct, loss of self-control, lack of self-discipline, social irresponsibility, lack of social trust, etc.
- Physical health problems arising from damage to important organs of the body such as chest infections, lung cancer, liver damage, poor state of nutrition; injuries arising from frequent accidents at home, school, workplace or in the traffic, and sexually transmitted infections and reproductive problems.
- Psychological and mental health problems such as: slowed reflexes, inability to think clearly and understand properly, memory and perceptual disturbances, severe forms of mental illness such as dementia, psychosis and morbid anxiety.
- Poor academic performance leading to school drop-out, falling into crime, single parenthood, prostitution, imprisonment etc.

METHODS USED IN DEALING WITH PHYSICAL AND PSYCHOLOGICAL DEPENDENCE

- Assessment of the affected persons:
  - History of the illness from a key informant and or the patient: The involvement of a family member is essential.
  - Mental and physical examination of the patient.
  - Evidence of injuries, impairment of body systems e.g. cardiovascular system.
  - Evidence of impaired mental functioning e.g. psychotic behaviour.
  - Screening tests e.g. Urine test kits for drugs.
  - Counselling of patient in the early phase of the disorder can be done at the Primary Health Care (PHC) level. Wounds can also be treated at the PHC level.

RECURRENT/PROLONGED DRUG ABUSE AND REFERRAL

- Referral to a secondary or tertiary health care facility.
- At the treatment centre, the following treatment procedure will be followed:
  - Admission;
  - Detoxification and treatment of co-morbid physical illness;
  - Commencement of psychological methods of treatment e.g. group psychotherapy, brief dynamic psychotherapy, family psychotherapy etc.;
  - Involvement in self-help groups like church societies, Muslim societies, Alcoholic anonymous, Narcotic anonymous.
  - Psychosocial Rehabilitation: This will involve:
    - Post discharge follow-up,
    - Vocational rehabilitation to ensure independent living,and
    - Provision of suitable accommodation.

  It is essential to note that a drug abuser needs support from the family, the community and therapist.

- After the initial phase of detoxification and taking care of any existing physical problems, the

counsellor should encourage the adolescent to enlist into a drug treatment programme where psychological forms of treatment may be used to assist him or her to get out of the habit of taking drugs. Counsellors manage such programmes and peers are used to reinforce new behaviour.

- The addict will also be assisted to develop skills that may equip him for independent economic existence when he goes back to society. This process is called rehabilitation. Rehabilitation programmes are of different types and can be set in different locations or for specific groups, such as adolescents.
- On discharge back to society, some drug addicts may be advised to attach themselves to self-help groups for further reinforcement of their determination to stay free of drugs. Self-help groups are made up of people who have similar problems in the past and have decided to come together to help and reinforce themselves so that they can continue to stay away from drugs. The most common of these groups is the AA or Alcoholic Anonymous. The group has established a set of regulations to guide their conduct, which they follow faithfully. These guidelines or rules are called the 12 steps and 12 traditions of the AA.
- Apart from these, the drug abuser needs constant support from the family, the community and his or her primary therapist. He needs to be counselled regularly to assist him have factual information to make the right life choices.

SUMMARY

Summarize the participant's reactions to the role-plays. Also summarise the counselling tips for adolescents under the influence of substance use and abuse.

EVALUATION

- Describe how to identify adolescents who may be abusing drugs.
- Explain how a counsellor should handle such adolescents.

MODULE TEN: SESSION 8
COUNSELLING PRACTICES USING SELECTED CASE STUDIES ON ADOLESCENT HEALTH ISSUES

TIME: 2 Hours

THE LEARNERS' OBJECTIVE

By the end of the session, participants will be able to:

- Improve their counselling skills after participating in the practice counselling scenarios.

SESSION OVERVIEW

- Practice of counselling sessions

METHODS

- Role-play
- Discussion
- Demonstration
- Films on counselling

MATERIALS

- Flip charts stand/paper
- Markers
- Overhead projector /screen/transparencies
- VCR/TV/video cassette e.g. Gather PPFN

UNSAFE ABORTION IN ADOLESCENTS

Scenario 1

A 14 year old girl, dressed in her school uniform, comes to see the duty medical officer in the casualty department of a General Hospital during school hours.

She explains to the doctor that she thinks she is pregnant and wants a termination. She doesn't want to talk about who the father might be, even on probing.

She is the first born in a family with six children. She attends a local Catholic Secondary School and lives with an uncle who is her local guardian and is paying for her upkeep. Her parents are poor farmers living in a rural area.

The nurse on duty with the medical officer is a staunch born-again Christian who believes that abortion is murder and will not entertain any discussion of abortion in the clinic.

The girl believes that her future, education and her relationship with her family will be damaged by carrying through this pregnancy. She says that she depends on the support of the medical officer to find a solution.

Roles: Doctor, Nurse, 14 year old girl.

Scenario 2

A young woman (18 years) had died in a hospital from septic incomplete abortion, and was in the care of a certain middle aged male doctor.

Two months before her death, the woman had come to the hospital seeking an abortion. She had met with this doctor who had told her that he could perform the procedure in his private clinic, on payment of a stiff fee (and had then refused to do so because she did not have the money required).

This doctor now has to break the news of her death to the family, and he has in his office both her parents and her sister.

The sister breaks down sobbing and in anger reveals what had happened two months earlier when her sister came to the hospital for help.

The doctor wants to comfort the family but of course, his own part in the affair makes this very difficult. He feels torn between his own guilt, genuine sympathy for the family and his real concerns about safeguarding his position…

Roles: Doctor, the young woman's mother, father and 21-year-old sister.

HEALTH PROBLEMS ASSOCIATED WITH THE USE/ABUSE OF PSYCHOACTIVE SUBSTANCE IN ADOLESCENTS

CASE HISTORY 1

Ali is a 14 year old adolescent who visits the adolescent health clinic on his own. He lives with his parents and attends secondary level education at a local school. When Ali enters the doctor's room he is welcomed by the doctor.

The doctor asks Ali to explain what problems he has. Ali tells the doctor that he has been referred to the clinic by a National Law and Drug Enforcement Agency (NLDEA) officer after having been fined for smoking in a non-smoking zone. Ali hesitates, but the doctor prompts him, non verbally to continue speaking and he tells the doctor that he has been smoking cigarettes for a year. The doctor asks for more details such as how many cigarettes a day, and when did Ali smoke his first cigarette.

The doctor asks why he has been smoking. Ali explains to the doctor that he thinks smoking is good because he sees many adults smoking and in addition his close friends smoke as well.

The doctor asks Ali if there are any other good or bad things associated with smoking. Ali explains that in general smoking is good, and that the only bad thing about smoking is that one has to pay a fine when one is caught by the authorities. He explains that he is aware this is only temporary and that when he grows up he can smoke as much as he wants.

The doctor further explores other reasons why Ali came to the adolescent health clinic. Ali continues to narrate the story and tells the doctor that he has been fined x100.00. The doctor asks Ali what he did next. Ali responded that he borrowed money from two friends. When he got the money he went and paid the fine.

When asked whether he has thought of quitting smoking, Ali responds reluctantly and says that he feels it is a good thing for him to smoke because all his friends smoke. The doctor advises Ali that he is still in school and he does not have money to buy cigarettes or pay for the fine if caught.

The doctor goes over the reasons given by Ali for seeking help. You think it is not good to smoke only because you can get into trouble with the law and that you have no money to pay the fines or buy cigarettes, and yet you think there are no health risks because many adults and friends smoke and they are still healthy" . Ali nods his head in agreement with the doctor's summary.

The doctor asks Ali if it would be alright to spend a few minutes talking about smoking and its effect on health. Ali says, yes it is okay, in fact that is why he has come because when he was paying the fine he was told to get advice from a doctor.

The doctor emphasises that even if many people smoke, smoking is not good for health. Passive smoking is also dangerous to health, that is why there are strict laws which do not permit smoking in certain areas. He explains that in a few years, he can expect his teeth to be stained due to the tar in the cigarettes, that his breath, fingers and clothes will smell after just one cigarette, and that he can get lung infections and will start coughing all day, and might get cancer of the lung later in life.

This explanation worries Ali. Ali tells the doctor that he has only been smoking since he was 12 years old and that older people still smoke and they do not have lung cancer.

The doctor explains to Ali that he may think it is okay to smoke because his friends and the adults he knows are smoking and seem to be healthy. Other people still smoke because they become dependent on cigarettes and find it difficult to quit easily. Dependency is one health problem that cannot be easily recognised, but is a serious problem. It can pose a lot of problems on social, physical and mental well being. People who smoke, slowly develop chronic problems such as heart and lung diseases. Major health problems related to smoking sometimes take a long time to appear. The doctor further explains to Ali that he is at a great advantage of not being severely dependent on cigarettes. If he quits now, he could prevent several future problems.

Although the doctor understands why Ali finds it difficult to see the side effects of smoking as Ali does not believe he will become dependent, the doctor advises Ali to find out from the adults who smoke if they have ever tried to quit smoking at any time. Nevertheless, the doctor praises Ali for coming to seek help and that they will work together to help him quit smoking.

The doctor ends by giving Ali pamphlets to read until the next appointment when he could start the counselling sessions.

CASE HISTORY 2

John, a 19 year old adolescent male, came to the clinic in the early morning hours of Saturday. His friends were terribly worried as John had an episode of vomiting at the end of the school year party. John's friend explains to the nurse that everybody had a good time at the part. They had a variety of drinks and were all having good time. They were surprised about two hours into the party, John started vomiting on and off. They all felt concerned and thought that taking him to the health centre would be appropriate.

Upon examination, John was drowsy, slightly dehydrated, and ha slurred speech. When asked if he could remember what had happened to him that night, he did not seem to recall anything. The doctor thanked John's friend for bringing him to the hospital and invited John into the examination room to examine him and further talk to him. John explained how he was put in charge of the drinks at the party. Given the opportunity, he decided to taste all the drinks that were there, mixing a variety of them. While his friends ate and drank, he was just drinking and serving his friends the drinks. It was his first time to drink like this although he drank from time to time, when he was with friends.

The doctor asked if he had tried other substance apart from alcohol. John responded yes, he smoked. The doctor again asked whether he thought he should be concerned about these other times when he had been drinking at parties (trying to establish if he was aware that drinking alcohol could be excessive at times). John said he did not see anything wrong with drinking at the party, as most of the time he was taken home by his friends who could manage to drive his car. It was the first time he had vomited. The doctor asked about the amount and frequency of the episode.

The health care provider realised that it would be better to defer the discussion till the following day. The discussions resumed the following day when the health care provider reviewed John's condition. The health care provider asked about school and his family relationships. John said that he was actually happy that he was going to university. He thought he might have a little more freedom to go out and do what he wants. His father drinks and says that alcohol tends to relax him after a hard day's work but his mother really gets upset with his father. When talking about this John seemed uncomfortable.

The doctor told John that he had some important information about how to prevent alcohol intoxication. The doctor asked John if he could spend sometime talking a little bit more about alcohol and its consequences. John was in agreement with this proposal.

The doctor explained some strategies for safer alcohol use at parties. Eating food before drinking, sipping (not gulping) drinks, not mixing several kinds of alcohol, alternating alcoholic and non-alcoholic beverages with the goal of slowing down the drinking rate to one alcohol beverage per hour, not drinking and driving. The doctor asked John if he would consider to stop drinking. John said he did not see the reason why he should stop drinking, he only drank excessively once. He had never vomited when he was drunk on other occasions. As far as driving is concerned he did not really worry because his friends drove him home in such situations.

The doctor asked John whether his mother would be pleased if she knew that he too was drinking like his father. John told the doctor that he was concerned that his mother was not happy with his father's drinking and that she would certainly not be happy if she knew that he drank a lot as well. He now realised that it is important for him to control his drinking.

HEALTH PROBLEMS ASSOCIATED WITH THE USE/ABUSE OF PSYCHOACTIVE SUBSTANCE IN ADOLESCENTS - Facilitator's Notes

Case History 1

- Adolescents may come alone to seek help at health facilities because they do not want anybody to know their problems, especially their parents. The health care provider should be alert and conduct a thorough history so as to get to the bottom of all health problems and needs that the adolescent might be seeking help for.

- It is always good to encourage the adolescent to clarify his/her problems in order to have a broader perspective of their problems.

- Many adolescents initiate substance use because this behaviour has been 'modelled' for them by older and or media figures. Knowing the reasons why the adolescent is involved in substance use helps to determine how best they could be helped.

- Asking adolescents what they like about their substance use offers two key advantages: (a) it serves to decrease adolescent's reluctance to discuss the subject (b) it provides the physician with clues as to the adolescent's motivation for using the substance(s).

- Finding out how adolescents get money for smoking can provide further insight into other potential problems.

- It is important to ask adolescents for their views regarding any possible disadvantages to their substance use. This provides the doctor with important information that can be used later to encourage the adolescent to stop smoking. In this case, because Ali mentions cost as one disadvantage of smoking, the doctor is now aware that borrowing money could land Ali into yet another social problem if he fails to return the money to his friends. In addition, exploring other reasons as to why the adolescent might have come to the clinic other than the given reasons helps to reveal other hidden problems.

- After completing the interview process, it is helpful to summarise the adolescent's main comments. This serves two functions (a) it demonstrates careful listening (b) it also allows the adolescent to hear some of his/her own ambivalence about the substance use.

- Ali will be more receptive to the doctor's information regarding substance use if Ali gives the doctor permission to tell him this information.

- It is important to explain the immediate consequences of smoking to him and to those around him. This could help Ali gain insight into the magnitude of the problem. Adolescents understand better when immediate consequences are described to them than consequences that could take place in the future.

- It is vital to stress that one could easily become addicted and that it is difficult to quit smoking much later. This could inevitably result in other chronic health conditions.

- Praising Ali for coming to seek help is an encouragement for him to trust the doctor and continually seek help. By asking Ali to find out from other adults about quitting attempts, Ali is likely to realise that they are indeed dependent and it will become more and more difficult for him to stop as the years pass. The doctor can come back to this question in the next appointment and discuss again the possibility of quitting and Ali's readiness for change.

- Even though Ali is not ready to quit right now, the doctor wisely gives him more information and an appointment date for further counselling. He does not simply end by handing him pamphlets.

Case History 2

- Although John has been brought by a friend to be seen by a doctor, it is important to show respect to him by talking to him in privacy. In this way, the health care provider may gain more cooperation from the adolescent. The fact that John does not remember facts from the previous night is already related to excessive drinking called blackout (acute impairment of memory during intoxication).

- Asking John about his concerns provides important information that can be used later in the interview. For example, smoking is often related to drinking and both John's alcohol use and smoking should be addressed.

- Frequent intoxication and daily drinking are high risk factors which can be related to future alcohol dependence.

- The condition of the client may not always permit a health care provider to explore all issues. It is easier to get reliable information when the client is feeling better and is comfortable.

- Family history of alcohol problems are also risk factors for dependence, and this needs to be discussed as well. Sometimes dependency could be related to family and social problems, child abuse and violence.

- John will be more receptive to information regarding safer alcohol use because the doctor has asked permission to tell him this information.

- Apart from advising adolescents about excessive drinking, there are several strategies that adolescents can use to minimize physical harm when drinking as described in the text. The doctor must alert John about the safety of going home with friends if they also drink too much.

- It is important to get John's perspective about the strategies described to him. This may help him feel involved in the process and make him more likely to follow through changing behaviour.

- Mentioning the mother at this point is a further motivating factor for John. John had expressed the need not to cause any more suffering to his mother. This is an important point to pick up in helping him to decide to stop drinking. The doctor can explore the possibilities of improving John's relationships with his parents and how this may help him as well.

Scenario 1

A 17-year-old adolescent male comes to you (the private health practitioner) with a genital ulcer and urethral discharge. As you begin to examine him closely, you realize that his breath smells of alcohol. When you ask him about his sexual life he tells you that he has a steady girl friend but that of late he has been seeing a girl who has come into town from another city and he suspects that she might be the one who has given him this condition.

Describe how you would handle this situation.

Scenario 2

An 18 year old girl is brought to the health facility by her mother because she has been coughing for the past two weeks. She thinks that her daughter has lost a bit of weight. At this point you tell the mother to wait outside while you examine the adolescent. You then call the female "chaperone" to be present while you try to determine what other problems this adolescent might be having. You

discover that she has been smoking to maintain her weight, and each time she quits smoking she gains weight.

Roles: Mother, girl, doctor and chaperone.

Scenario 3

At about 4am at the hospital, a foreign adolescent is brought in with minor cuts on his face and arms. You attend to him. After a few questions you realize that he has been at a party with friends and confesses to you that he has taken a pill called 'Ecstasy".

As a health care provider on duty, and knowing the laws of the country on illegal substance use, how will you handle this situation?

Scenario 4

In a rural village, a 14 year old girl is brought to the health facility by her father, a rubber plantation worker, as advised by the school teacher, for poor performance at school and lack of interest and concentration in class. After a thorough history and physical examination you discover that this 14 year old girl might be slightly malnourished. She comes from a family of seven children and the only source of income for the family is the rubber plantation where her father works. Compounding this problem are the alcoholic habits of her father, who seems to spend more money on alcohol than the family's welfare. This is common knowledge in this sparsely populated community.

How would you respond to meet the needs of this adolescent and her family?

Scenario 5

Peter, 17, the oldest son of a well-known surgeon in the city, is brought by his father to a private clinic because of weight loss. Peter wants only a physical examination to practice gym at school, but the father is terribly worried that something is wrong. During history taking, the doctor is able to identify some "clues" of marijuana smoking and cocaine sniffing. The rest of the exam is normal. Peter thinks this fact is just "normal" as most of his friends also experiment just for curiosity. The doctor tries to bring up the health risk associated with drugs in a clear, formal but friendly way.

Roles: Peter, the father, the doctor.

Scenario 6

Monica is a middle aged and concerned schoolteacher, who is quietly preparing her students for the mathematics final exam. Suddenly, one adolescent falls asleep over his desk. The other classmates start to laugh and one of the groups shouts aggressive and obscene words accusing Tom, who is 14 years old, of giving the boy some drugs that are causing this strange effect. A fight begins and the turmoil continues, until the Principal is called in. The class is suspended, the parents receive a letter explaining why drugs and violence can cause school learning problems and vice versa. Monica and the principal decide to ask for the help of a health professional and a meeting is arranged.

Roles: Monica (the teacher), the Principal, the doctor.

Scenario 7

A group of four adolescent friends, 13,14,16, and 18 years old, are having a great time at a house party organised by one of them during his parent's absence. They drink beer, inhale glue, smoke cigarettes and pot (Marijuana). A neighbour calls the police because of the loud music at night. The next day, the main newspaper of the city plans to publish an article about this scandal, entitled: "The threat of youths and drug abuse". The reporter who has to write this article asks your opinion as an adolescent health expert.

Roles: The reporter and the health professional.

INTRODUCTION TO SOME RISKS AND CONSEQUENCES OF ADOLESCENT SEXUALITY - CASE HISTORIES

CASE HISTORY 1

Kate was a 14-year-old schoolgirl in Nigeria. She attended a girl's boarding school and was the top pupil in her class. Her closest friend, Maria, was equally bright and in the same class. They were two star students in their class. Kate came from a rural village in Southern Nigeria. Maria was a daughter of a prosperous businessman in Lagos.

The two girls shared many secrets. They were both virgins and members of the Christian Union. One weekend in their second year in high school they were attending a Christian student camp. They became friends with two boys from a nearby school. They ended up having sex, their first time. This was one month before the school holidays.

The following month they both missed their menses. They were on vacation and did not share this secret until the school opened. Could they be pregnant? As the school was near Nairobi, Maria's mother used to visit her every month. On her next visit Maria disclosed to her mother the problem. The mother immediately understood what was going on. She asked for permission for Maria to attend the family emergency, took her home and arranged for an immediate termination of pregnancy by her gynaecologist. Maria was back in school that Monday.

Kate remained in school and soon the teachers started suspecting that she might be pregnant. She had been frequently unwell, moody and her performance in class had deteriorated.

The school nurse was summoned to examine her. Pregnancy was confirmed and according to the school policy she was immediately suspended and given a letter to take to her parents. Kate was devastated. She had no money to go home. Her parents were elders in their church and would kill her if they heard what had happened.

Maria gave her some money. She left school that day and travelled to Lagos to see her uncle. The uncle was a construction worker and lived in one of the slums of Lagos.

When her uncle returned from work in the evening Kate feigned sickness and told him that she had been sent away because of school fees. The uncle sympathized with her but could not raise any money. He instead sent a letter by post to Kate's parents, asking them to send the money.

Kate was now four months pregnant. The pregnancy became more difficult to hide each day. At six months her uncle's wife noticed the pregnancy. Her uncle, furious, chased her out of his house. Lonely, with no money and nowhere to go, Kate accepted accommodation from a young man in their neighbourhood.

Two months later Kate delivered a premature baby boy at a nearby health centre. The baby had to be kept in the nursery for two weeks. When Kate returned from the hospital she found that the young man who had accommodated her had moved.

She was now desperate, young with a newborn, nothing to eat and homeless. Kate took refuge in the only place that could accept her. A businesswoman selling gin in the slum area employed her to help serve her customers. That became Kate's life.

CASE HISTORIES AND SCENARIOS: Facilitator's Notes

Case History 1
This case history highlights socio-cultural and legal issues, for example:

- Inadequate access of adolescents to information and services for reproductive health, especially contraception and safe abortion services,

- Inadequate communication on reproductive health issues between adolescents, parents and other adults, and

- School policies on pregnant adolescents.

PREGNANCY PREVENTION IN ADOLESCENTS: CASE HISTORIES

CASE HISTORY 1
You are a male doctor, in your mid 40s. You run a private general practice in a lower middle class neighbourhood of the capital city. Most evenings, your waiting room is full of patients and their accompanying friends and relatives. One evening, your nurse ushers in a young man of 15, who you have never treated before (a 'new' case). The young man's presenting problem is burning pain on passing urine. Through the history taking it becomes evident that he has a sexually transmitted infection. You carry out an examination, discuss your findings and your diagnosis with him, and ask your nurse to start a course of antibiotics. Before sending him off, you have a few minutes to talk to him while your nurse is preparing the next patient.

What would you ask him? What would you tell him?

CASE HISTORY 2

You are a nurse-midwife in a General hospital. Along with the other members of your small Obs-Gyn team, you run an antenatal outpatient clinic, twice a week (in the mornings). One Friday morning, as you walk into your clinic, you see two young women, in their late teens, huddled together in a corner of the waiting room. One of them is obviously crying, and the other appears to be trying to console her. You say to yourself that this is a sight you have seen several times before – yet another possible unintended unwanted pregnancy. When it is their turn, your suspicions are proved right. The two young women are students in a nearby technical training institute. The one in tears tells you that her periods are delayed by four weeks, and she suspects that she is pregnant. On further questioning, she tells you that she has unprotected sex only once with a young man who is her neighbour. You carry out an examination and request a urine test for pregnancy. You ask them to wait for the results. An hour and a half later, a technician from the laboratory brings you the results: the urine test for pregnancy is negative. You call the two women into the room to share the news with them. Both of them start sobbing in relief.

What advice would you give them before they leave?

CASE HISTORY 3

You are a female doctor in your late 40s. Along with your husband, who is also a doctor, you run a private practice in a well-to-do suburb of a large city. Your clinic has been in operation for nearly 15 years and is a well established one. You and your husband are well known in the neighbourhood. One evening, an adolescent female (aged 14 and a half) is brought to your clinic by her mother. You know the family and have treated several of its members over the years. The presenting problem, as stated by the mother, is that the adolescent is having her period with a lot of pain. After exchanging pleasantries with them both and posing a few general questions, you ask the girl to accompany you to the examination room. Once you are alone with her, you get a very different presenting complaint – and a different history. She says that she and her boy friend were petting each other on the previous day, and they went too far. They apparently had unprotected vaginal sex, at a party, the previous night. The girl pleads for your understanding and help.

How would you deal with the girl – and with her mother who is waiting anxiously?

CASE HISTORY 4

You are a female junior doctor at a General hospital in Surulere. The Local Government Medical Officer has requested volunteers to give a series of health education talks to students in the senior classes (who are aged 14 – 17) of the secondary schools in Surulere on the subject, 'avoiding teenage pregnancy and AIDS'. You volunteer, because you have seen the impact of this problem on some of your own classmates in school and medical college. The Medical Director of the hospital says that he has no objection to your giving the talks, as long as it does not interfere with your work in the hospital. Your first lecture and question and answer session is in a boys' school and it goes well. You are pleased. Your second one is in a girls' school. After your talk, a small group of girls gather around you and ask for additional information and clarification. A few of them even ask for your autograph. You are pleasantly surprised. As you are putting down an encouraging message, one of the girls says

in a low tone, 'I would not have the courage to ask my boy friend to use condoms; he would say that I am a prostitute'. There is an echoing murmur of agreement from two or three of the other girls.

How would you respond?

CASE HISTORY 5

As usual, you are conducting your morning clinical rounds in the obstetrics ward of your General hospital. One of the patients you have to see is a young woman of 19 years, who delivered a healthy baby in the hospital two days earlier. She had to have an emergency caesarean section because of foetal distress. At the time of the ward round, baby and mother are both well. The woman is beaming and says she is waiting to take the new baby home to her husband. You gently raise the issue of contraception, and she turns to you with a half surprised half worried look and says that she is determined to wait for at least 18 months before she has another one.

What advice would you give her?

PREGNANCY PREVENTION IN ADOLESCENTS – Facilitator's notes

Particular attention should be paid to [what] when working with adolescents at various points in the course of a professional interaction.

Draw the attention of the participants to the section titled: What health care providers could do differently, to meet the needs of their adolescent patients. Go over the sub titles of the section, displayed on the screen. Then give them about 5 minutes to go over the section individually.

Switch off the overhead projector, invite comments and questions, and respond to them yourself or better still encourage other participants to respond to them. After a few minutes, go on to the next part of the session.

Explain

We will now look at a few real life situations, which highlight some of the key points made in the handout.

Divide the participants into 4 groups. Ensure that one or more adolescents and non-health care providers are represented in each group. Give each of the 4 groups a scenario, and ask them to discuss the scenario for 15 minutes and answer the question posed. Participants should specify what they would do in the given situation, and reasons for their responses. Each group should nominate a representative to present their responses.

Allow about 3 minutes per group for the presentations.

Scenario 1

A 16 year old boy is brought to your clinic by his mother. His mother explains that he told her he had been injured in his groin while playing football with his friends. When taking the history, you notice that the boy is silent, and does not interrupt his mother, or add to anything that she says. You listen to her for a while, and then lead the boy to the examination room. When you have shut the door

behind you and he has settled down on the couch, you ask him to explain what the problem is, in his own words. He is silent. You wait for a few minutes and gently probe once again. He asks in a low tone if you will promise not to say anything he tells you to his mother.

Question to pose: How would you deal with this situation?

Points to highlight in this scenario: This scenario highlights the importance of establishing rapport with the patient and eliciting information on the nature of the problem facing him/her. It also deals with the difficult issue of finding a balance between the rights of parents to know about the problems of their offspring, and the rights of adolescents to privacy and confidentiality.

Scenario 2

A young woman (aged 16) has come to the clinic in the General hospital of a semi-urban area, because she has vaginal discharge and some painful sores around the vagina. She is received by the duty nurse who has briefly examined the young girl, and asked her a few questions. She then calls in the junior doctor (who joined the general hospital recently). The doctor (a woman too) is appalled by the nurse's brusque manner and rude words, to the young woman. As the nurse moves around the examination room, slamming drawers and banging metal trays, she mutters quite audibly; 'shameless woman, stealing other people's husbands, deserves her punishment…' The patient remains silent, but starts weeping silently. The doctor takes her aside, completes her examination, gives her the appropriate medication and asks her to come back for review in a week. She is gentle and courteous with the woman, which appears to inflame the nurse, further.

Question to pose: How would you deal with this situation, if you were the junior doctor?

Points to highlight in this scenario: This scenario clearly highlights the challenges of helping colleagues to see the advantages of a courteous and respectful approach, even when one does not endorse their life styles/actions.

Scenario 3

A young man (aged 20) presents at a rural health centre, with urethral discharge. He tells the duty doctor that he has been suffering from this, on and off, for a year. He knows that this is an STI, but does not seem very concerned about it. He says that he has had similar episodes in the past after visits to prostitutes in the nearby town. He is rather open about this, and says all his friends do the same. On enquiry, the doctor learns that the young man is married and has a wife who is 16 years old. The doctor explains that it would be important for both partners to be treated. The young man shakes his head, saying that would be out of the question.

Question to pose: How would you deal with this situation, if you were the doctor?

Points to highlight in this scenario: This scenario highlights the challenges associated with communicating the diagnosis of a Sexually Transmitted Infection (STI) and its implications, discussing treatment options and providing treatment. Beyond that, it highlights the importance of helping the patient deal with the social implications of the condition.

Scenario 4

An 11-year-old girl is brought to a semi-urban clinic by her mother, because she has noticed that her daughter has genital sores. No meaningful history could be obtained either from the mother or from the child, on how and when the sores started. The girl was examined behind a screen while her mother sat in the same room. Examination revealed that the child had florid clinical features strongly suggestive of syphilis. The nurse in charge, a mature and experienced woman, took the girl into another room and probed the matter gently. After several minutes of gentle but persistent probing, the girl told the nurse that her uncle had been playing with her and had warned her that if she told anyone he would kill her.

Question to pose: If you were faced with this situation, how would you deal with it? How would you manage the girl's condition?

Points to highlight in this scenario: This scenario touches on the extremely difficult problem of child and adolescent abuse (including sexual abuse) and the challenge of finding ways and means of dealing with it effectively, in conjunction with other agencies, such as law enforcement agencies, and governmental bodies/non governmental organisations which provide social services to meet these needs.

Plenary feedback: Ask groups to share their conclusions in turn in plenary and to respond to any comments or questions that others pose. As the feedback and the question-answer session proceeds, have someone record noteworthy points on a flip chart.

Finally, wrap up the session, highlighting the key points raised in the discussion, and refer the participants back to the handout.

PREVENTION OF STD IN ADOLESCENTS: SPECIAL CONSIDERATIONS

30 Minutes

Explain

The planning, implementation, monitoring and evaluation of strategies for the prevention of STI's in adolescents, at the national and local levels – is extremely important. This session will focus on the special contributions that health care providers could make when working with adolescents within their health centres.

Role play

Invite two participants to volunteer to enact the 1st role play (using scenario 5). Conduct the role play, and then facilitate a debriefing session (as outlined in the facilitator's overview). Then, repeat the process with the 6th scenario. Ensure that you allocate enough time for each.

Scenario 5

You are a doctor working in a busy municipal clinic, in an urban area. You have had a busy morning, running the outpatient clinic. The young man aged 18 who is seated in front of you is your 40th new

case for the day. You have diagnosed gonorrhoea, and handed him a prescription to take to the pharmacy in the clinic. He thanks you and rises to leave. You realise that you have not discussed prevention with him, and tell him to sit down.

Role: Doctor and male patient (aged 18).

Points to highlight in this scenario: Adolescents, who have come for the treatment of an STI, obviously have had unsafe sex, with an infected person. They need help to avoid these infections in the future. In this scenario, the health worker has an opportunity to provide the young man with information (that builds on his knowledge and experience and is relevant to his stage of development and circumstances), and skill (to enable him to cope with the realities of his everyday life). In addition, he/she has the opportunity to provide the young man with condoms. If the health worker cannot provide these things, he/she should at least direct him to some other individual or organisation, who could do so.

Scenario 6

You are a woman in your mid 40s. You are a doctor, and run a private practice in a middle class area of a big city. The practice is an established one, and you are well known by the local residents. In fact, you are the family doctor for many families in the area. The young woman seated in front of you is someone whom you have known for over 10 years. She is now a college student, and is stylishly dressed. She is still single. She has come to ask you for help with her pimples. You have dealt with that, and as she is about to leave, you realise that you have not kept a promise that you made some time back, to her mother, about talking to her about the risks and consequences of 'unsafe sexual activity'. You decided to try to do so now…

Roles: Doctor and female patient aged 17.

Points to highlights in this scenario: This young woman, like the young man in the previous scenario, needs to be provided with information that is tailored to her special needs. She also needs to have the skill to put the information to use. In addition, if she is sexually active, she will require condoms and contraceptives to avoid sexually transmitted infections and an unwanted pregnancy. The additional challenge facing the doctor in this scenario is that of introducing the sensitive subject of sexuality to the discussion.

Wrap up the discussion by highlighting some of the key points made in relation to each of the scenarios.

Module Review and Close

5 minutes

Inform the participants that you have come to the end of the module. Display OHT of STIs once again and ask the participants if they have any final comments or questions to rise.

CARE OF ADOLESCENT PREGNANCY AND CHILDBRITH: CASE HISTORIES

CASE HISTORY

Abibat, a 15-year-old Yoruba girl was admitted to the General Hospital one Monday afternoon. She had been in labour at home for three days under the care of a Traditional Birth Attendant (TBA).

This was her first pregnancy and she was already nine months on. She had not attended any antenatal clinic. According to the accompanying relatives, labour had started 3 days earlier. The TBA had attended to her and had given her several traditional herbs to speed up the labour but nothing had happened. Instead, Abibat had complained of severe abdominal pains and was now bleeding through her vagina.

She had grown progressively weak, hence the decision to bring her to hospital. Further inquiry revealed that Abibat got married one year ago to a 60 year old man. She was the fourth wife. Examination revealed a young girl with pregnancy at term. She was pale and dehydrated. The abdomen was tender and firm and the foetal heart could not be heard. There was moderated vaginal bleeding. Vaginal examination revealed a fully dilated cervix with marked protrusion or swelling. The head of the baby had progressed downwards in the birth canal (3/5) and fixed.

A diagnosis of obstructed labour with intrauterine foetal death was made. Arrangement was made for emergency caesarean section. She was catheterised and started on antibiotics. At caesarean section, the foetus was found in the abdominal cavity. The uterus had ruptured at the fundus, extending to the left lateral side. There was marked bleeding. The doctors considered uterine repair but decided against it. A sub-total hysterectomy was done and the abdomen closed.

Abibat had a stormy post operation period. Her temperature remained high despite antibiotics and on day 5 she started having urinary incontinence although a Foleys catheter had been left in place.

The fever settled after 10 days but the urinary incontinence continued. At the examination under anaesthesia three weeks later, a Vesico-Vaginal Fistula was confirmed. She was discharged home and asked to return after 3 months for attempted surgical repair of the fistula.

Scenario 1

A doctor and his team are conducting a ward round at the maternity unit on Monday morning. There are 25 patients. Ten of them are teenagers. There is a 14 year old girl admitted with anaemia. Her haemoglobin is 7gm%.

As they reached the bed the nurse started scolding the young girl. She told her that she had no business getting pregnant. The doctor was more understanding and wanted to obtain additional information from the patient. The patient's parents were waiting in the corridor. Her father had picked a quarrel with her mother and had refused to speak with her.

Roles: Doctor, nurses, 14-year girl, mother.

Scenario 2
A woman and her 15-year-old pregnant daughter (24 weeks) were in the health centre to see the doctor. He carried out a physical examination of the girl, which was within normal limits except that he found her conjunctivae and nail beds to be very pale. He had thus sent them for a blood test and the report revealed that the girl had haemoglobin of 9gm%. He was then trying to initiate treatment.

Roles: Doctor, 15-year-old pregnant girl (24 weeks) and mother.

Scenario 3
The principal of a school brings a 16-year-old school girl (in school uniform) to the emergency department. She has severe lower abdominal pains. The teacher does not know what is wrong but suspects that the student may be pregnant.

On examination by the midwife, a term pregnancy is confirmed. The patient's blood pressure is 150/100. She is also in labour and her cervix is 4 cm dilated. The midwife calls the doctor to talk to the teacher. The girl is sent to the labour ward for monitoring of her labour. She delivers a 2kg male infant 6 hours later.

Roles: Doctor, nurse, teacher, and girl.

Scenario 4
A 15-year-old single girl has just delivered at the health centre. She is a housemaid and claims that her employer raped her. She does not accept the pregnancy and does not want the baby. She knows nothing about breast-feeding. Her family is in the rural area 500km away. She has no money and the employer had kicked her out 2 days before she went into labour.

Role: Nurse, doctor, and girl.

Scenario 5
A 14-year-old girl was discovered to be pregnant by the school nurse during one of her visits. She was referred to the health centre for antenatal care, and after three weeks of hesitation she had finally summoned enough courage to come to the health centre. She came by herself for the first antenatal visit.

Roles: Receptionist, matron, nurse and 14 year of pregnant schoolgirl.

Scenario 6
A 15-year-old single girl delivered a baby boy three days ago at the maternity. She is now ready to go home and the nurse is meeting with her.

Role: 15-year-old girl, 3-day-old baby (doll), nurse.

CARE OF ADOLESCENT PREGNANCY AND CHILDBIRTH: Facilitator's Notes

Case History

This case history highlights health issues associated with labour and delivery in adolescents, for example,

- Supervision of labour by non skilled persons,
- Complications such as prolonged obstructed labour, operative delivery, postpartum fever, and consequences – vesico-vagina fistula.

Scenario 1

This scenario should depict the following:

- Poor attitude of some health workers to adolescents, and
- Dilemma of parents of adolescents.

Scenario 2

This scenario should depict the following:

- Appropriate counselling of a young pregnant girl whose mother is aware of the situation;
- Good listening skills;
- Good knowledge of anaemia during pregnancy, and what to do; and
- Realisation that intervention on nutritional problems in adolescents often involves the family, since the control of food in the household often lies beyond the adolescent.

Scenario 3

This scenario should depict the following:

- The commonly occurring disappointment of teachers to pregnancy in their students;
- The commonly occurring denial of adolescent when they are pregnant; and
- The fact that children of adolescent age tend to be of low birth weight.

Scenario 4

The scenario should depict the following:

- Denial of some adolescents of their pregnancy;
- Ignorance of some adolescents concerning issues related to baby care; and
- Appropriate counselling of the health worker regarding post-partum issues, especially breast feeding and contraceptive advice.

Scenario 5

This scenario should depict appropriate counselling of a pregnant young adolescent covering issues related to support, care, danger signs, etc.

Scenario 6

This scenario should depict appropriate counselling of an adolescent post partum covering issues related to breast-feeding, contraception, and care of the baby.

MODULE ELEVEN
SCHOOL HEALTH PROGRAMME IN NIGERIA

This module is designed to help relevant stakeholders gain a comprehensive insight into the diverse and important fields of school health. It aims to give relevant information on the rationale, the scope and the state of the School Health Programme in Nigeria. It is divided into six sessions:

SESSION 1: SCOPE OF THE SCHOOL HEALTH PROGRAMME IN NIGERIA

SESSION 2: HEALTHFUL SCHOOL ENVIRONMENT

SESSION 3: SCHOOL FEEDING SERVICES

SESSION 4: SKILLS-BASED HEALTH EDUCATION

SESSION 5: SCHOOL HEALTH SERVICES

SESSION 6: SCHOOL, HOME AND COMMUNITY RELATIONSHIPS

MODULE ELEVEN: SCHOOL HEALTH PROGRAMME IN NIGERIA
SUMMARY AND TIMING ESTIMATE

SESSION TITLE	DURATION	OBJECTIVES	METHODS	MATERIALS
Scope of The SHP In Nigeria	20 Mins	• Explain the importance of an effective SHP in Nigeria. • Enumerate the scope and objectives of the SHP.	Lecture	Policies-NSHP*and Implementation guidelines. Flip chart/markers.
Healthful School Environment	45 Mins	• List facilities and services for safe learning environment in school. • Describe the state of healthful school environment in Nigeria. • Describe the characteristics of a healthful school environment.	Lecture Discussion Brainstorming	Policies-School Sanitation, NSHP* and Implementation guidelines. Flip chart/markers. Projector.
School Feeding Services (SFS)	45 Mins	• Describe school feeding services. • Describe the state of the school feeding services in Nigeria. • Discuss the models of school feeding programme. • Enumerate the nutritional composition of an adequate meal. • Discuss the preparation of a weekly menu table depicting an adequate diet.	Brainstorming Demonstration Discussion Lecture	National Guideline for School meal planning National Training Manual for Implementers of SFS (FME/UNICEF). Flip chart/markers. Projector.
Skills-Based Health Education (SBHE)	45 Mins	• Explain skills-based health education approach. • List common adolescent issues or problems. • Enumerate the basic skills in the skills -based health education approach.	Discussion Brainstorming Role play/ Demonstration Lecture	SBHE teachers' manual& learners' workbook. Projector. IEC materials. Flip chart/markers.
School Health Services	45 Mins	• List the objectives of the school health service. • List the contents of the school health service. • Identify common health problems among in-school adolescents. • Discuss the current state of school health services in Nigeria.	Lecture Group work Field visit Health screening Demonstration	First Aid box School health records Flip chart/markers Projector
School, Home And Community Relationship	45 Mins	• Identify ways of promoting relationships between the school and community. • Identify roles and responsibilities of communities in SHP*. • List activities that can promote the relationship between the school and the host communities.	Lectures Brainstorming Role play Discussion	Policies- SHP& Implementation guidelines. Flip chart/markers Projector

SHP* - School Health Policy *NSHP- National School Health Policy

MODULE ELEVEN: SESSION 1
SCOPE OF THE SHP IN NIGERIA

TIME: 20 Minutes

OBJECTIVES

At the end of this session, participants will be able to:

- Explain the importance of an effective SHP in Nigeria.
- Enumerate the scope and objectives of the SHP.

METHODS

- Lectures

MATERIALS

- Policies-NSHP and Implementation guidelines
- Flip chart/markers

CONTENT

IMPORTANCE OF AN EFFECTIVE SCHOOL HEALTH PROGRAMME (SHP) IN NIGERIA

The school system is a key setting for health promotion. The school is seen as an important context for health promotion, principally because it reaches a large proportion of the population of people who are in their formative years and who are willing to learn for many more years. The emphasis on schools is also a recognition that the learning of health-related knowledge, attitudes and behaviour begins at an early age and that schools provide the right atmosphere for children and adolescents to learn. In-school adolescents spend the better part of their days in school when compared to the time they spend at home or elsewhere. Thus, it is important that an effective school health programme is in place in schools to take care of their health.

Schools are formal centres of learning that have been put in place for the achievement of educational goals. Education and health are interrelated: education influences health just as health influences education. Good health is needed to accomplish quality education while good education also enhances the quality of health in adolescents. The school system represents one of the most efficient and organised ways to reach large portions of the population in terms of health. The potential population include young people and their families, school personnel, and entire communities. Thus, an effective school health programme does not only promote the health of in-school adolescents but is a major boost for Nigeria's health system as a whole.

Over 22% of Nigerians are adolescents aged 10-19 years and available data show that a significant proportion attend schools. According to the NDHS 2008, the Gross Attendance Ratio (GAR) for secondary school ranged from 100.1% in the South-west zone to 38.6% in the North-East zone with the national average at 73%. The GAR for secondary school is the total number of secondary school students, of any age, expressed as a percentage of the official secondary school-age population. Similarly, the total Net Attendance Ratio (NAR) of students in secondary schools in Nigeria ranged from 68.7% in the South-west and South-east zones to 25.7% in the North-East zone with the national average at 49.1%.

The NAR for secondary school is the percentage of the secondary-school age (13-17 years) population that is attending secondary school. Since the age group 13-17 years falls within the adolescents' age range, it can be safely assumed that many adolescents are in school in Nigeria although there are regional variations. Thus, the School Health Programme should be a rallying point for all interventions on adolescent health in Nigeria by virtue of the fact that many adolescents in Nigeria are in school, and that they not only represent the future of this country, but also represent a "critical mass" that can take the vital message of health promotion and disease prevention to the whole populace.

SCOPE AND OBJECTIVES OF THE SCHOOL HEALTH PROGRAMME

According to the Federal Ministry of Education (FME), the School Health Programme (SHP) comprises all projects /activities in the school environment for the promotion of the health and development of the school community. The main goal of the SHP is to improve the health of learners and staff as responsible and productive citizens who can also influence their communities positively.

The objectives of the School Health Programme are to:

- Promote growth and development of every child taking into consideration his/her health needs.
- Create awareness of the collaborative efforts of the school, home and the community in health promotion.
- Develop health consciousness among the learners.
- Create awareness on the availability and utilization of various health related resources in
- the community.
- Promote collaboration in a world of interdependence, social interaction and technological exposure in addressing emergent health issues.
- Build the skills of learners and staff for health promotion in the school community.

SCOPE OF THE SCHOOL HEALTH PROGRAMME IN NIGERIA

According to the National School Health Policy (NSHP), the scope of the School Health Programme in Nigeria covers-

- Healthful school environment,
- School feeding services,
- Skills-based Health Education,
- School Health Services, and
- School, Home and Community Relationships.

The policy clearly spells out how to implement each component of the School Health Progamme using the proven principles of Capacity Building; Advocacy, Partnership and Collaboration; Community/ Social and Resource Mobilization; Monitoring and Evaluation; and Delineation of Institutional roles.

One of the more recent innovations in school health which has gained worldwide acceptance and which has also been well recognized in the National School Health Policy is the Health Promoting School, a concept initiated by the World Health Organization (WHO) in 1996. According to WHO, a health promoting school is "one that strives to build health into all aspects of life and community" and it has six key features:

- Engaging students, teachers, parents, health and education officials, and community leaders in efforts to promote health.
- Providing a safe, healthy environment (physical and psychosocial).
- Providing skills-based health education.
- Providing access to health services.
- Implementing health-promoting policies and practices that support health.
- Improving the health of the community.

Apart from the Health Promoting School, other international initiatives or programmes that have been embraced in principle by Nigeria include-

- FRESH- Focusing Resources on Effective School Health (WHO, UNICEF, UNESCO and the World Bank initiative)

- Child Friendly School- UNICEF
- Learning Plus- UNICEF

SUMMARY

The School Health Programme is an important context for health promotion because it reaches a large proportion of the population who are in their formative years and who are willing to learn for many more years. The main goal of the SHP is to improve the health of learners and staff as responsible and productive citizens who can also influence their communities positively.

EVALUATION

- What are the objectives of SHP?

MODULE ELEVEN: SESSION 2
HEALTHFUL SCHOOL ENVIRONMENT

TIME: 45 Minutes

OBJECTIVES

At the end of this session, learners will be able to:

- List the facilities and services necessary for a safe learning environment in school.
- Describe conditions required for healthful school environment.
- Describe the state of healthful school environment in Nigeria.

METHODS

- Lecture
- Discussion
- Brainstorming

MATERIALS

- National School Health Policy
- Policy Guidelines on School Sanitation
- Implementation Guidelines on National School Health Policy
- Flip chart
- Writing markers
- Projector

CONTENT

OVERVIEW OF HEALTHFUL SCHOOL ENVIRONMENT

The school environment plays an important role in the normal growth and development of school age children. Most common childhood illnesses like measles, malaria, diarrhoeal diseases, and malnutrition are directly linked to unhygenic environmental conditions. Injuries and accidents are also linked to hazardous conditions in the school environment. A healthful school environment (HSE) is that which embraces the health and safety of learners and other members of the school community. It is an essential factor in achieving the overall goals of the SHP because it has implications for all aspects of school health.

According to the FME, the objectives of the healthful school environment are to:

- Create a healthy and safe learning environment in the school.
- Provide adequate safe water supply and sanitation facilities for use in schools.

Broadly speaking, healthful school environment refers to:

- The physical environment in the school.
- The psycho-social environment of the school.

The biological environment - for example, freedom of the environment from stray and dangerous animals- is also important and is taken as part of the physical environment by many authors.

Activity 1:

Learners should brainstorm on how our environment affects our health.

Physical Environment

According to Federal Ministry of Education and the Federal Ministry of Environment, important elements in the physical school environment include-

(1) The school site and size. (2) The school grounds. (3) The school building and classrooms. (4) Illumination. (5) Ventilation. (6) Water supply. (7) Toilet facilities and waste disposal. (8) Fire and safety. (9) Kitchen and lunchroom.

Specific details about these nine elements are in the NSHP implementation guidelines [electronic copies of which will be made available to learners].

The Psychosocial Environment

The psychosocial environment includes the interrelated physical, emotional and social conditions that affect the well-being and productivity of learners and staff of the school community. It encompasses the attitudes, feelings, and values of students and staff. Physical and psychological safety, positive interpersonal relationships, recognition of the needs and success of the individual, and support for learning are all part of the psychosocial environment.

According to the WHO and UNICEF, a school environment can enhance social and emotional well-being, and learning, when it:

- Is warm, friendly and rewards learning.
- Promotes cooperation rather than competition.
- Facilitates supportive, open communications.
- Views the provision of creative opportunities as important.
- Prevents physical punishment, bullying, harassment and violence, by encouraging the development of non-violent policies and procedures.
- Promotes the rights of boys and girls through equal opportunities and democratic procedures.

A healthy psycho-social environment simultaneously provides support to teachers, students and their families. Part of the services that can promote a healthy psycho-social environment in school are the establishment of counselling programmes, conflict mediation programmes, and peer education programmes, and other mechanisms to encourage "child-to-child" learning.

CHARACTERISTICS OF A HEALTHFUL SCHOOL ENVIRONMENT

The major conditions required for a healthful school environment include:

- Location of schools away from potential environmental hazards.
- Protection of the school community from excessive noise, heat, cold and dampness.
- Provision of adequate buildings, constructed in line with approved standards, with particular emphasis on facilities for physically challenged learners.
- Provision of an appropriate and adequate amount of furniture for learners and staff.
- Provision of an adequate number of gender-sensitive toilet facilities.
- Provision of adequate safe water supply and sanitation facilities for the school community.
- Provision of proper drainage and waste disposal facilities.
- Provision of safe recreational and sport facilities.
- Perimeter fencing of the school.
- Observation of Annual School Health Days.
- Promotion of healthy human relationships in the school community.
- Promotion of health related-school policies.
- Promotion of a maintenance culture.

THE STATE OF HEALTHFUL SCHOOL ENVIRONMENT IN NIGERIA

Statistics from the National Study of the School Health System in Nigeria by FMOH and FME in collaboration with WHO in 2003 revealed the following:

- Physical Location of School: Most of the schools (71%) were located at a distance of less than 5km to main markets, and 68% were located less than 1 km to busy main roads.

- Physical State of Classroom and Structural Facilities: Most schools had good ventilation (94%), and more than two-thirds had satisfactory doors, windows and adequate light.

- Availability of Environmental Health Facilities: About three-quarters of schools assessed had recreational facilities, one-quarter had ventilated pit latrine, 46% had pipe-borne water or bore hole and 67% were reported to be clean.

In a recent study done in four geo-political zones in Nigeria by the Learning Plus team from Federal Ministry of Education and OAU, Ile-Ife, more than 50% of the schools sampled were overcrowded, and only 25% of the schools had dedicated spaces for psychosocial services such as counselling. In general, the schools involved in the study tried to provide counselling services to students in need. Half of the schools had no potable water and toilets were completely inadequate in many schools. In one school, the toilet : student ratio was as high as 1:102 and in another, it exceeded 1:200. Facilities for hand-washing were almost non-existent and safety and security posed a problem at several of the Nigerian schools in the study.

SUMMARY

HSE is one of the components of the SHP and it is broadly classified into physical and psychosocial environments. The biological environment of the school is also important. HSE is a very essential component of the SHP and often gives a good impression of the state of health of a school. Provision of healthful school environment must be guaranteed in all schools for efficient performance of staff and learners. All the necessary services, facilities and tools needed for the physical, social and emotional well being of the school population must be assured, provided, safeguarded and sustained.

EVALUATION

- List some of the facilities and services for safe learning environment in schools.
- Discuss the relevance of the healthful school environment to the SHP.

MODULE ELEVEN: SESSION 3
SCHOOL FEEDING SERVICES

TIME: 45 Minutes

OBJECTIVES

At the end of this session, participants will be able to:

- Describe school feeding services.
- Discuss the models of school feeding programme.
- Enumerate the nutritional composition of an adequate meal.
- Discuss the preparation of a weekly menu table depicting an adequate diet.
- Describe the state of the school feeding services in Nigeria.

METHODS

- Brainstorming
- Demonstration
- Discussion
- Lecture

MATERIALS

- National Guideline for School Meal Planning
- National Training Manual for Implementers of School Feeding Services (Federal Ministry of Education/UNICEF)

CONTENT

OVERVIEW OF SCHOOL FEEDING SERVICES

School Feeding Service (SFS) is another essential component of the SHP. The more nourished children are, the better their learning ability and overall state of health. Many children die before school age and many of those that survive suffer from severe hunger, malnutrition and diseases which affect their learning abilities. Some children do not attend school due to hunger and poverty. SFS is recognized as a strong means of improving enrolment, attendance, retention, completion and learning achievement among pupils because it reduces hunger among them and address the gaps in their nutritional and health status. In places where a free meal is offered to pupils, it also provides an incentive for poor families to send their children to school as the children would have at least one good meal at school.

In order to assist with the realization of Universal Basic Education (UBE) and attainment of Millennium Development Goals (MDGs) in Nigeria and to show government commitment to this cause, the Home-Grown School Feeding and Health Programme (HGSFHP) was launched in September, 2005 by the Nigerian President. HGSFHP has a national framework which provides guidelines for its operations. The HGSFHP aims to provide an adequate meal per day for students using locally available resources (FME, 2006a). It is however regrettable that only one or two state governments are at present trying to meet up with the ideals of the HGSFHP.

The objectives of the school feeding service are to:

- Reduce hunger and malnutrition among learners.
- Enhance participatory learning.
- Contribute to increased school enrolment, attendance, retention and completion.
- Serve as avenue for teaching basic hygiene and nutritional facts to learners.

The characteristics of school feeding services include:

- Provision of, at least, one adequate meal a day to school children.
- Adequate sanitation and hygiene practices among food handlers including routine medical examination and vaccination.
- Food fortification and supplementation.
- Regular de-worming.
- Promotion of health related-school policies.

The components of the School Feeding Services include:

- Nutritional services
- Feeding services
- Food procurement services
- Food inspection services

Nutritional Services

A nutritionist/dietician from the Ministry of Health in collaboration with the School Based Management Committee (SBMC) shall produce a daily menu that is culturally acceptable and locally

sourced for school feeding service. Menu must meet one third (1/3) of the daily requirements of all major and micro nutrients for children. Basic food items available in the communities therefore, should be combined with leafy vegetables, fish or meat and vegetable oil.

Feeding Services

Each school shall have a standard well-equipped kitchen. The kitchen shall be appropriately sited within the school premises with adequate provision of safe water, well ventilated store, functional refrigerator for perishable items, power supply, safe waste disposal and school farms and gardens. The feeding should take place in the dining room/hall where the meals are served under the supervision of the teachers with appropriate teaching on good hygienic practices.

Food Procurement Services

SBMC should liaise with the farmers within the community to establish a mechanism for coordinating and monitoring of procurement activities. As much as possible, food should be obtained by direct procurement and payment made to boost further food production.

Food Inspection Services

SBMC should ensure hygienic practices in the cooking and serving of the food which should be served hot at all times and Food Vendors/handlers have up-to-date certification.

MODELS OF SCHOOL FEEDING PROGRAM

1. On-site meal preparation by private local food vendors

In this model, the certified food vendors' source for food materials, come to the school daily and prepare the meal within the school premises. The main advantage of this is that the quality control of meals is possible (the level of hygiene of the food preparation can be monitored by designated school staff) however mid-level and local level expertise are needed.

2. On-site meal preparations by employed kitchen staff of school

It is similar to the above, but, the procurement of materials and cooking is done by staff employed by the school.

3. Off-site pre-prepared meal by private food vendor

The food procurement and cooking is done by an authorised private food vendor outside the school premises and brought to the school. The school authority needs to monitor such private vendors hygiene, and the quality and quantity of food provided. If it is not well monitored, disadvantages include monotony of ration; inadequate size/quality to meet food/nutrition deficit; and difficulty in reaching inaccessible areas.

<u>Activity 1</u>

Discuss the interrelationship between the four components of the school feeding service.

NUTRIENT COMPOSITION OF AN ADEQUATE MEAL

Adequate Meal: An adequate diet is one that contains at least one food item from all the food groups (Energy, Body building and Protective food groups). Example of an adequate diet is yam + beans + leafy vegetable + orange or any fruit in season. The vitamins and the minerals are regarded as the protective food groups. It is vital that each nutrient is present in the right amount so that school children would not be malnourished (i.e. undernutrition or overnutrition). Children do not only need enough foods but also enough of the right kinds of food. The requirements for protein and some other nutrients are relatively greater than that of adults and they tend to be at a great disadvantage when these nutrients are not sufficient.

School feeding not only helps to supply the essential nutrients to children's meal but it helps the child to learn good eating habits and good hygienic practices. The school child is at a formative stage and a school feeding programme can help him to grow and also influence his ideas and attitudes towards food. Thus it becomes important to teach them the basics of nutrition through giving daily adequate meals. Thus, school feeding services contribute to basic hygiene and nutritional feeding.

Activity 2:

Participants should brainstorm on how the SFS can be more effective in Nigeria.

Nutrients

Food provides human beings with the energy needed for growth, physical activity and for basic body functions, such as breathing, temperature control, blood circulation and digestion. Food also supplies the materials to build and maintain human bodies and to resist disease. These different functions are made possible by the nutrients contained in food. Nutrients are chemical substances found in food that nourish the body. The types of nutrients in food are carbohydrates, proteins, fats, vitamins, minerals and water. All foods contain one or more of these nutrients in varying amounts.

Table 11.1: Nutrients, food sources and functions

Nutrients and their food sources	Function
Carbohydrate (e.g. bread, yam rice, corn, cassava etc)	Energy giving
Protein (e.g. milk, meat, fish, eggs, cheese, chicken, beans etc)	Body building
Fat (e.g. butter, vegetable/palm oil groundnut oil)	Energy giving
Minerals (e.g. vegetables and fruits)	Protective
Vitamins (e.g. vegetables and fruits)	Protective
Water	Aids digestion, transport and assimilation of nutrients

Source: FME.(2007). National Home Grown School Meal Planning and Implementation guidelines.

Nutritional Deficiency Diseases are diseases that occur when one or more nutrients are not adequately supplied or not effectively utilised in the body. This may lead to certain functional disorders and sometime mal-formations in the body.

Table 11.2: Examples of common Nutritional Deficiency Diseases

Nutrient	Disease
• Protein /energy	• Kwashiorkor, Marasmus
• Vitamin D and Calcium	• Ricketts
• Vitamin A	• Night blindness / Skin disorders
• Vitamin B1	• Beri-Beri
• Vitamin C	• Scurvy
• Iodine	• Goitre, mental retardation
• Iron	• Anaemia, cognitive impairment

Source: Adapted from FME (2007), National Home Grown School Meal Planning and Implementation guidelines.

Vitamins and minerals are called micronutrients. They are needed in much smaller amounts than protein, fat and carbohydrate but are essential for good nutrition. They help the body work properly and stay healthy. Foods with added vitamins and minerals are called fortified foods. Foods are fortified to make sure that sufficient micronutrients are present in them. Examples of commonly fortified foods include fortification of sugar, vegetable oil and flour with vitamin A and fortification of salt with iodine. Fortification of foods is important because micronutrient deficiencies can lead to harmful conditions such as goiter, night blindness etc.

Learners are to be divided into four groups and each group is to draw a weekly time table of examples of adequate school meals using their knowledge of locally available foods and these will be discussed together after.

State of school feeding services in Nigeria

Findings from the survey conducted by the Learning Plus team, show that about 40% of the schools visited had no nutritional services at all and 60% had a feeding programme in which food was sold on site. Food vendors were certified and monitored in only about 25% schools.

SUMMARY

SFS is an essential part of SHP. The school feeding service comprises four components – Nutritional, Feeding, Food procurement and Food inspection services. The aim is to provide sufficient nutrients to school children through provision of in-school adequate meals from locally available sources and to impart healthy eating habits and hygienic practices to school children in their formative years.

EVALUATION

- Define an adequate meal?
- In practical terms how can we make meals adequate both in the school and at home?

MODULE ELEVEN: SESSION 4
SKILLS-BASED HEALTH EDUCATION

TIME: 45 Minutes

OBJECTIVES

At the end of this session, learners will be able to:

- List common health issues or problems among in-school adolescents in their communities.
- Describe the skills-based health education approach.

METHODS

- Class discussions
- Brainstorming
- Demonstration and guided practice
- Role play
- Lecture

MATERIALS

- Skill based health education- teachers' manual and learners' workbook
- Projector
- IEC materials- flyers, posters, charts, story books.

CONTENT

INTRODUCTION

The skills-based approach to health education centralizes on the development of knowledge, attitudes and skills needed to make and carry out positive health decisions. Knowledge is crucial, but not sufficient, to guarantee the adoption and maintenance of health-promoting behaviour. Simply stated, **skills-based health education goes beyond ensuring that people *know* things, to ensuring that people *do* things**. *Knowledge and attitudes prepare individuals to do something. Skills make it possible for them to actually do it.*

ADOLESCENT HEALTH ISSUES/ PROBLEMS IN OUR SOCIETY

Adolescents face peculiar health challenges worldwide. Although some health problems can vary widely from place to place, adolescent health problems are almost universal. These health problems threaten the well-being of adolescents, their ability to stay in school or to work and their health in later life.

Activity 1:

Based on the contents of this manual and the National Policy on the Health and Development of Adolescents and Young People in Nigeria, participants are to identify the major adolescent health challenges or problems in Nigeria (Electronic copies of the policy will be made available to participants).

ACQUIRING SKILLS THROUGH SKILLS-BASED HEALTH EDUCATION METHODS

Skills-based health education relies on **relevant** and **effective** content and **participatory** or **interactive** teaching and learning methods. According to UNESCO, when planning skills-based health education, it is important to consider first the **goals** and **objectives**, then the **content** and **methods**.

1. The **goals** of skills-based health education describe in *general* terms a health or related social issue to be influenced in some particular way.
Example: - To reduce the rate of HIV infection among students.

2. The **objectives** describe in *specific* terms the behaviours or conditions, which if carried out, will have a significant impact on the goals.
Examples: - To ensure that students know how HIV is, and is not, transmitted; students will demonstrate the ability to resist pressure to have sex.

3. The **content of** skills-based health education is a clear delineation of the specific knowledge, attitudes and skills, including life skills, that young people will be helped to acquire so that they can adopt behaviours or create the conditions described in the objectives.

Knowledge refers to a range of information and the understanding thereof while ***Attitudes*** are personal biases, preferences, and subjective assessments that predispose one to act or respond in a predictable manner. ***Skills*** are abilities that enable people to carry out specific behaviours.

The skills referred to in the skills-based approach to health education include-

- ***Practical skills*** associated with specific health behaviours- e.g. competencies in first aid (e.g. bandaging), in hygiene (e.g. hand washing), or sexual health (e.g. using condoms correctly).

- ***Life skills***- a group of cognitive, personal and interpersonal abilities that help people make informed decisions, solve problems, think critically and creatively, communicate effectively, build healthy relationships, empathize with others, and cope with and manage their lives in a healthy and productive manner.

Once the content is delineated, teaching **methods** that are most appropriate to the content are then chosen. For example, lectures are suitable methods for helping students acquire accurate knowledge; discussions are suitable for influencing attitudes; and role plays are suitable for developing skills.

Participatory teaching methods for building skills and influencing attitudes include-

- Class discussions,
- brainstorming,
- Demonstration and guided practice,
- Role play,
- Educational games and simulations,
- case studies,
- Storytelling,
- Debates,
- Practising life skills specific to a particular context with others,
- Audio and visual activities, e.g., arts, music, theatre, dance, and
- Decision mapping or problem trees.

In general, when the goal is to influence student attitudes or behaviours, participatory teaching methods are more effective than didactic (instructive or moralizing) approaches. Interactive or participatory teaching and learning methods replicate the natural processes by which children learn behaviour. These include observation, modelling, and social interaction. Listening to a teacher describe skills or read or lecture about them does not necessarily enable young people to master them. Skills are learned best when students have the opportunity to observe the skills being practiced and then use the skills themselves. It has been argued that if young people can practise the skills in the safety of a classroom environment, it is much more likely that they will be prepared to use them in and outside of school.

FRAMEWORK FOR SKILLS-BASED HEALTH EDUCATION

According to UNESCO, a framework for skills-based programmes should aim at developing competencies in these four areas:

1. Knowledge and critical thinking skills (learning to know),
2. Practical skills (learning to do),
3. Personal skills (learning to be), and
4. Social skills (learning to live together).

The practical skills are the manual skills under learning to do what has been mentioned above and the psycho-social life skills are the skills under learning to know, to be and to live together. A life skill approach to education is one that teaches an essential combination of skills needed in a particular and specific context, both practical and life skills. The framework is shown in figure 1 below and the other three skills- learning to know, learning to be and learning to live together are explained further.

Figure 11.1: A FRAMEWORK FOR SKILLS-BASED HEALTH EDUCATION

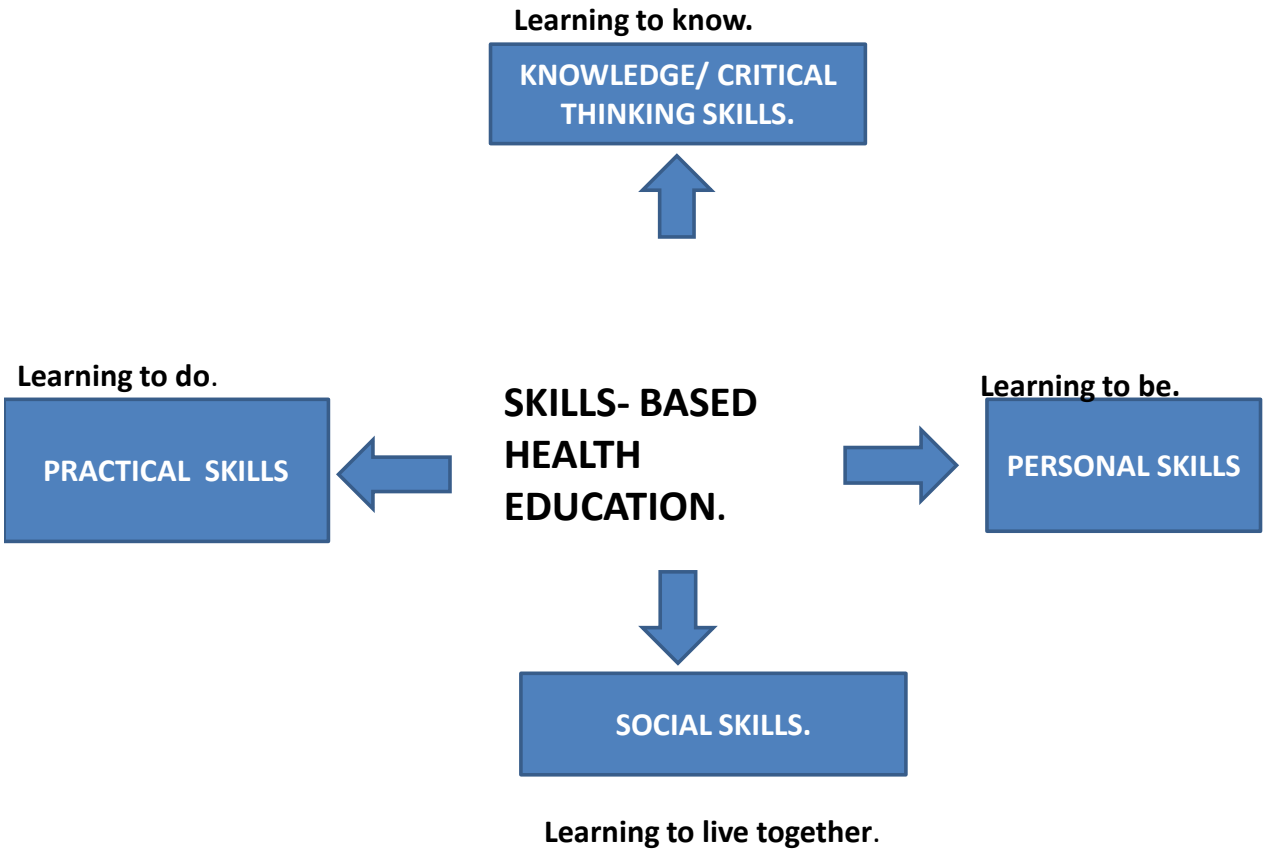


TABLE 11.3: TYPES AND EXAMPLES (APPLICATIONS) OF PSYCHOSOCIAL SKILLS

TYPE OF SKILL	SUB-TYPES	EXAMPLES/ APPLICATIONS
KNOWLEDGE & CRITICAL THINKING SKILLS (LEARNING TO KNOW/ COGNITIVE ABILITIES)	i. Decision making/problem solving skills	Information gathering skills. Evaluating future consequences of present actions for self and others. Determining alternative solutions to problems. Analysis skills regarding the influence of values and attitudes of self and others on motivation.
	ii. Critical thinking skills	Analyzing peer and media influences. Analyzing attitudes, values, social norms & beliefs & factors affecting these. Identifying relevant information and information sources.
PERSONAL SKILLS (LEARNING TO BE/ PERSONAL ABILITIES)	i. Skills for increasing internal locus of control	Self esteem/confidence building skills. Self awareness skills- awareness of rights, influences, values, attitudes, strengths and weaknesses. Goal setting skills. Self evaluation / Self assessment / Self-monitoring skills.
	ii. Skills for managing feelings	Anger management. Dealing with grief and anxiety. Coping skills for dealing with loss, abuse, trauma.
	iii. Skills for managing stress	Time management. Positive thinking . Relaxation techniques.
SOCIAL SKILLS (LEARNING TO LIVE TOGETHER)	i. Interpersonal communication skills	Verbal/Non-verbal communication. Active listening and expressing feelings; giving feedback (without blaming) & receiving feedback.
	ii. Negotiation/ refusal skills	Negotiation & Conflict management. Assertiveness skills. Refusal skills.
	iii. Empathy	Ability to listen and understand another's needs and circumstances and express that understanding.
	iv. Cooperation and Teamwork	Expressing respect for others' contributions and different styles. Assessing one's own abilities and contributing to the group.
	v. Advocacy Skills	Influencing/ persuasion skills. Networking and motivation skills.

NOTE: Though the table suggests that the three categories of 'psychosocial skills' are distinct from each other, health behaviour typically requires the use of a combination of skills simultaneously. For example, to avoid early pregnancy a young woman may need decision-making skills ("what are my options?"), values clarification skills ("what is important to me?"), self-management skills ("how can I protect myself / how can I achieve my goals") and interpersonal skills ("how do I resist pressure to have sex and communicate my decision to others?"). Ultimately, the interplay between the skills is what produces powerful behavioural outcomes.

Activity 2

Case study 1: Femi and Yemi are in a relationship. Yemi is pressurizing him to have sex with her, but Femi wants to wait till they get married in about six month's time. Femi is under intense pressure to yield to Yemi's desires because she is insistent and he has just come to you as a confidant so that he can get some help. Participants are to discuss how they will handle this situation as individuals using the skills based health education approach?

Case study 2: Risikat and Sikirat are roommates who are often at loggerheads and their relationship seems to be like the proverbial cat-rat relationship or the comical Tom & Jerry. Risikat is often the trouble-maker and she has just touched a raw nerve by wrongfully accusing Sikirat of what she has not done and tempers are about to fly. If Sikirat were to possess life skills, how would she handle the situation? Two participants are to volunteer to role-play/ demonstrate this scenario.

Case study 3: A young male student has just lost his virginity inadvertently when he met with a strange lady who came into his life as quickly as she appeared within a six-hour period. He not only regrets the action but he is afraid that he has probably contracted HIV and other STIs. Which skills would have prevented this situation? Which skills would he benefit from now?

SUMMARY

Skills-based health education goes beyond passing across knowledge or information to adolescents to actually empower and equipthem with skills that really enable them to bring about behavioural change. Skills-based health education contributes to the development of attitudes and values that promote respect for oneself and for others, tolerance of individual differences and peaceful co-existence. It results in the adoption of health-promoting habits, such as healthy eating, and reduces risk-taking behaviour associated with HIV/STI infection, unplanned pregnancy, drug and alcohol abuse, violence, injury, etc. Young people who receive quality skills-based health education are more likely to adopt and sustain a healthy lifestyle not only during their school years, but throughout their lives.

EVALUATION

- Compare and contrast the traditional health education that has been taught in our education curriculum for decades with the newer concept of skills based health education?

MODULE ELEVEN: SESSION 5
SCHOOL HEALTH SERVICES

TIME: 45 Minutes

OBJECTIVES

At the end of this session, learners will be able to:

- List the objectives of the school health service.
- List the contents of the school health service.
- Identify common health problems among in-school adolescents.
- Discuss the current state of school health services in Nigeria.

METHODS

- Lecture
- Discussion
- Demonstration
- Field visit/Health screening.

MATERIALS REQUIRED

- First aid box
- School health records
- Flip chart
- Projector

CONTENT

OVERVIEW OF A SCHOOL HEALTH SERVICE

The school health service (SHS) is an important component of the SHP and it provides basic promotive, preventive and curative health services. It is all inclusive and it makes use of skills and capacities within the learners themselves, the school staff and the community in general. The service encourages schools to seek to develop and implement school policies that promote and sustain health, improve the physical and social environment within which children learn and develop and improve their capacity to become and stay healthy. Most of the common conditions of ill-health among school-age children can be managed successfully, through school-based health services.

STATE OF SCHOOL HEALTH SERVICES IN NIGERIA

According to statistics from the National Study of the School Health System in Nigeria by FMOH and FME in collaboration with WHO in 2003,

- 14% of head teachers indicated that pre-medical examination was compulsory in their schools.
- Food handlers were screened in only 17% of schools.
- 80% of schools had First Aid Box.
- 17% of schools had school nurses.
- 6% of schools had linkages with government designated clinics.
- 29% of schools had social welfare services provided mainly by community based organizations.

In terms of the health status of students, the same study stated that-

- 30% of students had low Body Mass Index (BMI).
- 0.2% of students had lice on their heads.
- 3% of students had skin rashes.
- About 20% of students did not have normal visual acuity.
- Dental plaque was observed in more than 10% of students.
- About 19% of students did not have normal hearing.

From the Learning Plus team, 25% of schools had sick bays, but they lacked essential equipment. Most schools had first aid kit, though several of these also lacked essential items.

The objectives of the school health services are to:

- Provide basic services for disease prevention and management of injuries in the school.
- Build capacity of the school community to identify, treat, and manage simple illnesses, injuries, infections and infestations.

CONTENTS OF THE SCHOOL HEALTH SERVICE

A. **RESOURCES**

- **Personnel** - The school health nurse is the principal health personnel of the SHS. He/she is a person that has been trained and/or gained experience in matters pertaining to the health of school children. Ideally, every school should have a school health nurse who can work in concert with other visiting health workers such as physicians, physiotherapists and dentists, and also with school staff, students and members of the larger community to appraise, protect and promote the health of members of the school. The school health nurse must establish links with health facilities in the locality and must know when to refer and who to refer a sick student to when the need arises. She has the responsibility to take sick students and staff to where they can access care that is not available within the school. Many schools improvise with auxiliaries instead of a trained nurse and other schools appoint a teacher who already has teaching responsibilities to oversee the health of students and staff, but, this is not ideal.

- **Facility** - School Health Clinic/ Sick Bay
  The school health clinic or sick bay should be sited on the school premises and its location must be central and easily accessible to students and staff. It must operate everyday during school/boarding hours. It should have a constant and regular supply of drugs and consumables according to the prevailing diseases in the community as well as provision of safe water, means of sterilization of equipment and instruments and provision of safe disposal of medical waste. Many schools in Nigeria lack school health clinics or sick bays.

- **Equipment** - First Aid Box and other medical equipment or materials.
  The minimum any school should have is a well equipped and functioning First Aid Box that should contain: Tincture of benzyl chloride (TBC), savlon or dettol , Methylated spirit, crepe bandage , plaster, cotton wool, small scissors, paracetamol, gauze, gentian violet, glucose, etc. Other important equipment include: thermometers, weighing scales, equipment for measuring heights, stethoscope, sphygmomanometers etc. Other medical consumables are also important. Most schools have a First Aid Box, but, a perennial challenge is how to maintain the box in terms of supply of materials.

- **Health records for students and staff**- It is very important for health records of both students and staff to be kept properly. The health record should contain personal and family history, history of past illnesses/hospitalization with relevant information on treatment received and whether follow-up is necessary and being carried out, results of teacher's routine observations, records of immunization, records of screening tests, records of heights and weights taken at regular intervals. Anthropometric indices such as weight for age, weight for height and height for age of all students should be taken and kept in each individual's record. Student health records are a source of important information for education authorities on needs, trends and the impact of health issues on educational outcomes. Without such information, it is difficult to determine priorities or evaluate strategies for future planning. Health records of staff and students just like that of any other group or individual can also be used for medico-legal reasons in law courts.

B. **SERVICES**

- **Medical Inspection/ Routine Medical Examination:** Class teachers should be encouraged to carry out regular medical inspection of their students. It does not require any special training or expertise for teachers to be able to identify basic hygiene or health problems like poor oral hygiene, uncut nails, a rash, a wound that doesn't heal in time, fever, laboured breathing etc. It is important that all students have an extensive pre-entry medical examination, the records of which should be properly kept and this should be followed with regular or routine periodic examination. A pre – employment medical/dental examination should also be conducted for all other members of the school community including food handlers. Pre – entry medical screening should be done by trained health personnel. Routine, periodic medical examination is designed to detect defects that require medical attention. The medical examination also provides the opportunity of discussing with parents and teachers the health problems and needs of the children. It includes screening for defects of hearing and sight. The school examination will ascertain whether the child is fit to take part in school activities, including sports.

- **Assessment of children with special needs:** The school health programme must include some mechanism for finding children who are physically or mentally challenged, assessing them, supervising them and placing them in the most appropriate institution if special care is indicated. The main categories of children with special needs are the blind and the partially sighted; those with a defect in hearing and/or speech; epileptic; educationally subnormal; maladjusted and psychotic or other physical challenges. Apart from routine screening done by school teachers, there is a great need for certain levels of screening to be done by health professionals periodically and some of such screenings will include visual, dental or oral health screenings.

- **Treatment of common ailments and injuries- use of the First Aid Box**: The major reason for the establishment of the SHS is the provision of basic health services to students and staff of the school. The SHS is not meant to be run as a specialist clinic, but it is to provide limited primary and immediate (emergency) care to the sick or the injured within the school setting. As many teachers and students as possible should be trained in first aid and should have access to the box if the health personnel is not available. A First Aid Box can be kept in the sick-bay or in the Head-teacher or Principal's office if a sick-bay is not available. Apart from use of the First Aid Box, other services commonly rendered by SHS include initial treatment of fever, regular deworming of children and immunization in partnership with the National Primary Health Care Development Agency (NPHCDA).

- **Referral services/ partnership with health teams, NGOs etc.**
  A system should be established to effectively link students, school staff and families to community-based providers. Pre–identified (near-by) health facilities and pre-identified means of transportation should be used as much as possible. When a health problem is suspected or detected, schools should provide parents, or the young person him/herself with practical information about appropriate and accessible providers that can be of assistance. The school can also offer to make an appointment for the child or young person with a provider with whom the school has established a relationship. All referrals should be followed up. Schools can also partner with non-governmental organizations, the Local Government Area health department etc in

various ways to promote the health of students and staff. In recent times, schools have been in active collaboration with the National Programme on Immunization (NPI) for immunization of school children.

Activity 2

Learners are to visit a public and a privately funded secondary school and are to-

1. Examine and comment on the resources of the SHS available in both schools.
2. Carry out a health screening exercise (routine medical/ dental examination) on students of selected classes or the whole school with the help of school teachers.

SUMMARY

The SHS is another essential component of the SHP and it provides basic promotive, preventive and curative health services. It makes use of resources such as the school health nurse and other health workers, students and staff of the school; the school health clinic or sick bay; medical equipment and materials such as a well equipped First Aid Box and school health records to meet basic and immediate health care needs of the school community. Some of the services usually provided include pre-entry and routine medical examination or health screening, treatment of common ailments and injuries, deworming and immunization programmes, referral and follow-up services etc. All stakeholders including government at all levels as well as the private sector, school authorities, parents and the community in general must play their roles so that the noble ideals of the SHS will be achieved.

EVALUATION

- What is the relevance of networking or cooperation between schools, between schools and parents, schools and communities, schools and governments in the delivery of basic health services to schools?

MODULE ELEVEN: SESSION 6
SCHOOL, HOME AND COMMUNITY PARTNERSHIP

TIME: 45 Minutes

OBJECTIVES

At the end of this session, learners will be able to:

- Identify ways of promoting relationships between the school and community.
- Identify roles and responsibilities of communities in SHP.
- List activities that can promote the relationship between the school and the host communities.

METHODS

- Lectures
- Brainstorming
- Role play
- Discussion

MATERIALS REQUIRED:

- Policies- SHP& Implementation guidelines
- Flip chart/markers
- Projector
- IEC materials- flyers, posters, charts, story books and other teaching materials.

CONTENT

THE IMPORTANCE OF COLLABORATION BETWEEN SCHOOL, HOME AND COMMUNITY

Schools operate within communities, which comprise individuals, groups and institutions. Learners and staff in schools come from homes located in the communities. Collaboration between schools, families and the community where schools are located is thus important to optimally achieve the goals of school health programme.

The success of the SHP depends on the extent to which community members are aware of, and willing to support the efforts of the school. Schools have a lot to gain by collaborating with communities where they are located. When a school is an integral part of a community, there is enhanced academic performance, less violence, fewer discipline problems, higher staff morale, and improved use of resources. For communities, collaboration with schools can strengthen the fabric of family and community life because schools can play an important role in improving the health and development of the community as a whole. It therefore becomes imperative for schools to actively encourage parents and community members to make inputs regarding the design, delivery, content and assessment of the SHP so as to respond to their concerns and obtain their commitment.

Activity 1

Participants should brainstorm on the benefits of collaboration among the School, the Home and the Community.

PROMOTING RELATIONSHIP BETWEEN SCHOOL AND COMMUNITY

We have been able to establish the need for a strong mutually benefiting relationship between the school and the community. Schools need to identify with the communities wherein they are located and oftentimes they have to be the first to extend the hand of fellowship to the community. People in most communities have a vested interest in schools located within their communities because they have their children and other friends or relatives there. School authorities can take advantage of this 'bias' by involving the community in all their efforts to promote the health of students and staff. School authorities can do this through the processes of advocacy, community mobilization and participation and capacity building. There must be a continuing effort to secure meaningful involvement of the community in the planning, implementation and maintenance of the school health programme. To achieve this, there is a need for a school health team or school based management committee (whose efforts are to be complimented by a community based school health team or community advisory committee). In some institutions both the school based and the community based school health team are combined to form a single committee while in others they are separate but work together to achieve common goals.

AREAS OF COLLABORATION AMONG SCHOOL, HOME AND COMMUNITY

The school, the home and the community can collaborate in several areas, some of which include:

1. Health
2. Education
3. Social services

4. Work, career
5. Recreation
6. Neighbourhood/ community improvement
7. Juvenile justice.

Activity 2

Learners are to brainstorm on various ways by which the school, the home and the community can collaborate in the first three areas listed above.

ROLES AND RESPONSIBILITIES OF SCHOOL-BASED MANAGEMENT COMMITTEE AND COMMUNITY MEMBERS IN SCHOOL HEALTH PROGRAMME

As stated above, there is a need for an SBMC and a community-based committee (CBC) which may or may not be merged if the goals of the school health progamme are to be realized. The SBMC takes the lead and is made up mostly of teaching staff and students. Other members may include- school administrators e.g. principal or vice principal; at least one parent; a local nurse or health care provider from the school or the community; a food service provider; Parents Teachers' Association representative; and leaders of teachers' representative organizations e.g. Nigerian Union of Teachers.

The roles and responsibilities of the SBMC include:

- Providing leadership in developing a shared vision and an action plan for the SHP or other health promotion efforts that school officials can accept and support.
- Working with parents to identify needs, solicit ideas and encourage involvement.
- Working with the community representatives or CBC.
- Leading or coordinating plans to provide information to school staff and community members and to arrange for training.
- Establishing links with district education personnel, local health officials and provincial or national network or ministry-level staff.
- Keeping good records of all health related events.

The **Community Advisory Committee** or **CBC** complements the SBMC. It is made up of leaders in the wider community who understand the health related issues affecting the community and school or who have access to resources that can contribute to health promotion. Committee members can broaden the impact of health promotion efforts, improve health services and reinforce relationships between the school and the community at large.

Membership can be drawn from but not limited to the following fields or groups-
Healthcare (nurses, clinic workers, physicians, public health staff), Families and youth, Labour /trade unions, Women's groups, Proprietors of private institutions, Local government officials, Traditional institutions, Religious institutions, Recreation, Arts and crafts, Banking, Sanitation/public works, Law enforcement, Local businesses, Transportation, and NGOs, charities, development organizations. It is not compulsory that members from all these be members of the CBC.

The roles and responsibilities of the CBC include:

- working with the SBMC to advocate for health promotion of school staff and students with leaders, staff and members of their own organizations and agencies;
- reaching into all parts of the community, sharing information about the health-promoting activities taking place in schools and building support for the work;
- encouraging additional community groups to express their views and become involved in health issues;
- helping to identify potential strengths in the community and obtain resources for project activities; and
- helping to assess health problems and opportunities that affect health in the Community.

Activity 3

How can community representatives or CBC help in the implementation of an effective School Health Programme? Discuss.

Activities promoting environmental and behavioural change among members of the school and neighbourhood communities

1. Home visits by teachers, school nurses and social workers.
2. Regular visit of parents to school.
3. Regular communication of the health status of the learner to the home by the school health personnel and the teachers.
4. Regular communication of the academic performance of the learner to the home by the school health personnel and the teachers.
5. School initiated environmental sanitation in designated parts of the community especially around schools.
6. Active participation of the school in community outreach activities and campaigns.
7. Active participation of the school in community health planning, implementation, monitoring and evaluation.
8. Advocacy and community mobilization for the SHP through traditional and modern media.
9. The community shall be involved in the promotion of health related school policies.
10. Schools shall involve the homes and communities when formulating school health policies as collaborators in its implementation.
11. Schools shall mobilize community resources in the design and execution of school health projects e.g. using artisans and professionals from the community in executing school projects as well as available local materials.
12. The home and community shall be involved in decision making on matters relating to the health of the school community through stakeholders meetings.
13. Parents shall be encouraged to participate in school-based management activities as members of PTA executive and school-based management committee in charge of various schools projects activities.

Activity 4

Learners are to role-play as students, teachers and parents. Some learners are to act out the roles of teachers on a home visit to the houses of their students to meet with the parents of the students on key issues affecting the students.

Key elements of effective school-community collaboration

1. Vision- shared visions and goals.
2. Policy support: School- Community collaboration must be backed up by relevant policies and adequate steps to implement them must be put in place.
3. Formal agreements between school and community including well- defined working relationships with well stipulated roles so as to avoid confusion.
4. Shared governance (power, authority, decision-making and accountability) -Shared decision making involving school staff, students, families and community representatives.
5. Capacity building especially for both school based management committee members and community members.
6. Systemic changes may be required in leadership, planning, implementation, and accountability.
7. Evaluation mechanisms to assess the effectiveness of the collaboration must be put in place.

The CBC and SBMC are vital to establishing and sustaining the relationships between the school, the home and the community. There is a great need to put them in place in all schools and enlist their support for health promotion in the school, the home and the community. The government should put in place policies that will encourage collaboration between schools and communities and institutionalize school based management committees and community based committees in all schools.

Activity 5

Learners are to list the barriers to building effective school-community collaboration.

SUMMARY

For the school health programme to succeed, the home, the school and the community must be involved. There is a great need for collaboration between the home, the school and the community. The school and the community have a lot to share in many aspects especially in the areas of health, education and other social services. It is important to put in place SBMC and CBC who are to work together to implement the goals of the SHP in each school.

EVALUATION

- As a stakeholder, what can you do to contribute positively to the development of a functional SHP in your community?
- Itemize activities that can contribute to the development of healthy school, community and home relationships in your community?

MODULE TWELVE
COMMUNICATION AND ADVOCACY INTERVENTIONS

This module is divided into five sessions. It is designed to help participants acquire communication and advocacy skills to facilitate and promote adolescent reproductive health and developmental issues. It is expected that at the end of the training, participants would understand and be able to apply basic communication and advocacy strategies in counselling.

SESSION 1: INTRODUCTION TO BASIC COMMUNICATION SKILLS IN COUNSELLING

SESSION 2: OVERVIEW OF ADVOCACY

SESSION 3: USING ADVOCACY TO STRENGTHEN ADOLESCENT REPRODUCTIVE HEALTH PROGRAMMES

SESSION 4: THE PEER EDUCATION APPROACH TO ARH

MODULE TWELVE: COMMUNICATION AND ADVOCACY SKILLS
SUMMARY AND TIMING ESTIMATE

SESSION TITLE	DURATION	OBJECTIVES	METHODS	RESOURCES
Introduction to Basic Communication Skills in Counselling	2 Hours	• Explain the meaning and qualities of effective communication. • Describe types and divisions of communication. • Explain the purpose of effective communication. • Describe the process of effective communication. • Recognize barriers to effective communication. • Identify and select appropriate channels for effective communication.	Brainstorming Lecture Group-work Whispering Game	Flip Chart Stand/paper Chalk Board/chalk Flip chart paper/Chalk Markers Tape Paper (possibly three colors) Samples of IEC Materials Posters Leaflets Video tapes VCR/TV
Overview of Advocacy	1Hour	• Explain the concept of advocacy in Adolescent Reproductive Health programming. • List the steps in advocacy process. • Describe the characteristics and qualities of a good advocate.	Brainstorming Lecture Group work Game	Flipchart and stand/paper Chalkboard/chalk Markers Tape Paper (possibly three colors) Samples of advocacy materials
Using Advocacy to Strengthen ARH Programmes	1 Hour	• Identify specific tools for effective advocacy in ARH programmes. • Demonstrate skills in the use of advocacy tools. • Monitor and Evaluate advocacy activities.	Brainstorming Lecture Role play Discussion	Flip Chart Stand/paper Chalk Board/Chalk Markers Tape Samples of advocacy materials/evaluation tools
The Peer Education Approach to ARH	1 Hour 30 Minutes	• Define peer education. • Explain the importance of peer education. • Describe the processes involved in selection and training of peer educators. • Roles of peer educators • Discuss advantages and limitations of peer education system. • Identify ways of building support for a peer education in the community.	Brainstorming Discussion Lecture Role play	Flip Chart Stand/paper Chalkboard/ Chalk Markers Tape Video tape on Peer Heath Education VCR/TV

MODULE TWELVE: SESSION 1
INTRODUCTION TO BASIC COMMUNICATION SKILLS IN COUNSELLING

TIME: 2 Hours

LEARNERS' OBJECTIVES

At the end of the session, participants will be able to:

- Explain the concept of effective communication.
- List the qualities of effective communication.
- Describe types and divisions of communication.
- Explain the purpose of effective communication.
- Describe the process of effective communication.
- Recognize barriers to effective communication.
- Identify and select appropriate channels for effective communication.

SESSION OVERVIEW

- Definition of communication
- Types of communication: Verbal and Non- Verbal, Mass Media, Intra-personal, Interpersonal
- Purpose of communication
- Process of communication
- Skills and rules for effective communication
- Barriers to effective models of Communication
- Overcoming barriers to effective communication
- Channels of communication
- How to select appropriate channels for effective communication.

METHODS

- Brainstorming
- Game [whispering down the line]
- Lecture
- Group work
- Role play

MATERIALS

- Flip Chart Stand/paper
- Chalkboard/Chalk
- Markers
- Tape
- Paper (possibly three colors)
- Samples of IEC Materials: Posters, leaflets, handbills.

- VCR/TV/video tapes

***CONTENT*DEFINITION OF COMMUNICATION**

Communication can be defined in any of the following ways:

- The expression of thoughts and ideas/making known one's ideas or feelings to another person or group of persons.
- The attempt at trying to establish commonness/understanding between and among people.
- A two-way process of establishing understanding/making known thoughts, ideas, etc between one person and the other.

TYPES OF COMMUNICATION

1. **VERBAL** - Through spoken word.
2. **NON VERBAL** - Facial expressions, gestures, nods, smiles, sign language.
3. **MASS MEDIA** - Passing information to a large and, diverse audience through some specialized media.

Communication can also be subdivided into intra-personal and interpersonal:

- **INTRA-PERSONAL** Communication within oneself
- **INTERPERSONAL** Face-to-face, verbal and non-verbal exchange of information, ideas, etc.

PURPOSE OF COMMUNICATION

Communication can be used for:

- Information: to define, explain; demonstrate new techniques/ innovation or knowledge.
- Education: to deepen understanding or teach new skills.
- Persuasion: to convince, change attitudes, beliefs, values, seek commitment.
- Motivation: to get people to change and act on new ideas.
- Promotion: to heighten awareness of people, product and organization and foster good relationship, etc.

COMMUNICATION PROCESS

Communication process is dynamic and can change over time. Communication is often done unconsciously reflecting on past experiences, what is currently happening and what will happen in the future. It has to be improved upon to have the necessary impact. The following components are essential for effective communication and are usually represented by the acronym " MSCREFS".

M - Message
S - Source/Sender
C - Channel
R - Receiver
E - Effect

F - Feedback
S - Setting

Message: This is the content of the information, the idea or thoughts the sender passes on to another person or group of persons. For a source to succeed in passing across his/her message effectively, she/he must use a code/symbol understood by the target audience. Secondly, the message must be timely, meaningful and applicable to the situation.

Source/Senders: This is the person passing on a piece of information or message. She/he is the originator of the message. Several factors influence how a source operates in the communication process. These are:

- Communication skill;
- Attitude towards his audience, and the subject on which he is communicating; and
- Knowledge of the subject, the audience, the source itself, and other background factors, which influence in the way he/she operates.

Channel: This is the path chosen for the transmission of the message. Different channels appeal to different senses e.g. television appeals to sight and sound, radio appeals to sound only, newspapers, flipcharts, and other written channels appeal to sight only. The appropriate channel must be used to give the message.

Receiver: The person who gets the information is the receiver. The receiver is the targeted audience. The sender must know who they are and prepare the message the way they will understand it.

Effect: The impact of the message on the receiver is called the effect. Sometimes the intended effect is not received because of style of presentation. There are times when the communicator has something in his/her mind (latent content) and ends up saying a different thing (manifest content). When he/she is able to say clearly what he means, he/she may end up achieving effective communication.

Feedback: What the receiver ends up doing as a result of the message he/she receives is called feedback. It is the assessment of the impact of the message. A feedback can either be positive or negative. It is positive if the receiver does react as expected by the sender. If he/she does what is not intended, the feedback is negative. The responsibility for getting a feedback belongs primarily to the sender and this can be facilitated through the use of role-plays, audio-visuals, and animation.

Setting: This is where communication is made. It could be in an office, clinic, bedroom, lecture hall etc. The setting of a communication influences the message and style of presentation.

Table 12.1: CHANNELS OF COMMUNICATION

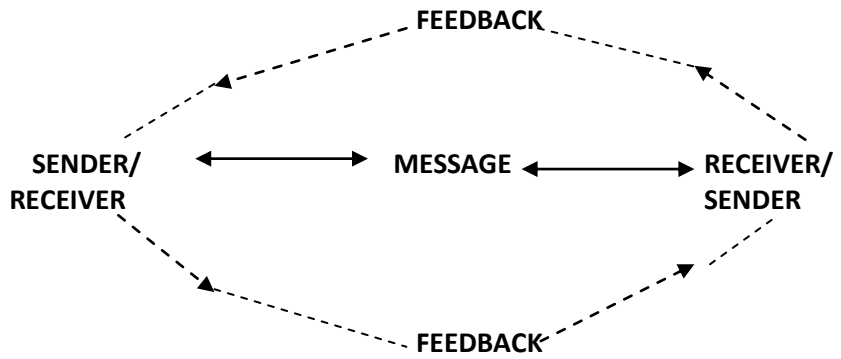
CHANNEL	EXAMPLES	ADVANTAGES	DISADVANTAGES
Interpersonal	Person-to-Person	• Probably most influential widely used channel. • Addresses individual needs. • Powerful in counteracting rumors, negative ideas, beliefs and in supporting positive actions. • Can be used with other media.	• Time consuming. • Attention to message design and delivery.
Indigenous media	Folk drama, song, dance,town crier, puppetry, other theatre.	• Uses traditionally acceptable forms. • Health messages can be put in place in a familiar context. • Can be developed by local groups.	• May reach relatively small audience. • May not be available when needed. • Too few trained experts.
Print	Pamphlets Booklets Manuals Flipcharts Posters, Stickers, flyers, newsletters annual reports, fact-sheets.	• Supports and reinforces interpersonal communication. • It is eye-catching and easy to read. • Can be passed to others within the target audience. • Can help health workers provide accurate, standardized information. • Can be produced locally. • Reusable .	• May not be cost effective. • Often used out of cultural and educational context. • Posters can be damaged easily. • Low suitability for non literate audience.
Newspapers	Literature, Articles, letters to editor.	• Provides timely information. • Distribution systems already in place.	• May have limited rural distribution. • May not be useful to an illiterate audience. • Affordability.
Radio and television	Spots, Jjingles, programmes, interviews, drama Questions and Answers	• Authoritative sources. • Reaches wide audience. • Can complement other media, especially print and interpersonal communication. • Used in promoting community dialogue.	• Difficult to co-ordinate media and service delivery. • Difficult to tailor programmes to specialized audience. • Providing feedback may be difficult. • May not be cost effective. • Lack of receivers in some areas. • Needs power supply.
Other channels	CD/VCD/DVD/ TV Overhead Projector, Internet, SMS	• Appeals to sight and sound. • It is eye-catching and can be used for demonstrations. • Supports and reinforces interpersonal communication.	• Access to films on relevant issues may be difficult • Costly to acquire hard wares • Needs power supply • Requires skill to operate it.

COMMUNICATION MODEL

There are many models of communication. However the most effective model is participatory communication model.

PARTICIPATORY COMMUNICATION MODEL

Figure 12.1



This model is an improvement on other models, because it has an element of feedback.

In this model, the sender and the receiver operate on the same level as the sender encourages the receiver to act. It implies that the receiver can also act as an effective sender, not just a passive receiver/beneficiary. This process encourages active involvement of both the sender and the receiver, which enhances informed decision-making. And since counselling is about taking informed decisions, this model is most suitable for effective counselling. Counsellors should always strive to have participatory relationship with their clients.

EFFECTIVE COMMUNICATION

Effective Communication is achieved when the intended message from the source gets to the intended audience as packaged, void of distortions. The following skills are necessary for effective communication

The source must:

'KISS' the message. In this context, KISS means

K - Keep
I - It (that is, the message)
S - Simple &
S - Sensible/Straight

- To be effective, communicators must use language that can be understood by everybody.
- They must rid their presentations of clichés and jargons that their audience cannot understand and therefore, use direct and active words. Also, the use of long sentences and phrases should be avoided where short ones will do.
- Know audience's background, interests and language.

- Have good manner of speech in terms of coherence, presentation and use of gestures/expressions that animate the scene.
- Accord respect to the receiver.
- Establish rapport.
- Be a good listener.
- Use appropriate medium/channel e.g. IEC materials.

The Message must be

- Clear
- Timely
- Meaningful
- Applicable to the situation

Channel

- Must be devoid of distractions (clear)
- Accessible

Receiver

- Must overcome his/her own barriers (This area is explained explicitly in the barriers to communication**).**

Always Evaluate

- Ask yourself if you have gained the audience's attention, understanding, and acceptance in order to achieve action and desired results.

Know that

- Important ideas have no use, unless communicated.
- Skills in communication have no use without important ideas.

RULES FOR EFFECTIVE COMMUNICATION

Basically, there are seven rules for effective communication known as the "7Cs" of Communication.
These rules are:

- Command Attention.
- Cater for the head and the heart.
- Clarify the message.
- Convey a benefit.
- Create trust.
- Convey consistent message/theme.
- Call for action.

Command Attention

To do this, the communicator must use codes and symbols, which attract the interest of the audience while remaining sensitive to the dictates of the environment in which s/he is operating. For example, before a poster could be noticed by the audience, it must be clear, bold and colourful. Nothing is as ineffective as an unnoticed message.

Cater for the head and the heart

A message that arouses emotion is most effective in moving people in that people learn better when their emotions are aroused. Emotional appeals can be employed in drama, folklore, music and the like. Their strength lies in their staying power. They have lasting effect on the audience long after the emotion has cooled down.

Clarify the message

The message should convey a single important theme/point. Multiple themes can cause confusion known in communication parlance as 'Information Overload'. This is a situation where the audience has so much information to act on as a result of which s/he becomes confused or distracted.

Convey a benefit

People need a strong motive to compel them to change their behaviour. Many a time, their best motivator is the expectation of personal benefit(s). In trying to convince people therefore, make your presentation in such a way that they will see how they stand to gain from the idea/product or concept you are passing across to them.

Create Trust

Before people expose themselves to, and act on an innovation, they usually look for people they can trust (i.e. credible people) to convey the new ideas to them. If a promise of a future benefit does not come from a credible personality or source, people will not believe it; consequently always use models the audience will trust.

Convey Consistent Theme/Message

Reception is essential: it gives legitimacy to message. A message repeated many times over even with variations but with consistent themes tend to become more familiar and the audience can understand and recognize it effortlessly. Therefore it is more effective.

Call for Action

It is not just enough to convey a message; the audience must be told what to do. Once convinced that the promised benefit is worth pursuing, people need to know where to go and whom to call. For instance, a message advising people on good reproductive health culture should inform people of where to get services as well.

Note: Trainers should demonstrate these skills and rules by placing posters before participants and ask them to assess the best in terms of boldness and clarity of messages and themes.

BARRIERS TO COMMUNICATION

Often times the intended message from the source does not get to the audience/receiver as packaged. Along the line there could be barriers or distortion. Barriers tend to inhibit communication leading to misunderstanding, lack of response or giving of wrong response resulting in conflict. This can occur at any point in the communication process: between sending and receiving and understanding the message; and between understanding and accepting or acting on the message. Generally, there are four basic types of barriers, which affect the communication process.

Physical barriers: These are usually environmental factors, which disrupt or prevent the sending and receiving of messages, i.e. physical distance, distraction, noise, heat, competing messages, etc. This category also includes the physical disability of either the sender or receiver, e.g. being visually or hearing impaired, sleepy, tired, ill.

Personal barriers: These include social and psychological factors, which involve judgments, emotions and values held by both the sender and the receiver. Frequently we see and hear what we want to; we consider the source and reject or accept the message. Personal barriers include bias, suspicion, rumour, customs, taboos etc.

Semantic barriers: These arise from different meanings and uses for words, symbols, images and gestures, as well as differences in verbal and visual literacy. Visual literacy is defined as the individual capacity to extract the intended information or message from a photo or illustration.

Structural barriers: These include social, political and economic barriers, which may affect how the message is transmitted and received, who has access to it or controls its use. As senders/receivers, we need to be aware of the role we personally play in contributing to communication breakdown. Consider the following barriers, which may affect the way messages are sent and received.

OVERCOMING COMMUNICATION BARRIERS

Often times we assume people have the same perception as we do. However everyone has a unique set of experiences, therefore, no two people can possibly share an identical view of reality. Our experiences influence how we see things and how we interpret situations. To be able to overcome communication barriers, the art of giving and receiving feedback must be used.

Guidelines for giving effective feedback

- Be descriptive rather than judgmental: state what happened and not your opinion of what is right or wrong.
- Be specific rather than vague. Give details, do not generalize.
- Address behaviour the person can do something about. What does the person have to do differently?
- Give feedback on one on one as appropriate so that the person can speak freely.
- Be timely- give feedback immediately after the occurrence.
- Be sure that what you say is clear and understood by the person receiving the feedback.

Guidelines for receiving feedback (from the client)

- Listen openly without putting up defenses.
- Make sure you understand what he/she is saying. Give your interpretation of what the other person has said.
- Appreciate the fact that the person is providing you a feedback.
- Seek the person's opinion on the issue.
- Take action to resolve the problem.

CHOOSING APPROPRIATE CHANNELS FOR EFFECTIVE COMMUNICATION

Even if all barriers have been removed, communication can still fail without good presentation. The use of appropriate channels will ensure that presentations achieve desired effect on the audience because communication scholars have established that no single channel of communication is 100 percent in carrying messages across. This is because PEOPLE REMEMBER:

- 10% of what they read.
- 20% of what they hear.
- 30% of what they see.
- 50% of what they see and hear.
- 70% of what they say and write and.
- 90% of what they say as they perform a task.

ACTIVITY

The Whispering Game

Whisper a long statement to somebody and ask him/her to whisper to the next person. Let it continue up to 10 persons and ask the last person what he or she heard. Compare this with the original message. Identify distortions if any and wrap up. Note that messages need to be simple and straightforward, and secondly, that distortions are likely to occur when messages have been transmitted through many individuals.

SUMMARY

Communication is a process. It helps to inform, educate, persuade and motivate. It also helps to promote ideas and products. Communication can be verbal, non-verbal or through the mass media. Channels of communication include print and electronic media as well as interpersonal and intra-personal. There are barriers to communication, but these can be easily overcome through the use of appropriate channels.

EVALUATION

- Identity the types of communication .
- Mention the barriers which hamper effective communication.
- Identify channels of communication.
- Define the process of effective communication.

MODULE TWELVE: SESSION 2
OVERVIEW OF ADVOCACY

TIME: 2 Hours

LEARNERS' OBJECTIVES

By the end of the session, participants will be able to:

- Explain the concept of advocacy in Adolescent Reproductive Health programming.
- State the steps in the process of advocacy.
- Describe the characteristics of a good advocate.

SESSION OVERVIEW

- What is Advocacy?
- Definition of Advocacy.
- Purpose and objectives of Advocacy.
- Advocacy and related concepts.
- Understanding steps in the advocacy process.
- Rationale, Components and Activities of each step in the advocacy process.
- Highlights of characteristics and qualities of a good advocate.

METHODS

- Brainstorming
- Lecture
- Group work
- Game

MATERIALS

- Flip Chart Stand/ paper
- Chalk Board/Chalk
- Markers
- Tape
- Paper (possibly three colors)
- Samples of advocacy materials
- Projector
- Computer

CONTENT

DEFINITION OF ADVOCACY

Advocacy is the act or process of influencing policies, laws and programmes, norms and values in supporting a cause or issue. An advocacy campaign is a set of targeted actions in support of a course or issue. We advocate a cause or issue because we want to:

- Build support for that cause or issue;
- Influence others to support the cause or issue; and
- Try to influence or change legislation that affects the cause or issue.

Purpose and Objectives of Advocacy

In Adolescent Reproductive Health, as in other spheres of life, advocacy can be used to bring about a lot of transformations. These transformations can be in policies, laws and statutes that impinge on the young ones' Reproductive Health and Rights. Parts of areas where advocacy is commonly used are stated below:

- Campaign against child/gender preference;
- Promotion of legislation against Female Genital Mutilation;
- Campaign against all forms of child abuse; and
- Provision of Youth Friendly Services.

ATTRIBUTES OF A GOOD ADVOCATE

To succeed in advocacy, one must have certain attributes:

- Dedication to community work and ARH programme;
- Being accessible to the people whose lives s/he is trying to change;
- Ability to bring people together in coalitions and network. The action-song in this area is TEAM, that is, Together Everyone Achieves More;
- Possessing leadership qualities and can recognize/nurture such qualities in others;
- Having tolerance and can persevere in the face of problems.

THE ADVOCACY PROCESS/PARADIGM

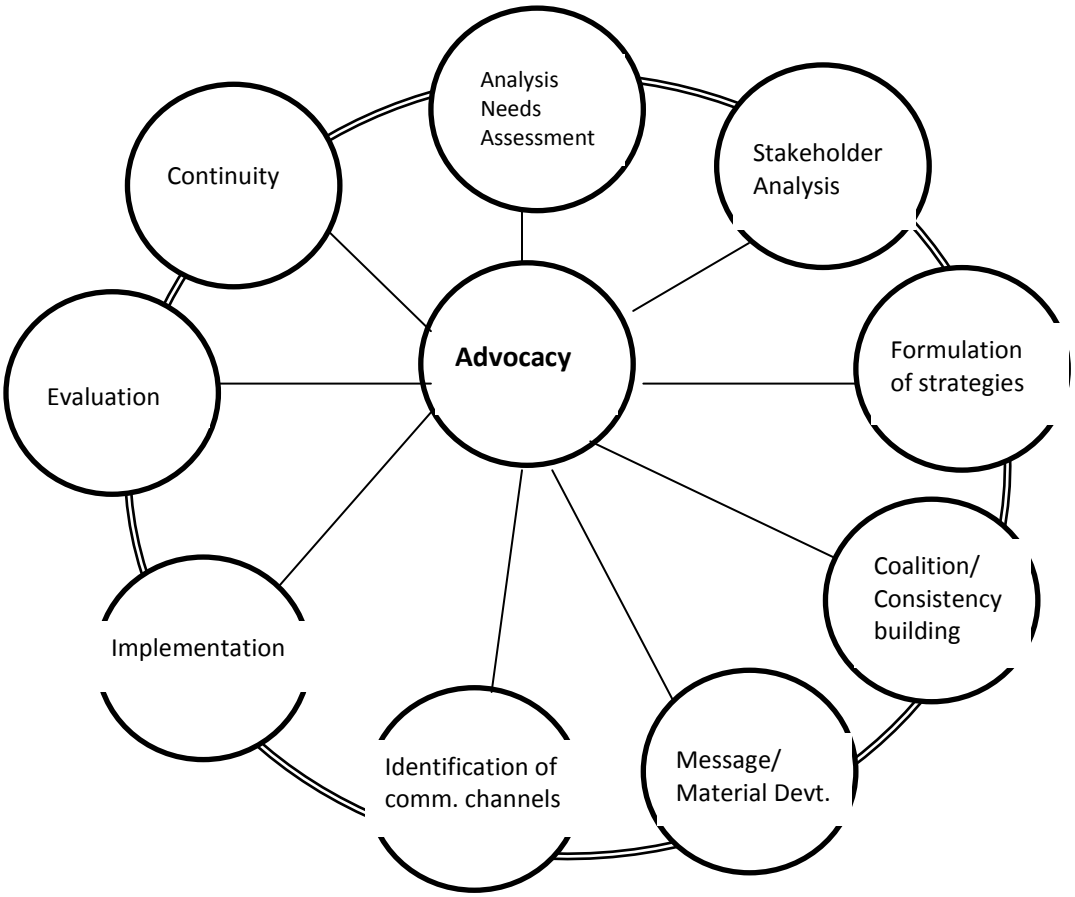
Advocacy is a dynamic and multi-faceted process. There are many stages in the process but these stages vary according to advocate's mission and circumstance.

The stages in the process include:

- Needs Analysis
- Formulation of Strategy
- Coalition/constituency Building
- Message Development
- Communication Channels Identification
- Implementation of Activities
- Monitoring and Evaluation
- Continuity and Sustainability

The stages are shown in the diagram below.

Figure 12.2



The above diagram is not exhaustive as some stages include data collection, formulation of goals and objectives separate from strategy formulation. Some advocacy may include fund raising, but as explained earlier, what is included is dependent on the mission and circumstance.

Step 1: Needs Analysis

The first step in the process is the Needs Analysis. At this stage you assess the problem/issue at stake or analyse the problems confronting the people whose lives you are trying to change. Without a thorough assessment and knowledge of the issues and the people involved, an advocate cannot succeed in carrying out any meaningful task. This stage is also called the **Issues/Agenda Stage.**

In setting the agenda, the would-be advocate needs to ask and seek answers to the following questions:

- What is the problem?
- What is the magnitude of the problem?
- How can the problem be solved?
- When will the problem be solved?
- Who can solve the problem?

Step 2: Conduct Stakeholders Analysis

Closely linked to the Needs Analysis is what is known in advocacy parlance as Stakeholders Analysis.
Simply put, stakeholders are people concerned with an issue. They can be categorized into three:

- Primary Stakeholders: These are the people who are ultimately affected by the interventions the advocate is trying to carry out. They are the direct beneficiaries/primary target audience of the intervention.
- Secondary Stakeholders: These are the people/intermediaries that are being used to reach the target audience. Again, secondary stakeholders may be positively or negatively affected by the intervention.
- Key Stakeholders: These are the people who can influence the success of the intervention. Ready examples of these are policy-makers at the government level and traditional/opinion leaders at the community levels.

The overall goal of conducting a stakeholders analysis is to get a comprehensive picture of the actual and potential supporters and opponents of the intervention; and also, to determine how to relate with the various stakeholders to achieve your mission.

Step 3: Strategy Formulation

The follow-up to the former is strategy formulation, including formulation of goal and objectives. At this stage, you plan (having known the people, problems and the issues) how to solve the problems. One starting point is to define your mission. In defining your mission, you need to ask yourself this question: what is the purpose of this advocacy effort? A clear mission statement is very essential because with it you can formulate a good goal and objectives.

Step 4: Coalition/ Constituency Building

The power of advocacy is seen in the number of people who support your goal and cause. It is important to involve many interest groups to champion the cause being advocated. Networking both within and outside your organization is essential to meeting your goal. While networking, it is important to have a defined goal and clear roles/norms for group members. It is essential also that the networks are extended to other stakeholders that share your vision and are ready to work with you.

Step 5: Message and Materials Development

A message is a concise and persuasive statement about your advocacy goal, which captures what you want to achieve, why and how. In developing the message, you should include specific actions (s) you want the audience to take.

There are basically six elements:

- **Contents/Ideas** – What ideas do you want to convey? What arguments will you use to persuade the audience?
- **Language** - What words will you choose to get your message across clearly and effectively?
- **Source** –Who will deliver the message? One of the rules for effective communication is to create trust by using personalities your audience will find credible to deliver your message.
- **Format** – This is the communication channel you use to deliver your message. How will you deliver your message for maximum impact? Some of the formats are face-to-face meetings, executive briefing packets, press kits, public rallies, fact sheets, public service announcements, posters, flyers, press releases/conferences sensitization seminars etc.

- **Time** – When is the best time to deliver the message?
- **Place** – Where is the best place to deliver the message that will give it a wider coverage and credibility?
- **Consistency** – Always convey simple consistent theme/message even when using multiple channels. This is one of the rules of effective communication. Too many themes could distract the audience.

Step 6: Identification of Communication Channels

Having developed your message, your next step is to identify means by which you will get your message to the various target audience. The means by which you get to them is known as the channel. Although there are many channels available to the advocate, s/he must consider the target audience, timing, cost, the reach and effectiveness of each medium as well as other factors when selecting message channel(s).
Apart from knowing the merits and limitations of each medium, you need to have good media relations.

Hints on working with the media:

- Identify the reporters covering your beat/issues. Develop a good relationship with them by contacting and sending them newsworthy information regularly.
- Be familiar with their media houses before contacting them i.e. know the kind of stories they are interested in and, possibly what kind of spokespersons that can capture their attention.
- Keep track of their efforts by having newspaper cuttings/other reports on the air waves and thank them for their efforts.
- Adopt these 5Fs when dealing with them—fast, frank, factual, friendly, and fair.

Step 7: Implementation

The next and very crucial stage after the channels have been identified is implementation of the set activities.

Step 8: Monitoring and Evaluation

This step involves taking stock of the advocacy efforts. There is need to measure regularly and objectively what has been accomplished and what more remains to be done. The result would enable the advocate to know which of the strategies are working or not. It will also help to ascertain what has been ineffective, and fine-tune them to achieve the set objectives.

Step 9: Continuity/Sustainability of Efforts

Advocacy is an on-going process; as such after stock taking, the advocate must concentrate on what works. How to sustain the advocacy efforts should be taken into consideration right from early stages of the advocacy campaign.

GENERAL TIPS FOR ADVOCACY

- Build trust with your colleagues and your audience.
- Make a long term commitment and develop a sustainable vision for the issue.
- Be an information source on the subject matter.

- Develop a culture of reading and intellectual exchange on the issues. Control your personal biases and be as objective as possible.
- Do not create enemies; learn to identify your opponents and develop capacity to handle opposition and resistance.
- When reacting to negative situations, do not give in to combative instincts. This could weaken your support base.
- Develop critical skills such as political analysis; leadership; strategic planning; fund-raising; lobbying; negotiation; alliance building and coalition management.
- Develop rapport with the media in order to make breakthroughs.
- Learn how to make an impression and convince people and market an idea using a multi-media approach.
- Be business-like in planning and implementing the campaign.
- Use gender-inclusive language for all your advocacy efforts.
- Aim at being SUCCESSFUL… DO NOT GIVE UP.

SUMMARY

Advocacy is the act or process of influencing policies, laws and programmes, norms and values in supporting a cause or issue. It requires trust, skills, dedication and commitment. Steps in advocacy involve needs analysis, stakeholders' analysis, strategy formulation, coalition building, message and materials development. A good advocate should be accessible to the people, have tolerance as well as possess leadership qualities.

EVALUATION

- Define the concept of advocacy.
- State the steps in advocacy process.
- Mention three qualities of a good advocate.

MODULE TWELVE: SESSION 3
USING ADVOCACY TO STRENGHTEN ARH PROGRAMMES

TIME: 1 Hour 30 Minutes

LEARNERS' OBJECTIVE

At the end of the session, participants will be able to:

- Operationalize the stages in advocacy efforts.

SESSION OVERVIEW

- Review the advocacy process
- Tools for advocacy
- Case Scenarios
- Developing Stakeholders Analysis
- Developing Advocacy implementation plan

METHODS

- Brainstorming
- Lecture
- Role play
- Discussion

MATERIALS

- Flip Chart Stand/ paper
- Chalkboard /Chalk
- Markers
- Tape
- Samples of advocacy materials/evaluation tools

CONTENT

TOOLS FOR ADVOCACY

The tools available to the advocate include:

LOBBYING

Lobbying is a common word used in the legislative system and in democratic settings to describe the act of persuading people through presentation of factual information and good use of communication skills to convince them to support a course or see things from your own perspective. It is not bribing or inducing lawmakers. Any resort to this (i.e. bribing) amounts to corrupting the powers that be as this is unethical and may backfire.

Lobbying could serve as an effective tool for reaching policy makers. This tool of advocacy is most effective when in need of something specifically from the legislative system. For example, a bill that permits more funding for ARH programmes.

Tips for Lobbying

To succeed in lobbying, you must be credible, that is, capable of being believed. Besides, you must be knowledgeable about the subject matter. Establish yourself as a resource for policy makers working on the issue at stake by providing them with position papers and other relevant materials about your issue.

Remember that there are no permanent friends or enemies; Last year's 'villain' on a particular issue may be this year's "hero" on a different issue that is of interest to you.

BUILDING NETWORKS

Advocates constantly build networks among people and sometimes coalitions among organizations in order to bring about change. The term, network, refers to a group of individuals and/or organizations working together with a common goal of achieving changes in policies, laws or programmes for a particular advocacy issue. Some organizations use the term coalition to describe a group of organizations sharing the same advocacy goals.

Benefits of Networking

Information Sharing

The coming together of individuals, organizations affords members the opportunity of information sharing thereby enriching each member with necessary information for achieving a common goal.

Networking for Impact

The pooling together of resources enhances the capabilities of networks and enables them to achieve results that would be difficult for any single member to accomplish alone.

Expanding Base of Support

The building of a network strengthens members' skill in mobilizing support for an issue, a useful skill when advocating with opinion leaders, policy makers, and the public.

PUBLICITY, INCLUDING MASS MEDIA

At one time or the other, media coverage should be employed for public education or enlightenment on adolescent sexuality and reproductive health issues. Stories on adolescent sexuality attract the attention of the mass media. Unfortunately, it is frequently covered in a negative way. Working with the media for instance provides advocates the opportunity to dispel negative stereotypes on adolescent issues. A successful media-plan would follow the five-step process below.

- **Define** the role of the media in the advocacy campaign. Reaching out to the public through media can enhance advocacy efforts and supports advocacy goals and objectives. It would be necessary to establish rapport with the media long before they may be needed. However, in this the following should be noted:
  - What kind of media attention will support the advocacy goal as well as how to generalize the desired media attention.
  - Placing the right message at the right time.
  - Think about the audience reach (or define the audience) and which medium is most appropriate to reach them. For example, in Nigeria, the radio has a wider reach than other media when thinking of reaching people regardless of socio-economic classes.

- **Choose** the message carefully. The media has the ability to generate public attention. This could be used to educate the public. However, the information should be interesting and persuasive. In this regard, the following should be done:
  - Enlist public support, first consider the characteristics, interest and opinions of the intended audience, especially regarding the youth; then present the issue in a way that is most likely to generate support and action from the audience.
  - Always tell the truth in public education efforts.

- **Determine** what activities to hold and what materials will be needed. The process involves:
  - Determining what material and staff time are necessary for the media activities, designating one or more spokespersons to work consistently with the media.
  - Creating a good working relationship with the relevant media personnel.

- **Evaluate** the press campaign. This involves keeping track of how the media covers adolescent issues. This provides advocates with information for improving their media outreach. It affords them the opportunity to present the campaign's side of the story fairly, and may present other viewpoints as well. Copies of press coverage that mention advocacy efforts, records of materials created for the press and information on contacts with the press will provide a sense of how well the campaign is working with the media.

- **Media Tools:** The final step is to select the specific ways you will get publicity. Among the most common tools are:
  - Press releases
  - Press conferences
  - Letters to the editor

- Editorials
- Articles in newspapers and magazines
- Television and radio appearances
- Televised or printed interviews.

DEVELOP CHECKLIST FOR EVALUATING ADVOCACY EFFORTS

To ensure that you are on track, you need to have a checklist. A good checklist should seek answers to the following questions:

- How many opinion leaders received information?
- How many pieces of educational materials were distributed to the public?
- How many presentations or meetings have been held with opinion leaders?
- How many favourable articles or programmes about adolescent reproductive health appeared in the media?
- How many members do the networks have?
- Has awareness of adolescent reproductive health issues among opinion leader increased?
- How many more opinion leaders publicly support the goal?
- Did the target organisation's policies change as a result of the activities?
- Was there a measured increase in the public's support of these policies?
- Was there a change in the incidence of unintended adolescent pregnancy?
- Were STIs rates among young people lowered?
- Was there an increase in adolescent use of contraceptive methods?
- Do more adolescents receive reproductive health information and services?

Any evaluation should be practical and sensitive to resource or labour limitation. If outside experience is needed, help may be found at a local college or university. The social sciences, psychology, education and public health departments may have professors or students who can help with the project. Often, graduate students are eager for experience and will work for lower fees than those charged by professional evaluators. Or they may be permitted to use the data for thesis or dissertation in exchange for their work. Conversely, the increased credibility of a professional evaluation may offset the additional expense of hiring a known, respected evaluator.

USING EVALUATION RESULTS

Evaluating an advocacy campaign can be time consuming, and the results of a well-executed evaluation are usually very useful. Results showing that a campaign has been effective in achieving its goals or objectives can motivate network members and funders.

Evaluation results also can be used to identify the most and least effective components of the campaign. Advocates must reformulate strategies when evaluation data indicates a lack of progress. Likewise, as an advocacy campaign matures and accomplishes its goals and objectives, new goals and objectives should be developed that target changes in other indicators of adolescent reproductive health.

PRACTICAL SESSION: CASE SCENARIO ON ADVOCACY CAMPAIGN

At this juncture, participants are divided into groups, depending on their size and are given different case scenarios and blank advocacy matrix and stakeholders analysis plan. Ask them to draw their plans on flipchart and nominate among them their group leaders and lead writers. Here are some sampled cases they can use for designing a prototype campaign.

Case 1

You represent an NGO that seeks to address the RH needs of young people, design an advocacy campaign to sensitize stakeholders on the subject matter.

Case 2

As an RH practitioner, you have discovered high prevalence of cases of HIV/AIDS in your locality, design messages to the key stakeholders about your finding.

Case 3

There has been upsurge in the number of girls being withdrawn from school against their wish for marriage in your community, concerned girls have approached your organization for help. How will you go about it?

Case 4

Female Genital Mutilation is rampant in your area based on myth that it prevents the girl-child from being promiscuous, how will you counter this myth?

After the group work which must be done on an agreed time span, ask participants to make their presentations. Thereafter, everybody—facilitators and participants should jointly assess the merits and limitations of each group work.

The following questions will guide the assessment session:

- Was the central advocacy theme/message clear?
- If you were in the shoes of the target audience will you be informed, motivated and moved to act as a result of the advocacy efforts?
- Which was the most effective of the advocacy activities?

ADVOCACY CAMPAIGN MATRIX STAKEHOLDERS ANALYSIS

Table 12.2: **Sample Advocacy Goal: To provide adolescents in FCT with access to youth-friendly services**

OBJECTIVES	ACTIVITIES	STAKEHOLDERS	LIKELY ALLIES	LIKELY OPPOSITION	SOURCE (S) OF SUPPORT	EXPECTED OUTCOMES
To sensitize 20,000 adolescents in FCT with information on reproductive health.	Conduct one-day sensitization seminar on ARH for 500 parents.	Religious/community leaders, Parents/guardians, LGA officials, Community Dev Association [CDA] officials, Primary healthcare workers, NUT/COPSHON/ ANCOPPS officials.	Health Ministry Workers, School Guidance Counsellors, Local NGOs around.	The Church, Other religious leaders.	Finance Donor agencies, Philanthropists, Local govt, etc. Logistics Local govt, MOH, NGOs.	Seminar conducted.
To reach 15,000 youths in 3 years.	Conduct monthly rallies for adolescents in the 12 zones in the project area at the rate of 1rally/zone/ Month.	ditto-	Youth clubs and others mentioned above.	-Ditto-	-Ditto-	@ Least 400 youth reached per /really. 12 rallies per /year X 3 years =14,400 youths reached through rally.

Table 12.3: Advocacy Implementation Plan (Example)

Advocacy Objective: To persuade the School Board in District X to implement a pilot Family Life Education (FLE) curriculum in secondary grades 7 through 9 beginning in the next academic year.			
Activity	**Needed Resources**	**Responsible persons**	**Time Frame**
• Ask for permission to attend the monthly school board meeting to present the idea.	Contact with a school board member	Advocacy network chairperson	1 week (June 15)
• Develop fact sheet for decision makers with data on Model programs in neighbouring countries, link between FLE and reduction in early pregnancy, school attrition, STDs/AIDS	Data Format for factsheet Printing capacity	Network's research/data team and communication team	3 weeks (July 7)
• Attend school board meeting to present the argument and secure support for pilot program.	Strong communicators, fact sheet, brochure/ contact information for the network.	Advocacy network chairperson and coordinator of communication team	1 Month (July 15)

SUMMARY

Important tools for advocacy include lobbying, building networks and publicity, including mass media. It is vital to develop a checklist for evaluating advocacy efforts as this can be used to assess the impact and reformulate strategies, if need be.

EVALUATION

- Identify tools for advocacy.
- Demonstrate skills for advocacy.

MODULE TWELVE: SESSION 4
THE PEER EDUCATION APPROACH TO ARH

TIME: 2 Hours

LEARNERS' OBJECTIVES

At the end of the session, participants will be able to:

- Define peer education.
- Explain the importance of peer education.
- Describe the processes involved in selection and training of peer educators.
- Discuss roles of peer educators.
- Discuss advantages and limitations of peer education system.
- Identify ways to build support for peer education in the community.

SESSION OVERVIEW

- Definition of peer education system
- Importance of peer education system
- Roles of peer educators
- Types and Operations of Peer Education System
- Selection and Training of Peer Educators
- Advantages and limitations of peer education system
- Building Support for Peer Education System

METHODS

- Brainstorming
- Discussion
- Lecture
- Role play

MATERIALS

- Flipchart stand/paper
- Chalkboard/chalk
- Markers
- Tape
- Paper
- Video tape on peer health education
- VCR/TV

CONTENT

DEFINITION OF PEER EDUCATION APPROACH

Peer education approach is a strategy for reaching adolescents and young adults with reproductive/ health messages and services through use of their age/playmates or colleagues already trained to do so.

It is a process whereby young people educate and counsel their peers with a view to influencing a positive sexual and social behaviour. This approach has been found to be very successful as it builds on the natural instinct, which propels young people to depend on one another for information especially in an environment where significant numbers of adults are unable to provide the needed (missing link) information.

When used in conjunction with other strategies such as provision of comprehensive sexuality education as well as other Information, Education and Communication (IEC) strategies, the peer education approach can have very powerful effect in empowering young people. It can also encourage them to adopt survival skills, including the use of appropriate health and clinical services.

JUSTIFICATION FOR PEER EDUCATION APPROACH

As part of their development, adolescents have tendency to work and relate in groups and develop increasingly close relationship with peers. As such, as the adolescent progresses in life, peer influences become increasingly dominant. The peer group becomes a source of behaviour and values. This dominant influence assists the peer education approach to disseminate accurate and dispassionate information to their peers.

And lastly, it is in line with the ICPD '94 provision, Chapter 6, Section B that young people should be involved in activities that affect their lives.

ROLES OF PEER EDUCATORS

The primary objective of peer educators is the provision of correct and factual information, education and counselling to their mates. To properly discharge this primary function, peer educators perform the following roles:

- **Development and distribution of IEC materials** such as badges, pamphlets, posters, leaflets etc. It is important that materials to be developed and distributed are first pre- tested before printing and circulation.
- **Mounting of awareness campaigns** which include rallies, puppet shows, drama, debates, quizzes, walks etc to get the target audience to be aware of their programmes.
- **Counselling:** Apart from awareness creation, peer educators perform some form of counselling, thereby helping their colleagues to arrive at informed decisions.
- **Referral and follow- up:** Peer educators are a veritable source of referral of their friends needing help. In many settings, peer educators apart from informing their friends, refer cases beyond their capability to service delivery points. Furthermore, they follow up on their clients/ friends to ensure that they are satisfied with the services provided.

- **Record keeping through Management Information System**: In many settings/ programmes, peer educators are given forms (in the case of Nigeria, a comprehensive package has been developed called Health Management Information System, NHMIS) to record contacts, counselling, contraceptives, IEC materials and referrals made. These forms can be submitted weekly/monthly. It provides a useful basis for evaluating the programme as well as the PE's performance.
- **Contraceptive Distribution**: Giving of contraceptives to young people is still a contentious issue. In programme environments where there is request for contraceptives among the target audience, Peer Educators do distribute non- prescriptive contraceptives like condoms and foaming tablets. Examples of this practice abound in many out- of- school projects in Nigeria.

TYPES AND OPERATIONS OF PEER EDUCATORS

Types

Peer Educators go by different names. Some are called Peer Counsellors, others Health Educators, but basically there are two types of Peer Educators:

- The- in- school
- The out- of- school

The In- School Peer Educators

This group is selected and operates among their colleagues in the school setting. It could be secondary or tertiary institution. They work most often under the guidance of their teachers. Hence they do not have the kind of latitude to do most things that their counterparts in out- of- school settings do. For instance, out of school PEs can freely distribute contraceptives to peers which could be restricted within the school setting. Besides, some in-school PEs may need to get their parents' consent before enlisting, and have to make time restrictions.

Nevertheless, the in- school environment is better to operate in as the target audience are clustered and are much more accessible.

The Out- of- School Peer Educators

These are in three categories:

- The Never- Been- to- School
- School Drop-Outs
- Students Awaiting Further Studies

The Never-Been-to-School: As the name implies, these are illiterates and are found mainly among artisans like mechanics, tailors, cabinet makers etc. Because they are illiterate, they are often by passed by most programmes. They could be difficult to relate with. These days, some programmes have been designed to address their problems by working with them through the use of special symbols and codes.

School Drop- outs: Although they are in the same category with the first group in terms of their vocations, they can still read and write to some extent and as such can fill and decode NHMIS forms.

Students Awaiting Further Studies: After completing their secondary school and are awaiting admissions to tertiary schools, most young people find themselves idle, they therefore engage in many things to keep themselves busy, including sex. Most programmes target this group and train them to operate among their colleagues.

OPERATIONS

Peer educators are usually supervised by a coordinator, who is responsible for the daily planning of activities. The coordinator may be a health educator, social worker, or other persons with interest in working with youths. The coordinator is responsible for their training, supervision and recruitment. The role of the coordinator in motivating peer educators is vital in order to minimize the rate of attrition.

The frequency and intensity of supervising peer educators vary from programme to programme. Some may meet monthly as a group, others may meet more frequently. To motivate peer educators, some programmes may organize retreats or meetings to give educators an opportunity to share successes and challenges with other peer educators. Some programmes provide manuals to peer educators as references for information on sexuality. Information includes contraception, components of sexuality, STIs/HIV/AIDS referral sources, and other useful information. Such materials are useful to avoid misinformation during counselling which is their primary function.

MOTIVATING PEER EDUCATORS

Most peer educators operate on volunteer basis, meaning that they work without salaries. What keeps them moving is the zeal to change the society for the better. In most settings, they are selected either by their colleagues or teachers while in other settings they come out to serve voluntarily. It has been observed that when peer educators come out to serve voluntarily, they are more active and tend to be more committed than when they are recruited or nominated by others.

Although peer educators are not on salaries, a lot of coordinators have ways of motivating them. Among these ways are:

- Taking them out on trips,
- Giving them transport refund whenever they perform activities,
- Providing them refreshments during functions,
- Providing educational materials,
- Stipends: many organizations give peer educators stipends, others do not, for different reasons. In deciding whether or not to provide stipends, the following should be considered:

Table 12.4

	Arguments for Stipends	**Arguments against Stipends**
1	It gives youths a concrete reward for their work.	Makes the programme more expensive.
2	It provides incentive to keep youths involved.	When money is the incentive to work, dedication may wane when they press for more money and could not get.
3	It allows youths, who financially need to be employed the opportunity to participate.	Project sustainability may be difficult when funds are exhausted.

Perhaps the most important, which are most often overlooked, include benefits Peer Educators derive from their roles, such as:

- Public recognition of their activities which enhances their self esteem.
- Enhanced leadership qualities and skills.
- Enhanced performance in schools/vocation centers.
- Adoption of better reproductive health behaviour.

SELECTION AND TRAINING OF PEER EDUCATORS

Young adults need programmes that respond effectively to their needs and earn their trust. Therefore in adopting the PE approach, attention needs to be paid to certain characteristics in the process of selection and training.

SELECTION CRITERIA

One of the most important components of the peer program is the recruitment of motivated, capable young people to serve as peer educators. Peer educators should possess the following characteristics:

- Leadership abilities
- Close ties to peer groups
- Enthusiastim
- Respectfulness
- Motivation to work in social service in the community
- Interest in the health of young people, particularly reproductive health
- Responsible nature

Recruitment is typically an ongoing process because of attrition. Programs should explain training, work and commitment that will be expected during the selection process.

TRAINING PEER EDUCATORS

For effectiveness, peer educators must be trained at the beginning of their work. Areas of training generally include sexuality and reproductive health education, counselling and communication skills. Training is provided through a series of lectures, group discussion, role-play and other participatory exercises, which help peer educators express themselves and become familiar with the situations and questions they confront. Training period is variable depending on the needs of the programme, and the duration could vary between 40 & 80 hours (refer to the guidelines of PE produced by FMOH and NERDC for additional information).

Nearly all programmes provide in-depth refresher trainings, which help clarify doubts or misinformation and address challenges PE may have encountered, including fieldwork. On the whole, refreshers aim at strengthening the knowledge, use and skills of the PEs and familiarize them with evolving issues.

Reach all the peer educators

To be an effective trainer, the coordinator must address and tailor training to the needs of the peer educators. Young people may represent a wide range of orientations: ethnic, gender, religious, socio- economic, among others.

Use Appropriate Language

Service providers/trainers must ensure that they are familiar with the terminologies and language of young people and then communicate to them in a way that they can clearly understand. Present information in factual and culturally sensitive ways. They should also be involved in decision making at all programme levels such as planning, design, monitoring and evaluation. The capacity of young people should also be developed in many practical areas such as resource generation, public speaking, mobilization, advocacy, material development etc.

ADVANTAGES AND DISADVANTAGES OF THE PEER EDUCATION APPROACH

Advantages

When compared with other interventions, this approach has far-reaching advantages which include the following:

- The vulnerable group is reached easily with information and services.
- Could be cost effective if well planned and implemented.
- Wide range of stakeholders are involved.

Disadvantages

Despite the many good reasons advanced in support of the peer education approach, it is not problem-free. These problems include the following:

- High rate of turnover: By their nature young ones are very mobile and active. As soon as the training is concluded, some of them drop out in pursuance of new adventures. This calls for constant recruitment and training, which may not have been anticipated in the planning of the programme.
- Allied to the high turnover is high cost: The approach is costlier to operate and sustain than school-based Family Life Education (FLE) programmes.

BUILDING SUPPORT FOR A PEER EDUCATION PROGRAMME

The Peer Educator approach needs a wide range of stakeholders support for success. Programme staff and service providers need to identify and persuade various stakeholders for support before the establishment of the peer education programme. In addition, key opponents need to be identified and services providers must be able to present facts to support the establishment and function of the PE approach (Advocacy skills in session 3 will be relevant in this regard).

The following are the steps to take in building support for the PE approach:

Know your community

What other youth programmes similar to your own exist? How are they received by the community? Which community groups need to be included in your project? When all stakeholders are involved at the beginning of project, few obstacles are experienced.

Educate service providers

Plan to educate all staff and service providers who come in contact with your programme. Educating them does not have to be a formal TOT, but can just be by talking with teachers, local NGO staff, etc. Offer the opportunity for other interested persons to be involved. In making presentations, be prepared to make informed and persuasive arguments for the programme. Presentations should address the need for the programme; its cost effectiveness and positive outcomes.

Be prepared for the common arguments against implementing a peer program such as:

- Sex education encourages youths to have sex.
- Parents won't support this, it's too controversial.
- We already provide family life education in schools. Why do we need more?
- Young people are not responsible enough to be peer educators.
- Youths won't listen to other youths, because they are not authority figures.

Plan the implementation and administration of the PE program

Your work plan should be developed, resources identified and additional personnel selected and trained. The purpose of the work plan is two fold:

- It allows you to emphasize programme elements and approaches that specifically fit your community and target population.
- It provides the vision of how the programme is expected to proceed, and places each stage of the programme within a time frame.

SUMMARY

Young people's perception about sex is often misleading, incomplete or distorted. They are also not comfortable discussing sex with parents or older people. Peer education is a very important approach in reaching youths with correct and adequate information on sex. They can also receive some other services, which can promote healthy sexual behaviour. Peer education, which cannot be done in isolation, encourages the full involvement of all stakeholders to succeed.

EVALUATION

- Define Peer education and state its importance.
- Describe the roles of peer educators.
- Highlight the advantages and disadvantages of the peer education system.

MODULE THIRTEEEN
PARENTAL INTERVENTION

This module is divided into two sessions. It gives an overview of strategic intervention that parents can adopt in contributing to the growth and development of their adolescents. It covers issues relating to basic knowledge of adolescent development, parental attitude, skills and actions.

SESSION 1: EFFECTIVE PARENT-CHILD COMMUNICATION

SESSION 2: BUILDING CAPACITY FOR PARENTAL MENTORING, SUPPORT AND SUPERVISION

MODULE THIRTEEN: PARENTAL INTERVENTION
SUMMARY AND TIMING ESTIMATES

SESSION TITLE	DURATION	OBJECTIVES	METHODS	MATERIALS
Effective Parent-Child Adolescent Communication Skills.	2 Hours	• Explain how parents' attitude can affect adolescent. • Explain how understanding, care and trust can enhance positive AHD. • Explain the importance of effective parent child communication. • Discuss factors that influence parent –child communication. • Discuss the need for parent education. • Identify barriers to effective communication between parents and young people. • Proffer suggestion to improve parent –child communication.	Brainstorming Lecture Role play Discussion Group work	Flip charts stand/ paper Markers Paper tapes Overhead projector (OHP)
Capacity Building for Parental Mentoring, Support and Supervision.	2 Hours	• Explain how influential supportive parent can be to an adolescent . • Explain the types of parenting styles. • Explain the importance of good role modeling from parents towards adolescents.	Brainstorming Lecture Role play Discussion Group work	Flip charts stand/ paper Markers Paper tapes Overhead projector (OHP)

MODULE THIRTEEN: SESSION 1
EFFECTIVE PARENT-CHILD COMMUNICATION

TIME: 2 Hours

LEARNERS' OBJECTIVES

At the end of the session, participants will be able to:

- Explain how parents' attitude can affect adolescent behaviour and health.
- Explain how understanding, care and trust can enhance positive adolescent health and development.
- Explain the importance of effective parent – child communication.
- Discuss factors that influence parent-child communication.
- Describe some barriers to effective communication between parents and young people.

METHODS

- Brainstorming
- Lecture
- Role-play
- Discussion
- Group work

MATERIALS

- Flip Chart Stand/Chalk Board
- Flip chart paper/Chalk
- Markers, Tape, Sheets of Paper
- Video tape/VCR/TV

CONTENT

EFFECT OF PARENTS ATTITUDE TOWARDS ADOLESCENTS SEXUALITY AND DEVELOPMENT

Parents are known to hold different beliefs about their adolescent which form the basis of their actions. Some of these views include:

- Investment for the future
- Source of pride
- Source of joy
- Security in old age
- Heir apparent (propagation of family name)
- Reflection of the home, and

- Weapon of retaliation.

- There is overwhelming evidence globally to suggest that in spite of their façade, adolescents are eager to listen to their parents and to engage them in healthy communication.
- Even though studies have indicated that adolescents most commonly rely on peers for information about sexual matters, parents are also mentioned as being important, sometimes prominently so. This is because parents are the first and most omnipresent force in the socialization of their children.
- For instance, adolescents in both developed and developing countries had indicated parents as their most preferred source of information on sexuality and evidences from empirical studies have confirmed the importance of parenting and parental communication in adolescent risk behavior.
- But a major obstacle to parental influence on adolescents is the attitudes of parents towards them. For as long as the parents see adolescents as being problematic and incorrigible and continue to operate based on popular misgivings, misinformation and misconceptions, the adolescents are unlikely to trust them nor open up to them neither will they engage them in any meaningful dialogue.
- Adolescents also have misconceptions about the true motives of parents especially when they are ambivalent and not living up to their own standards. They see them as domineering and from that viewpoint their good counsels go unheeded.
- When parents learn to put up a good and positive attitude towards adolescent, they find out that this helps in building trust, and once the adolescent is convinced that parents are really sympathetic towards their needs and have their best interest at heart, this becomes a turning point in the relationship.
- Having a right attitude is hence an unassailable milestone in parent adolescent relationship.

DEVELOPING A TRUSTING AND CARING RELATIONSHIP

Once attitudinal barriers have been overcome the next step is to build trust, which is another important cornerstone and in any relationship marks the point of no return.

Ingredients of trust include:

- Openness
- Truthfulness
- Commitment

Openness

- Adolescents are usually suspicious that parents hide and hoard information especially about sexual matters and they see and sense the reluctance of parents to answer their questions directly. Unfortunately while parents are being conservative with information, they (the adolescents) begin to explore other easily available (but sometimes not totally credible) options such as friends and the media.
- The ease with which they access this information further erodes the regard they have for their parents. It is therefore important for parents to be eager, ready and open to their adolescents.
- In actual fact, parents need not wait until information is sourced but should be proactive and sense when it is time.
- Even when details of information cannot be given for overriding reasons, it is important to explain the rationale to them why they need to wait. Adolescents even though not yet mature adults, they are not children and they demand not to be treated as one.

Truthfulness

- Once parents are unable or unwilling to provide accurate open and frank information, they sometimes resort to distortions, and half truths. This is a counterproductive strategy and undermines development of trust.
- There is hardly any information the adolescent seeks that he cannot access elsewhere and once it is discovered that parents are not telling the truth, their credibility often becomes irreparably damaged (a scenario which might come back to haunt the parent and to endanger the adolescent in future).
- It is therefore important that information given should be accurate as much as possible.
- When parents are unsure they should say so and make effort to source for accurate information on behalf of their adolescents knowing that once their credibility is established they will continue to reap the dividend.

Commitment

- Adolescents are almost always willing and eager to cooperate with whoever demonstrates a strong commitment to their cause and pays attention to issues of concern to them.
- Whereas parents are usually committed to the growth and progress of the adolescent through the provision of most of the basic needs such as clothing, feeding and education which is appreciated, adolescents also have other interest and concerns which parents might view as unimportant or as distractions.
- Adolescents are usually passionate about other issues ranging from relationships, sports as well as social interests like fashion and entertainment and it is prudent for parents to show that they equally care about these issues and are committed to these concerns rather than wave them aside.

THE NEED FOR EFFECTIVE PARENT-CHILD COMMUNICATION

- Parents are the primary educators. They are the first contact the children have. Most often, children have internalized life-long values before they come in contact with the outside world.
- Parents are role models: The children always look up to their parents, emulate them, their manner of walking, talking, dressing, and other habits and mannerisms.
- Parents are an important link between children (childhood) and adults (adulthood). Children grow up liking/disliking adulthood because they have been well/poorly linked.
- Survey reports indicate that young people want their parents to be primary source of information on such sensitive issues as menstruation, wet dreams and the like.
- Studies among adolescents rank their parents poor as a source of information, hence their reliance on peers who often misinform them.

FACTORS THAT INFLUENCE PARENT-CHILD COMMUNICATION

Socio-Cultural: In some traditional societies where children are supposed to be seen and not heard, it sometimes becomes difficult for the young people to express themselves. Moreover, parents who were themselves deprived of self-expression in their teen years are very unlikely to see anything wrong with the situation. Thus, the process of parent-child communication becomes one endless cycle of deprivation. Attitudes and beliefs of parents living in the same environment sometimes influence the way they relate to their adolescents.

Religious: Due to misinterpretation of religious texts, many parents do not give dialogue a chance in the home. Rather than have dialogue, their maxim is 'to spare the rod is to spoil the child'. Even in interpreting other religious injunction like 'train up a child in the way he should go…' the rod is central to the training.

Economic: Economic pursuit and communication are two extremes in many homes. In pursuit of wealth and comfort, many parents hardly spend 'quality time' with their children because they leave the house very early in the morning and come back very late. Even when they are not late, they are already too tired to discuss fruitfully with their children.

Psychological: This factor has to do with the parents' upbringing, which they later bring to bear on their children. Please see handout captioned "children learn what they live with".

CONSEQUENCES OF POOR PARENT-CHILD COMMUNICATION

- Misinformation from peers.
- Suppressed anger.
- Misunderstandings – unhappiness.
- Low self-esteem.
- Feeling of rejection leading to dejection.
- Imposed decision making.

- Disrespect.
- Nonchalant attitude.
- Lack of trust and confidence.
- Feelings of insecurity in terms of their well being.
- Negative exposure.
- Poor communication with future children (they don't learn communication skills from their parents).

BARRIERS TO EFFECTIVE COMMUNICATION

- Mutual distrust between adults and young ones.
- Lack of clear understanding of parenting.
- Un-clarified values on the part of the parents.
- Lack of knowledge of the topics of discussion by parents.
- Anxiety, fears and inhibitions on the part of the parents.

HOW TO IMPROVE PARENT-CHILD COMMUNICATION

- Adopt predictive-parenting mechanisms: Predictive parenting is based on working to set up the best possible conditions for the child or young persons. A predictive parent is therefore someone who 'exercises conscious judgment in every parenting situation and who recognizes the effects of natural programming on each child's future'.
- Be an 'askable' parent: Put yourself in the mind of the children in such a way that they find it easy to ask whatever questions they may wish to ask.
- Convey the attitude that no question is wrong.
- Be a good friend to your children.
- Be truthful at all times. If you do not have information, tell them so and let them know when you will find out and share it with them. And ensure that you do so.
- To be nervous and uncomfortable with certain question your child asks is quite normal, but do not allow that to affect your ability to explain the issues to the child.
- Be consistent. Let your deeds confirm what you say and let the standards you have set in the home to all regardless of gender or position be maintained.
- Use interactive communication rather than top-down communication, exploring options rather than giving directives.
- Always make only positive statements/declarations to young people.
- Keep the communication lines open even when you disagree on issues.

THE IMPORTANCE OF PARENT EDUCATION

Parents as the natural teachers of their children are more likely to pass on factual information that will assist young people cope with basic aspects of growing up. However, whilst most parents do not have factual information, they are also hindered in passing on information due to their beliefs and values. Also parents often lack the skills and assurance to discuss effectively with their children on sexuality issues.

The goal of parent education is to use the peer approach to provide education and communication skills to enable parents (including grandparents, foster parents, guardians and all those involved in raising young people) discuss health and developmental issues with young people. Parents, where well informed and equipped, can provide information and skills to promote positive development of the young person. Being there at every stage of the child's development, they are able to provide answers to their questions, give information and discuss concerns. They can make understanding sexuality a natural, normal and progressive experience for young people.

SUMMARY

As parents, developing a good attitude towards adolescent sexuality and development will pave the way for building a trusting and caring relationship and improving parent-child communication which will encourage adolescents to ask their questions in a non threatening environment and get accurate information to make informed choices about their development and sexuality. Parents must also be willing to have a positive attitude of openness, truthfulness and commitment as a foundation for trust.

EVALUATION

- Explain the importance of effective parent-child communication.
- Identify barriers to effective communication between parents and young people.
- Identify the components necessary for building a trusting relationship.
- Proffer suggestions to improve parent-child communication.

HANDOUT

CHILDREN LEARN WHAT THEY LIVE WITH

If a child lives with criticism,
He learns to condemn.
If a child lives with hostility,
He learns to fight.
If a child lives with ridicule,
He learns to be shy.
If a child lives with shame,
He feels guilty.
If a child lives with tolerance,
He learns to be patient.
If a child lives with encouragement,
He learns confidence.
If a child lives with praise,
He learns to appreciate.
If a child lives with fairness,

He learns justice.
If a child lives with security,
He learns to have faith.
If a child lives with approval,
He learns to like himself.
If a child lives with acceptance and friendship,
He learns to find love in the world.

COMMUNICATION TO AVOID IN THE HOME

- *You never listen when I talk to you***.**
- *Can't you do anything right?*
- *Close the door. Are you a bush boy/girl?*
- *You're so clumsy.*
- *You're just like your father (or mother, etc.)!*
- *When will you ever learn?*
- *Children should be seen and not heard.*
- *Can't you be more responsible?*
- *You're lazy.*
- *You're impossible!*
- *You're just not cut out for that.*
- *You can try it but I don't think it's going to work.*
- *I don't know why I put up with you.*
- *Just this once, try to tell the truth.*
- *You're always in a bad mood.*
- *You always interrupt.*
- *You always talk when you should be listening.*
- *Haven't I taught you anything?*
- *I'm at my wits end with you.*
- *Why should I listen to you?*
- *Why should I believe you?*
- *Why should I trust you?*
- *Why should I give you another chance?*
- *You're just no good at that!*
- *Your brother (or sister) never talks like that!*
- *What did I ever do to deserve this?*
- *I don't want to hear another word out of you.*
- *All you ever do is complain.*
- *Nothing is good enough for you!*
- *This time try to get it right for a change!*
- *Who do you think you are?*

- *Your room is always a mess.*
- *You have no respect for anything!*
- *You're always getting into trouble.*
- *You just don't think!*
- *This is the last time I'm going to tell you.*
- *Where were you when the brains were passed out?*
- *Nothing I say makes any difference to you. It just goes in one ear and out the other!*
- *You don't know where home is anymore!*
- *You think money grows on trees!*
- *Don't you know anything?*
- *Sometimes I just don't know about you.*
- *How stupid can you get?*
- *Can't you do anything right?*
- *I just can't talk to you anymore.*
- *Don't you care about anything?*
- *You just don't try!*
- *You think home is just a place to sleep!*
- *I'm through listening to you!*
- *What makes you think you're so special?*
- *I'll tell you what's wrong with you….*
- *You think you're so smart.*
- *Can't you get it through your thick head…*
- *You don't know the meaning of the word respect.*
- *You're lucky to even be living here!*
- *All you know how to do is cause problems!*
- *One day you'll be sorry.*
- *Just wait till you have kids of your own!*
- *All you want to do is sleep!*
- *All you want to do is avoid responsibility!*
- *All you ever do is talk back.*
- *All you ever do is argue!*
- *Where did I go wrong?*
- *Someday you'll learn!*
- *If you only knew what you put me through.*
- *Talking to you is like talking to a brick wall!*
- *I've had it with you!*
- *You are never home on time.*
- *You never come when I call!*
- *You never care about anyone but yourself!*
- *You never do anything that I don't ask you to do.*

- *You never pick up after yourself.*
- *You never finish anything!*
- *You never tell me the truth!*
- *You'll never get anywhere.*
- *You'll never amount to anything!*

SOME SPECIAL SELF-TALK, JUST FOR PARENTS

- I am an exceptionally good parent! I like being a parent, and it shows in every part of my life.
- I accept the responsibilities that parenting brings to my life. I am up to them, I meet them, and I welcome them.
- I am good at helping children learn to see themselves in the most positive possible way.
- I create harmony and happiness in my home.
- I am a good listener. I always listen with interest, understanding, and love. I let children know that I am easy to talk to – and that I listen!
- I am strong and determined, but I am also understanding and supportive.
- I never parent with idle threats or forgotten warnings. I can always be counted on to be true to my word.
- I understand the difference between punishment, discipline, and training, and I always work to keep them in their proper perspective.
- I can be counted on. Because I am reliable and consistent, I greatly increase the assurance of love and security in my home.
- I teach values by the examples I set. I see each day as an opportunity to show, by example, the very best way to live that day.
- I see each day as an opportunity to show, by example, the very best way to live that day.
- I never criticize or belittle a child's efforts or ideas.
- Instead of expecting perfection, I expect the best that my child has to offer.
- I am good at giving rewards, big or small, and at any time at all.
- I make it a point to tell each member of my family something special and good about that person each and every day.
- I keep myself up, enthusiastic, and in good, healthy spirits.
- My own positive attitude about parenting is reflected in everything I do.
- I really enjoy being a good parent and experiencing the many joys and benefits that positive parenting brings to my life and to the lives of those I love.

TEN WAYS TO BUILD HARMONY IN THE HOME

1. Keep your voice down.
2. Give each person a turn to talk at the table.
3. If you get angry and are getting ready to make a parenting mistake, go to your room.
4. Always treat every family member with equal respect.
5. Set rules about rooms, privacy, possessions, and individual rights and stick by them.

6. Practice and use the Rule of Personal Responsibility in every possible opportunity.
7. Never argue about an argument. Arbitrate and diffuse it.
8. Always act the way you want your children to act.
9. Be consistent and be ready to explain when you can't be.
10. Instead of focusing on the negative results of not getting along, show the benefits of doing it right.

WHAT SELF-ESTEEM POSITIVELY INFLUENCE IN A YOUNG PERSON'S LIFE

Attitude	Learning	Acceptance of criticism
Happiness	Patience	Self-confidence
Initiative	Responsibility	Anxiety and stress
Enthusiasm	Health	Security
Temperament	Physical appearance	Courage
Productivity	School work	Honesty
Energy	Getting along with others	Moods
Creativity	Posture	Follow-through
Problem handling	Speech	Trust
Spirit	Attentiveness	Character
Determination	Memory	Sensitivity
Expectations	Concentration	Habits
Openness	Sense of personal responsibility	Honor
		Value

SOMETHING NOT SAID CREATES JUST AS STRONG A PROBLEM AS SOMETHING SAID BADLY. LEARN TO SAY THE FOLLOWING:

That was really great!
You were wonderful!
You really do that well.
As always, you look good today.
You're a winner!
I trust you.
I can always count on you.
You're really smart.
People really like you.
I like the way you did that.
You're really fun to be with.
You make me feel good.
You really take responsibility for yourself.
I like the way you keep your room neat.
You sure have a lot of energy.

You're really positive!
You always seem to be able to keep yourself busy.
You ended up with the best of both your father and myself
I really rely on you.
That was close. Next time I know you'll make it.
Good job!
You're beautiful.
You're very pretty.
You're handsome.
You make every day brighter.
You sure have a nice smile.
I listen to what you have to say.
You're a good friend.
You really get along well with other kids.
You're very creative.
I've noticed you're a very good listener.
It's obvious that you care about yourself.
You're a good runner.
I'm proud of your schoolwork.
That's much better. You're doing great!
You're really special.
I love you but I like you too!
You make hard things seem easy.
You really practice good manners.
There is no one else like you in the whole world.
I need your advice.
You sure are talented!
Good answer!
Thank you.
You deserve it.
Can I help?

MODULE THIRTEEN: SESSION 2
CAPACITY BUILDING FOR PARENTAL MENTORING, SUPPORT AND SUPERVISION

TIME: 2 Hours

LEARNERS' OBJECTIVES

At the end of the session, participants will be able to:

- Explain the concept of supportive parenting.
- Explain the types of parenting styles.
- Explain the importance of good role modeling from parents towards adolescents.

SESSION OVERVIEW

- Supportive Parenting
- Parenting Styles
- Role Modeling

METHODS

- Brainstorming
- Lecture
- Discussion
- Group work

MATERIALS

- Flipchart/ Stand/
- Paper & Markers
- Chalkboard/ Chalk
- Overhead projector (OHP)

CONTENT

SUPPORTIVE PARENTING

The ultimate goal of all parents is that their wards grow up to become responsible and successful adults. Unfortunately adolescent period can be highly volatile, full of emotional upheavals as well as various hills and valleys of successes and failures. Parents must be ready to stand by and support their adolescent throughout this journey.

It is important to note that it will take some time and so a lot of patience, calmness and understanding is required throughout the process.

Adolescent will benefit from parental support in the following ways:

- Empathy and understanding in their ***"need"*** for dependency as well as their **"wish"** for autonomy.
- Demonstrating some tolerance for their natural "limit-testing" and "rule-breaking".
- Giving them more latitude in determining their preferences and choices.
- Understanding their need to choose their own values.
- Granting more and more freedom when earned.
- Granting more resources and opportunities for independence and further skill building.
- Having compassion for the heartbreak and failure that adolescent insecurity and experience offer.

PARENTING STYLES

There are different parenting styles and psychologists have identified four major styles into which most parents can be grouped with minor adjustments. The four styles all have a high likelihood to lead to different outcomes in the adolescents.

1. Permissive-Indifferent Parenting

This is a style in which the parent is much uninvolved in the adolescent's life. An uninvolved parenting style is characterized by few demands, low responsiveness and little communication. While these parents fulfill the child's basic needs, they are generally detached from their child's life. In extreme cases, these parents may even reject or neglect the needs of their children.

Adolescents whose parent are permissive and indifferent are socially incompetent. They show poor self-control and do not handle independence well.

Who is this?

Q: It is 10.00pm; do you know where your adolescent is?

A: No response.

Comment: Parent does not care about adolescent or is not getting on with adolescent or adolescent is defiant.

2. Permissive-Indulgent Parenting

These parents rarely discipline their children because they have relatively low expectations of maturity and self-control. According to Baumrind, permissive parents "are more responsive than they are demanding. They are nontraditional and lenient, do not require mature behavior, allow considerable self-regulation, and avoid confrontation" (1991). Permissive parents are generally nurturing and communicative with their children, often taking on the status of a friend more than that of a parent.

The adolescent of a permissive –indulgent parent never learns to abide by rules and regulations.

3. Authoritarian Parenting

This is a restrictive, punitive style that exhorts the adolescent to follow the parents directions and to respect work and effort. The authoritarian parent's places firm limits and controls on the adolescent and allows little verbal exchange. Authoritarian parenting is associated with adolescent socially incompetent behavior.

Adolescents of authoritarian parents often are anxious about social comparison, lack initiative and have poor communication skills.

Who is this?

"You do it my way or else, there will be no discussion".

4. Authoritative Parenting

Here the parents encourage adolescents to be independent but still place limits and controls on their actions. Extensive verbal give-and-take is allowed, and parents are warm and nurturant towards the adolescent.

Authoritative parenting is associated with adolescents' socially competent behaviour. The adolescent of authoritative parents are self reliant and socially responsible.

Who is this?

"You know you should have done that. Let's talk about how you handle the situation better next time".

ROLE MODELING

The greatest influence parents can have on adolescents goes beyond communication and support but by being good role model to them. Adolescents are often idealistic and highly impressionable and usually look for individuals that will serve as a role model for them, that represents their dreams and aspiration.

Parents are initially put at vantage position for this because they are the primary socializing force in the life of their children. But as the child grows into adolescent and his scope becomes widened with better exposure, there is a tendency to look outside the family for role model.

Unfortunately at this point in time the increasingly intelligent and inquisitive adolescent begins to discover the inconsistency , hypocrisy and double standard of the parents who most often are unwilling to live by their own rules, hence making the adolescent become disillusioned. It is important for parents if they must retain the respect of their adolescent to ensure they conduct themselves in such a way that the adolescent can be proud of them. Even if the adolescent initially succumbs to the lure of external influences from the media and idolizes others that are projected to them as they mature, they soon see beyond the glitz and glamour of the make belief world and continue to appreciate their parents more.

For parents to be effective as role models, they are expected to:

- **Live upright**: Adolescents expect that their parents be above board morally and upright so as to be proud of them.
- **Share the secrets of their successes**: Parents should take time to explain the secrets of their successes and guide their adolescents into the same path.
- **Admits to their failures**: Rather than pretending to be infallible, adolescents will benefit from parents owning up to their failures and teaching the adolescents to avoid repeating the same errors.
- **Delegate responsibilities to adolescents**:Aadolescents need to be given responsibilities as they grow since this will further add to their development.
- **Affirm the rights of adolescents:** Adolescents too have rights that parents should help to affirm and for which they will be endeared to their parents if they do so.
- **Be firm in discipline when the needs arise**: Adolescents might appear mostly to be averse to correction but they do need and do appreciate firm parents who can discipline them in love.

Parents are also expected to provide safe and nurturing psychosocial environment that will further enhance the development of their adolescent. Whenever possible this will include the following:

- Stable and functional marriages
- Endearing home and family life
- Personal integrity
- Good work ethics
- Sound moral and spiritual convictions
- Proper balance between home and work concerns
- Fair economic stability

Parents who work hard on these frontiers definitely are setting themselves up as good role model for their adolescents.

SUMMARY

The ultimate factor that determines a sustained and an enduring influence of parents on the adolescents is when parents can be there for their adolescents, supporting and encouraging them all the way. With a positive and proper parenting style that is authoritative but caring, firm but fair and when the parents themselves are able to live lives worthy of emulation which the adolescents can be proud of, parents can become effective role models.

EVALUATION

Who is a supportive parent?

List different parenting styles.

What are the features that will make a parent a good role model?

MODULE FOURTEEN
ADOLESCENT AND YOUTH FRIENDLY HEALTH SERVICES

Adolescent and Youth-Friendly Health Services (AYFHS) are services that have policies and attributes that make them attractive to young people. These services are developed and provided in a way that takes into consideration the fact that adolescents face challenges which are different from those of other age groups. Adolescent Friendly Services provide an appropriate setting for meeting the needs of young people, and retain their clientele for follow-up and repeat visits. This module presents an overview of AYFHS; the importance of having such services, qualities and the minimum requirements for AYFHS.

SESSION 1: **OVERVIEW OF ADOLESCENT AND YOUTH FRIENDLY SERVICES**

SESSION 2: **SETTING UP AYFHS**

SESSION 3: **REFERRALS AND NETWORKING**

MODULE FIFTEEN: ADOLESCENT AND YOUTH-FRIENDLY HEALTH SERVICES
SUMMARY AND TIMING ESTIMATES

SESSION TITLE	DURATION	OBJECTIVES	METHODS	MATERIALS
Overview of Adolescent /Youth Friendly Health Services	1Hour 15Minutes	• Describe AYFHS and Identify the types of AYFHS. • Discuss the Minimum Basic Package for AYFHS in Nigeria. • Discuss the characteristics of AYFHS. • Highlight the need for AYFHS. • Discuss the barriers to using youth friendly services and strategies to overcome them.	Plenary/ discussion Group work/presentation/ discussion Role play/discussion	Flipchart stand/papers Chalkboard/chalk Markers
Setting up AYFHS	1 Hour	• Discuss the elements of youth friendly health centres. • Enumerate the steps involved in the establishment of youth friendly services. • • List the basic requirements for establishing youth friendly services in schools, health facilities and the community. • Youth participation in A/YFHS.	Plenary/ discussion Lecture Discussion	Flipchart stand/papers Chalkboard/chalk Markers
Referrals and Networking	1Hour	• Explain the terms referrals and networking. • List the importance of referrals and networking. • Explain referral levels and community resources for effective networking. • Explain feedback and its importance in referral system. • Describe how to network with community resources. • Describe how to create a referral network.	Game on networking Plenary Discussion	Flipchart stand/papers Chalkboard/chalk Markers

MODULE FOURTEEN: SESSION 1
OVERVIEW OF ADOLESCENT AND YOUTH-FRIENDLY HEALTH SERVICES (AYFHS)

TIME: 1Hour 15 Minutes

LEARNERS' OBJECTIVES

By the end of the session, participants will be able to:

- Describe youth friendly services.
- Identify the types of youth friendly services.
- Discuss the characteristics of AYFHS.
- Highlight the need for AYFHS.
- Discuss the barriers to using youth friendly services and strategies to overcome them.

SESSION OVERVIEW

- Adolescent/Youth Friendly Health Services
- Types of AYFHS
- The need for AYFHS
- Barriers to using youth friendly services
- Strategies for overcoming barriers to utilizing AYFHS

METHODS

- Plenary/ discussion
- Group work/presentation/ discussion
- Role play/discussion

MATERIALS

- Flipchart stand/papers
- Chalkboard/chalk
- Markers

CONTENT

OVERVIEW OF ADOLESCENT AND YOUTH-FRIENDLY HEALTH SERVICES

Services are termed adolescent and youth-friendly if they have policies and attributes which make them attractive to youths and provide a comfortable and appropriate setting for meeting their needs. In addition, these facilities are able to retain their clients for adequate follow-up and repeat visits as necessary.

Adolescent and youth-friendly health services should be developed and provided in a way that recognises that the challenges, difficulties, and obstacles faced by young people are different from those of others.

TYPES OF ADOLESCENT AND YOUTH FRIENDLY HEALTH SERVICES

a. Adolescent and youth-friendly health services are usually classified under following categories: A specialized center providing AH services set within a hospital –in-services and drop-in services. This also serves as a secondary or tertiary referral centre for other health facilities, provides facilities for professional training and conducts AH.
b. A community-based health facility. This provides adolescent health services as well as other comprehensive services for other groups of the population. These could be stand-alone facilities often run by NGOs, private individuals or institutions and government-owned adolescent health units which are an integral part of primary/ district level health facilities / centers.
c. School-based services. These are services offered at the school setting often using the peer educator system among others.
d. Community-based centers which provide health and other facilities such as recreation.
e. Pharmacies and shops that provide reproductive health commodities such as condoms, emergency contraception etc.
f. Outreach information and service provision. These provide services to groups of young people who are marginalized and might be unable to access other services. These outreach centres are often located in places where young people come together such as shopping malls or where they work e.g. hotels, bus garages, or where they school.

CHARACTERISTICS OF ADOLESCENT AND YOUTH FRIENDLY HEALTH SERVICES (AYFHS)

Divide participants into 4 groups and request each group to discuss the characteristics of AYFHS under the following:

Group 1 Characteristics of adolescent and youth friendly health facility

Group 2 Characteristics of adolescent and youth friendly health provider

Group 3 Psycho-social characteristics (perception) of young people

Group 4 Administrative/processes for the provision of YFS

Give participants 10 minutes to discuss and 5 minutes each for presentation. Present the flip chart or OHP/T on the characteristic of YFS and compare with the group work presentations.

CHARACTERISTICS OF ADOLESCENT AND YOUTH FRIENDLY HEALTH FACILITIES

- **Convenient Hours**
  The time of operation should be one that would make it convenient for young people to access the services.

- **Convenient Location**
  The place where the services are situated should be one that young people can easily reach. It should be suitable in terms of proximity to the young people it intends to serve.

- **Adequate Space and Sufficient Privacy**
  The space should be one that would allow for private conversation between the provider and the young person, and makes the young person feel at ease. It should be one that allows free expression, and ensures privacy and confidentiality.

- **Comfortable Surroundings**
  The surroundings should be adolescent and youth-friendly and lively. They should have features that would easily attract young people (such as bright- colour buildings, posters on the wall, good ventilation).

CHARACTERISTICS OF ADOLESCENT AND YOUTH FRIENDLY PROVIDERS

- **Specially Trained Staff**
  Staff should be trained to be sensitive to young people's needs, and acquire skills in relating with young people.

- **Respect for Young People**
  Staff should be open-minded and non-judgmental. They should allow young people to make their own decisions after providing them with factual information, and options for dealing with whatever concerns they may have.

- **Privacy and Confidentiality**
  Staff should be trustworthy, and should assure young people that their concerns will not be revealed to other people.

- **Adequate Time for Client and Staff Interaction**
  The time set aside should be convenient for both the provider and young person, to ensure that there are no interruptions, and the young person's concern can be properly addressed.

- **Peer Counsellors Available**
  Young people relate well with other young people, because they perceive that the young person understands how they feel. Therefore, there should be other trained young people who can offer counselling services.

ADMINISTRATIVE/ PROCESSES FOR THE PROVISION OF AYFHS

- **Organisation Policies**
  Organisation policies and code of conduct must be youth friendly and conspicuously displayed on the wall.

- **Youth Involvement**
  Young people should be involved in the planning and implementation of programmes.

- **Group Discussions Available**
  Group discussions that would allow for interactions, expression of self and acquisition of information should be available.

- **Necessary Referrals Available**
  Young people should be able to access services of other networking partners if the facilities are not able to address a particular concern.

- **Flexibility of Service**
  Young people should be able to choose the time for special investigation and tests, provided it is safe to wait.

- **Affordable Fees**
  Charges for services, for example cost of drugs, should be one that young people can afford.

- **Wide Range of Services Available**
  Various services should be designed to address the diverse needs of young people. This would provide young people with alternatives, so as to choose the particular service that suits them.

- **Drop- in Clients Welcomed and Appointments Arranged Rapidly**
  Young people, who had no prior appointments, should be attended to and should be given quick attention.

-

- **Educational Materials Available On Site And To Take Away**
  There should be educational materials such as pamphlets, tracts, posters with information on adolescent sexual and reproductive health development which young people can take away.

- **Publicity That Informs And Reassures Young People**
  There should be information on the services that exist and where the services can be accessed. Youths should be assured that these services are meant for them.

YOUNG PEOPLE'S PSYCHO-SOCIAL CHARACTERISTICS

- **Perception of privacy and confidentiality at a facility**
  Young people should have the assurance that whatever they tell the provider will be kept confidential.

- **Perception that there is no discrimination**
  Young people should feel welcomed regardless of their colour, sex, tribe or religion. It should be one that would serve the interests of both sexes; preference should not be given to the female sex. Boys and young men should feel comfortable and welcomed.

- **Perception that surroundings are comfortable**
  Young people should feel secured and perceive their environment as one that allows them to express their feelings.

- **Perception that providers are attentive to youth needs**
  Young people should see providers as being attentive, trustworthy and youth friendly.

Overall, the WHO recommended that to be considered adolescent-friendly, health services should have the following characteristics**:**

- **EQUITABLE:** All adolescents, not just certain groups are able to obtain the health services they need.

- **ACCESSIBLE:** Adolescents are able to obtain the services that are provided.

- **ACCEPTABLE:** Health Services are provided in ways that meet the expectations of adolescent clients.

- **APPROPRIATE:** The health services that adolescents need are provided.

- **EFFECTIVE:** The right health services are provided in the right way and make a positive contribution to the health of adolescents.

Table 14.1 adopted from WHO's "Quality assessment guidebook: a guide to assessing health services for adolescent clients" (2009) explains each of the characteristics of adolescent health services.

TABLE 14.1: CHARACTERISTICS OF ADOLESCENT-FRIENDLY SERVICES

ADOLESCENT-FRIENDLY CHARACTERISTICS	
EQUITABLE: All adolescents, not just certain groups, are able to obtain the health services they need	
Characteristic	Definition
Policies and procedures are in place that do not restrict the provision of health services on any terms.	No policies or procedures restrict the provision of health services to adolescents on the basis of age, sex, social status, cultural background, ethnic origin, disability or any other area of difference.
Health-care providers treat all adolescent clients with equal care and respect, regardless of status.	Health-care providers administer the same level of care and consideration to all adolescents regardless of age, sex, social status, cultural background, ethnic origin, disability or any other reason.
Support staff treat all adolescent clients with equal care and respect, regardless of status.	Support staff administer the same level of care and consideration to all adolescents regardless of age, sex, social status, cultural background, ethnic origin, disability or any other reason.
ACCESSIBLE: Adolescents are able to obtain the health services that are provided	
Characteristic	Definition
Policies and procedures are in place that ensure that health services are either free or affordable to adolescents.	All adolescents are able to receive health services free of charge or are able to afford any charges that might be in place.
The point of health service delivery has convenient hours of operation.	Health services are available to all adolescents during convenient times of the day.
Adolescents are well-informed about the range of available reproductive health services and how to obtain them.	Adolescents are aware of what health services are being provided, where they are provided and how to obtain them.
Community members understand the benefits that adolescents will gain by obtaining the health services they need, and support their provision.	Community members (including parents) are well-informed about how the provision of health services could help adolescents. They support the provision of these services as well as their use by adolescents.
Some health services and health-related commodities are provided to adolescents in the community by selected community members, outreach workers and adolescents themselves.	Efforts are under way to provide health services close to where adolescents are. Depending on the situation, outreach workers, selected community members (e.g. sports coaches) and adolescents themselves may be involved in this.
ACCEPTABLE: Health services are provided in ways that meet the expectations of adolescent clients	
Characteristic	Definition
Policies and procedures are in place that guarantee client confidentiality.	Policies and procedures are in place that maintain adolescents' confidentiality at all times (except where staff are obliged by legal requirements to report incidents such as sexual assaults, road traffic accidents or gunshot wounds, to the relevant authorities). Policies and procedures address: – registration – information on the identity of the adolescent and the presenting issue are gathered in confidence; – consultation – confidentiality is maintained throughout the visit of the adolescent to the point of health service delivery (i.e. before, during and after a consultation); – record-keeping – case-records are kept in a secure place, accessible only to authorized personnel; – disclosure of information – staff do not disclose any information given to or received from an adolescent to

Continued from previous page

Characteristic	Definition
The point of health service delivery ensures privacy.	The point of health service delivery is located in a place that ensures the privacy of adolescent users. It has a layout that is designed to ensure privacy throughout an adolescent's visit. This includes the point of entry, the reception area, the waiting area, the examination area and the patient-record storage area.
Health-care providers are non-judgmental, considerate, and easy to relate to.	Health-care providers do not criticize their adolescent patients even if they do not approve of the patients' words and actions. They are considerate to their patients and reach out to them in a friendly manner.
The point of health service delivery ensures consultations occur in a short waiting time, with or without an appointment, and (where necessary) swift referral.	Adolescents are able to consult with health-care providers at short notice, whether or not they have a formal appointment. If their medical condition is such that they need to be referred elsewhere, the referral appointment also takes place within a short time frame.
The point of health service delivery has an appealing and clean environment.	A point of health service delivery that is welcoming, attractive and clean.
The point of health service delivery provides information and education through a variety of channels.	Information that is relevant to the health of adolescents is available in different formats (e.g. posters, booklets and leaflets). Materials are presented in a familiar language, easy to understand and eye-catching.
Adolescents are actively involved in designing, assessing and providing health services.	Adolescents are given the opportunity to share their experiences in obtaining health services and to express their needs and preferences. They are involved in certain appropriate aspects of health-service provision.
APPROPRIATE: The health services that adolescents need are provided	
Characteristic	**Definition**
The required package of health care is provided to fulfil the needs of all adolescents either at the point of health service delivery or through referral linkages.	The health needs and problems of all adolescents are addressed by the health services provided at the point of health service delivery or through referral linkages. The services provided meet the special needs of marginalized groups of adolescents and those of the majority.
EFFECTIVE: The right health services are provided in the right way and make a positive contribution to the health of adolescents	
Characteristic	**Definition**
Health-care providers have the required competencies to work with adolescents and to provide them with the required health services.	Health-care providers have the required knowledge and skills to work with adolescents and to provide them with the required health services.
Health-care providers use evidence-based protocols and guidelines to provide health services.	Health service provision is based on protocols and guidelines that are technically sound and of proven usefulness. Ideally, they should be adapted to the requirements of the local situation and approved by the relevant authorities.
Health-care providers are able to dedicate sufficient time to work effectively with their adolescent clients.	Health-care providers are able to dedicate sufficient time to work effectively with their adolescent clients.
The point of health service delivery has the required equipment, supplies, and basic services necessary to deliver the required health services.	Each point of health service delivery has the necessary equipment, supplies, including medicines, and basic services (e.g. water and sanitation) needed to deliver the health services.

ACTIVITY

ROLE PLAY ON THE NEED FOR ADOLESCENT AND YOUTH-FRIENDLY SERVICES

Request three volunteers and give each person the script to rehearse a day before or few hours before the session. After the play, ask the rest of the group what they think might happen to Titi, the various gaps that exist in adolescent sexual and reproductive health, and how youth friendly services might bridge these gaps.

ROLE- PLAY ("WHO CARES")

SCENE 1:

Titi, a young girl has been having some concerns recently and needs someone to talk to, so she approaches her mother.

Titi: Mum, I really need to ask you some questions.

Mother: Titi, as you can see, I'm very busy, I have too many things to do right now.

Titi: (Obviously sad) Please mum, I promise I won't take much of your time.

Mother: (Sighing) O.K., but make it very snappy.

Titi: (Sitting down) Thanks mum. Hmm.. Mum, there's this boy who really likes me, and I think I like him too. He…

Mother: (Dismayed, she puts her hands on her chest) What! Ehn ehn, so that's what you go to do at school. No wonder you did not do well in your last exams. You are a very stupid girl. You are just too young to be talking about boys.

Titi: No mom, I…

Mother: Shut up! Shut your dirty mouth. Stupid girl. (Getting up) I'm going out now, I will deal with you when I get back.

Titi: (Gestures with her hand) whom do I talk to? Mum doesn't understand. Nobody does.

SCENE 2:

School (Titi and her friends, Chioma and Grace are having a chat):

Chioma: So, Titi, how about you and James? Have you agreed?

Titi: No. I'm not sure if I want to go out with him. I tried discussing it with my mum the other day, and…

Chioma: Are you stupid? How could you discuss such a thing with your mum?

Titi: I wanted to, but she did not listen.

Grace: What did you expect? That's how adults behave. Anyway, so what are you planning to do now?

Titi: **(**Biting her nails) I'm not sure, but I don't think I'm ready yet.

Chioma: Why? You are 15, beautiful and available. Look Titi, you are just a 'slacker'.

Titi: You guys don't understand. What if he wants to have sex? I might even get HIV/ AIDS.

Grace: So? What's the big deal? Please grow up. You are not a baby for God's sake.

Chioma: Besides that, remember you can't get pregnant the first time you have sex, and James doesn't look like someone who has HIV/ AIDS, he's a clean guy. Look, you better think of it very well. James is a nice guy and there are other girls who would like to go out with him.

Titi: I don't know…

Chioma You better know. (Getting up) Grace, please follow me to the canteen.

Titi: (Looks confused) I'm so confused. I don't know who to believe or what to do. I need help, but who cares?

Grace: There is a youth centre in town, I am told that the staff there are responsive to young people's needs, it might be helpful to give it a go.

Titi: Is it? I better give it a trial.

PROCESS THE ROLE PLAY: Ask participants to mention lessons learnt from the role-play.

BARRIERS TO THE PROVISION AND UTILIZATION OF HEALTH SERVICES TO ADOLESCENTS

ACTIVITY

Divide participants into 4 groups and request each group to discuss the barriers to the provision and utilisation of YFS and the strategies to overcome these barriers.

Group 1 Barriers that prevent health services from being provided for adolescents.

Group 2 Barriers preventing adolescents from seeking help from the health services they need.

Group 3 Barriers preventing adolescents who want help from reaching organizations which provide the health services they need.

Group 4 Barriers that prevent adolescents from using health services, even when they know which organizations provide them, and can reach them.

Give participants 10 minutes to discuss and 5 minutes each for presentation.

A range of barriers operate at different levels, which hinder the provision and utilization of health services (e.g. STI diagnosis and treatment) and health products (such as condoms) to adolescents.

Present the flip chart on these barriers thus:

BARRIERS THAT PREVENT HEALTH SERVICES FROM BEING PROVIDED FOR ADOLESCENTS:

- Laws and regulations forbid- or are believed to forbid- the provision of services to people below a certain age or to unmarried people.
- Judgmental health care providers withhold services from people below a certain age or from unmarried people (even when laws and regulations permit them to be provided).

BARRIERS PREVENTING ADOLESCENTS FROM SEEKING HELP FROM THE HEALTH SERVICES

Adolescents:

- Are reluctant to draw attention to themselves or to their actions (e.g. their sexual activity or substance abuse).
- Do not recognize their illnesses or are not aware of the serious consequences of their illnesses.
- Do not know that they could get help to prevent these illnesses, and to have them treated if they do arise.
- Do not know where to get the health services they need.

BARRIERS PREVENTING ADOLESCENTS WHO NEED HELP FROM REACHING ORGANISATIONS WHICH PROVIDE THE HEALTH SERVICES THEY NEED:

- The organizations are located a long distance away from where they live/ study/ work, or in places that are difficult to get to.
- The services are provided at times of the day when they cannot get away from their study/ work.

BARRIERS THAT PREVENT ADOLESCENTS FROM USING HEALTH SERVICES, EVEN WHEN THEY KNOW WHICH ORGANIZATIONS PROVIDE THEM, AND CAN REACH THEM

Based on their own experiences or the experiences of their peers, they may actually know- or may fear- that:

- They have to go to and/ or wait in a place where they could be seen by people who know them.
- They have to go through a long and bureaucratic procedure before they get to see the health provider.
- They have to wait for a long time to see a health care provider and to get the health services they need.
- Health care providers will humiliate them, ask them difficult questions, and put them through unpleasant and painful procedures.
- They will be examined by a health care provider of the opposite sex.
- Health care workers cannot provide them with the services they need without the consent of parents or guardians.
- Health care providers will not maintain confidentiality (and that people around them will know about their condition).
- They cannot afford to pay for the services they need.
- The quality of health services they get are poor, services are unlikely to be helpful and could even be harmful.

SUMMARY

The need to provide adolescents with youth friendly services cannot be overemphasized. As much as possible, barriers to the provision and utilization of health services should be removed so that youths can make use of the facilities as needed.

EVALUATION

What are the components of adolescent and youth-friendly health services?
List three barriers to using health services by adolescents.

MODULE FOURTEEN: SESSION 2
SETTING UP ADOLESCENT AND YOUTH-FRIENDLY SERVICES

TIME: 1 Hour

LEARNERS' OBJECTIVES

At the end of the session, participants will be able to:

- Discuss the elements of adolescent and youth-friendly health centres.
- Enumerate the steps involved in the establishment of adolescent and youth-friendly services.
- List the basic requirements for establishing adolescent and youth-friendly services in schools, health facilities and the community.

SESSION OVERVIEW

- Elements of adolescent and youth-friendly health centres.
- Steps involved in the establishment of adolescent and youth-friendly services.
- Basic requirements for establishing adolescent and youth-friendly services in schools, health facilities and the community.

METHOD

- Plenary sessions
- Lecture
- Discussions

MATERIALS

- Flipchart stand/paper
- Chalkboard/chalk
- Markers, masking tape
- Handouts

CONTENT

ELEMENTS OF ADOLESCENT AND YOUTH FRIENDLY SERVICES

Adolescent and Youth-Friendly Health Services should have the following elements:

- **Community support**
  - Well informed of its existence
  - Acknowledges its values
  - Supportive of its work

- **Youth participation**
  - Youths should be well informed about available services and their utilisation.
  - Active participation of adolescents and youths is crucial.

- **Youth friendly policies**
  - Guarantee confidentiality.
  - Do not require parental consent.
  - Do not withhold provision of services and product.

- **Youth friendly procedures**
  - Easy registration/retrieval procedure
  - Short waiting time
  - Drop in's with or without prior appointment possible
  - Strong linkage to other health and social service providers
  - Not expensive and flexible about payment

- **Adolescent and youth-friendly staff**
  - Technically competent, interested and concerned
  - Understanding and considerate, easy to relate to and trustworthy
  - Able and willing to devote adequate time
  - Can be contacted on repeat visit

- **Adolescent and youth-friendly environment**
  - No stigma
  - Appealing milieu
  - Convenient working hours
  - Convenient location
  - Information education material available
  - Privacy in the examination/consultation/waiting rooms, and in the entrance/exit
  - Safety guaranteed

STEPS INVOLVED IN THE ESTABLISHMENT OF ADOLESCENT AND YOUTH-FRIENDLY SERVICES

Establishing adolescent and youth-friendly services requires a carefully thought out plan, identification and assessment of structures to determine their suitability and appropriateness. There are already existing school-based clinics that need to be upgraded to conform to the standard of adolescent and youth-friendly services. Health providers and community members need to be trained and sensitised to the challenges of youth sexual and reproductive health, their peculiar needs and how some of these needs can be met by the provision of AYFHS. In establishing AYFHS it may be important to consider the following steps.

- **STEP 1**: **Baseline information**
  Using qualitative and quantitative methods to determine needs, identify resources and other gaps that need to be filled.

- **STEP 2**: **Training**
  Depending on the outcome of the assessment, basically there may be the need to train health providers and some selected members of the communities to sensitise them to the need for youth friendly services. This training will focus on ARH counselling skills for health providers and parent child communication for the community members.

- **STEP 3: Establishing adolescent and youth-friendly services require appropriate funding.**
  Funding is however limited these days as a result of other competing needs. Networking and securing resources from other organizations or other programme areas may be helpful. For instance, linkages can be established with institutions or organization for the supply of IEC materials or contraceptive commodities. Apart from sourcing for fund from donor agencies and individuals, philanthropists may be contacted for fund and/ or donation of structure for the establishment of youth friendly centres.

- **STEP 4**: **Setting up adolescent and youth-friendly services**: The outcome of the assessment is important for determining appropriate location for YFS to enhance its accessibility and utilization by youths. It may be necessary to renovate some structure, upgrade some, integrate YFS into already existing services or establish new ones entirely. There are already existing services that need to be transformed to make them youth friendly, these include:

  - Reproductive Health related services - (family planning, STIs, Maternal/Child health)
  - A health post that provides RH services
  - School based health services
  - Work place based health services
  - Pharmaceutical outlets/chemists that serve youths
  - A centre for youth that provides health services
  - A freestanding youth clinic
  - Mobile health services.

BASIC REQUIREMENT FOR ESTABLISHING YOUTH FRIENDLY SERVICES AT THREE SETTINGS (SCHOOL, FACILITY, AND COMMUNITY)

Equipment and materials needed for establishing YFS vary depending on the setting.

SCHOOL-BASED

Adolescent and youth-friendly services in schools will require the following equipment and materials:

- Furnishings: A set of tables and chairs for counselling/consultation, store cupboard for storing drug and consumables, shelves/cabinet for cards and IEC materials, examination couch, mobile screens etc.
- Trolley with bowls and lids, scissors dressing forceps.
- Consumables/Materials such as cotton wool, gauze and other materials for dressing, bucket for hand washing.
- Drugs such as antimalarials, analgesics, antihistamines, antacids, multivitamins, vitamin C and cough mixtures.
- Lotion such as methylated spirit, savlon, dettol, TBC, iodine etc.
- Apparatus such as thermometer, blood pressure apparatus, weighing scales etc.
- IEC Materials: this should include posters, pamphlets and leaflets that will provide information and education on sexual and reproductive health and development issues for the adolescent.

HEALTH FACILITY BASED

A facility based YFS should offer a more comprehensive service. Equipment and materials needed should include the ones stated above and other equipment and material for managing complex cases and for the provision of quality RH services. Facility based YFS should provide the following services, diagnosis and management of STIs/HIV/AIDS, provision of family planning information and services, counselling services, laboratory services, health education, nutrition education and may offer in and out-patient services.

Some facility based YFS may offer integrated services. This is integrating youth friendly programmes into already existing service centres to make them youth friendly. This involves introduction of a wide range of programmes and services that will enhance active participation of youths such as library services, vocational training for skills development, youth clubs, drama clubs, games and recreational activities. These wide ranges of services enable youths access to sexual/RH services and other services and at the same time relax in a friendly environment.

COMMUNITY BASED

This is using other outreach and community-based approaches to deliver services to locations where young people spend time such as Boy's Scout, Girls Guide, hotlines, peer promotion programmes, recreation and sports centres, social marketing and other outreach centres that provide services for young people. These various outlets can provide young people with services such as information/education, counselling and referrals to clinic services or other YFS needed.

YOUTH PARTICIPATION IN YOUTH FRIENDLY HEALTH SERVICES

Youth Participation in Youth Friendly services refers to youth partaking in, and influencing processes, decisions and activities taking place in the **Y**outh **F**riendly **S**ervices. Youth should be a part of these activities irrespective of their gender, level of education or other factors.

Refer to the clinical protocol for further information on youth participation in A/YFHS.

SUMMARY

The elements of youth friendly services are community support, youth participation, youth friendly policies, procedures, staff and conducive environment. In establishing these services, which would require huge funding, it will be necessary to determine the needs of youths and identify resources that will be required. Training of Health Care providers is also crucial for an efficient and effective delivery of the services.

EVALUATION

- Describe the elements of adolescent and youth-friendly health services.
- List steps involved in the establishment of adolescent and youth-friendly health services.

MODULE FOURTEEN: SESSION 3
REFERRAL AND NETWORKING

TIME: 1Hour

LEARNERS' OBJECTIVES

At the end of the session participants will be able to:

- Explain the terms referrals and networking.
- State the relationship between referrals and networking.
- List the importance of referrals and networking.
- Identify community resources for effective networking.
- Describe how to network with community resources.
- Describe how to create a referral network.

SESSION OVERVIEW

- Definitions.
- The importance of referrals and networking.
- Relationship between referrals and networking.
- The levels of referrals.
- The importance of feedback in referral systems.
- Community resources for effective networking.
- Networking with community resources.
- Creating a referral network.

METHODS

- Game on networking.
- Discussions.
- Plenary sessions.

MATERIALS

- Flipchart stand and papers.
- Markers.
- Cardboard and scissors.
- Grab-bag.

CONTENT

DEFINITIONS

- Networking is defined as working with other people, agencies or institutions to share resources and ideas for the ultimate achievement of set goals.
- Referral is defined as providing linkages with other sources where services can be obtained. It involves directing people to access the services of other networking partners.

THE IMPORTANCE OF REFERRALS AND NETWORKING

Referrals and networking are important for the following reasons:

- To exchange ideas, gain experience and seek technical support and assistance from experts.
- To get help to deal with difficult clients, and refer/direct clients with special needs to appropriate sources of support.
- To avoid duplication of efforts.
- To share expertise and materials, and access other resources and materials.
- To provide extra services to clients.

LEVELS OF REFERRAL AND IMPORTANCE OF FEEDBACK IN REFERRAL SYSTEM

- **Referral**

  There are various levels of referral such as:
  - Intra service referral: Young people can be referred to fellow youth.
  - Inter service referral: Young people may be referred from one service point to another.

- **Feedback** is an important aspect of referral. When referrals are made, it is important to receive report on the treatment or services given to the client to enable the service provider know the next line of action. Every service provider who refers must ensure that clients are properly followed up to ensure that adequate management has been given.

COMMUNITY RESOURCES FOR NETWORKING

Divide participants into groups, each group is to identify community resources available for networking, supplement with the list below:

- Other counsellors
- Consultants
- Referral centres
- Professional counsellors e.g. HIV/ AIDS counsellors
- Religious groups
- Peer counsellors or educators
- School administrators or counsellors
- Private medical practitioners

- Other organisations (NGOs) providing similar assistance, medicines, financial aid, material support, training and expertise.
- Others: Community members may refer young people to any of the above listed referral points.

PROCESS: Identify 2 things each sub-group can contribute to the benefit of the network.

CREATING REFERRAL NETWORKS

Creating referral networks can be achieved through the following ways:

- Referral letters
- Meetings
- Visits to other facilities
- Sharing support materials
- Participating in training activities together
- Participating in professional organisations
- Asking other counsellors for help and ideas.

These fora provide unique opportunities for interaction, sharing of ideas, seeking and providing technical assistance for the ultimate benefit of the clients and the program.

SUMMARY

Referrals and networking are crucial because idea can be exchanged, experiences and expertise shared and duplication of efforts can be avoided. To this end, referrals provide linkages necessary to access the services of networking partners.

EVALUATION

- What are the community resources needed for effective networking?
- Describe the relationship between referrals and networking.

NETWORKING GAMES 1: TRUST WALK

- This game involves blindfolding a participant; therefore it should be explained to the participant at the outset.
- Ask for a volunteer among the participants.
- Get a piece of cloth for the blindfolding exercise.
- Tie the participants face with the piece of cloth and tell the participant to walk from the back of the room towards the door without any assistance.
- Tell the rest of the group to watch without saying anything or offer any assistance.

Possible outcomes: Achieving the goal of moving toward the door takes more time, is more cumbersome, involves trial and error and may end up in non-achievement of the set goal.

Second attempt: Repeat the same process as above, but request the rest of the group to provide assistance by giving instruction that will aid the smooth movement of the participant to the door. For example give instruction like 'take two steps forward, move right or left etc'.

Possible outcomes: Achievement of goal is faster and easier, few mistakes are likely to happen, and trial and error is minimal.

Processing: Summarize by telling the participants the advantages of collaborating with one another and offering support for each other which will go a long way in achieving a set goal. Tell the participant the need to build trust on one another because it is the trust the blindfolded participant had that made her follow the instruction from the group.

NETWORKING GAME 2: WORD GAME

- Prepare cardboard by cutting into small pieces (20 pieces). Write each alphabet of the word 'Networking' in 2 sets in various colours.
- Mix these alphabets together in a container or grab bag.
- Divide participants into two groups.
- Distribute the pieces of alphabet among the two groups.
- Tell participants that each group is expected to form a 10 letter word and that they are free, if they like, to ask for assistance from each other.
- Give participants five minutes.
- At the end of 5 minutes, check which of the groups was able to complete forming the word NETWORKING.

Process questions

- Ask participants about what they have learnt from the game.
- What facilitated the completion of the word NETWORKING.
- How can this be applied to our daily work/ interaction with other people/organisations?

CONCLUSION

Conclude by telling participants the importance of sharing resources in order to achieve a desired goal.

MODULE FIFTEEN
SPECIAL PREVENTIVE HEALTH CARE SERVICES FOR ADOLESCENTS

The most serious, costly and widespread adolescent health problems are potentially preventable. Although adolescents consult healthcare workers less frequently than other age groups, any consultation provides the opportunity for preventive services. This module presents some preventive health care services relevant for promotion, prevention and control of preventable diseases in adolescents and young persons. It aims to give relevant information on the rationale, the scope and practice of hygiene and grooming routines by adolescents. It gives an overview of adolescent immunization, its benefits and discusses some of the recommended relevant adolescent immunization.

SESSION 1: PERSONAL HYGIENE

SESSION 2: ADOLESCENT IMMUNIZATION & GENOTYPE SCREENING

SESSION 3: SELF BREAST/TESTICULAR EXAMINATION

MODULE FIFTEEN: PREVENTIVE HEALTH CARE SERVICES FOR ADOLESCENTS
SUMMARY AND TIMING ESTIMATE

SESSION TITLE	DURATION	OBJECTIVES	METHODS	MATERIALS
Personal Hygiene	1 Hour 45 Minutes	• Discuss importance of personal hygiene. • Explain some good grooming routines. • Explain the importance of hand-washing and how to do it properly. • Discuss some common health problems that can be prevented through improved personal hygiene. •	Brainstorming Discussion Lecture Demonstration and return demonstration	Flip chart stand/ paper. Marker pen. Wash hand basin with running tap. Bowl for scooping water. Liquid soap. Individual tissues for hand wiping. Methylated spirit.
Adolescent Immunization	1Hour 30 Minutes	• Analyse current issues in adolescent immunization. • Explain the benefits of adolescent Immunization. • Discuss recommended adolescent immunization.	Lecture Discussion Brainstorming	Flip chart/markers Projector Vaccine samples
Self Breast/ Testicular Examination	1 Hour	• Explain the importance of Self Breast Examination. • Describe the essential steps for self breast examination. • Describe the need for and process of conducting testicular examination.	Brainstorming Demonstration Discussion Lecture	Flip chart stand & paper Marker Slides/transparencies Projector computer

MODULE FIFTEEN: SESSION 1
PERSONAL HYGIENE

TIME: 1Hour 45 Minutes

LEARNERS' OBJECTIVES

At the end of this session, participants will be able to:

- Discuss importance of personal hygiene.
- Explain some good grooming routines.
- Explain the importance of hand-washing and how to do it properly.
- Discuss some common health problems that can be prevented through improved personal hygiene.

METHODS

- Brainstorming
- Discussion
- Lecture
- Demonstrations

MATERIALS

- Flip chart stand/ paper
- Chalk board /chalk
- Marker pen
- Paper tapes
- Demonstration Materials: Wash-hand basin, Soap, Water e.t.c
- IEC Materials on Key-household practices
- Projector
- Toothbrush

CONTENT

INTRODUCTION

One of the most effective ways to protect ourselves and others from illness is through good personal hygiene. ***Personal hygiene can be defined as taking care of the whole body daily in order to be healthy and free from diseases***. This involves washing your hands and the rest of your body, being careful not to cough or sneeze into the faces of others, putting waste items into a bin and using protection like gloves when you might be at risk of catching or passing on an infection.

A number of infectious diseases, particularly gastro-intestinal infections can be prevented through proper hand-washing. Every external part of the body demands a basic amount of attention on a regular basis. Neglect of personal hygiene can cause some problems.

GOOD GROOMING ROUTINES

Here are some grooming routines.

Hair

The hair is usually referred to as one's crowning glory and it is easy to maintain. Hair should be kept at a length and style the individual can maintain. The hair should be washed using soap or shampoo. It should be rinsed well and dried after every wash. Girls who dress their hair should wash it once a week while boys are to wash it everyday. The hair should be brushed or combed after bathing.

Skin

Soap and water are essential for keeping the skin clean. Bathing with soap and water once or twice a day is recommended. Those who are involved in active sports should take a bath after such activities. A non-medicated soap will do the job adequately. Germicidal or antiseptic soaps are not essential for the daily bath. A bath sponge can be used for scrubbing. Drying with a clean towel is important. People should not share towels. A moisturising oil or cream can be rubbed on the body after bathing.

Teeth

The teeth can be kept clean by using a toothbrush and or chewing stick. Teeth should be brushed with fluoride toothpaste twice daily: morning and night, to prevent tooth decay.

While brushing, attention should be paid to the fact that one is getting rid of the food particles stuck in between the teeth and in the crevices of the flatter teeth at the back - the molars and pre-molars. The upper teeth should be brushed down while the lower teeth should be brushed up. The tongue should be brushed as well as the inner surface of teeth. For those using toothbrushes, the following should be taken into consideration:

- A quality tooth brush should be used.
- It should be rinsed well and left to dry after use.
- It should be changed every three months.
- People should not share toothbrushes.

Nails

It takes five months for nails to replace themselves. Nails should be kept long only if one can keep them clean. Short nails cause less problems. Nails should be clipped, along their shape. However they should not be cut so close that they pinch the skin.

Feet

The feet should be given a good scrub with a sponge. After a bath, ensure that in-between the toes are kept dry. Keep toenails clipped.

A clean pair of cotton socks may be worn every day. Many people have sweaty feet, and socks and shoes can get quite smelly. The same pair of unwashed socks should not be worn every day. At least two pairs should be kept and used alternately.

Genitals

The genitals and the anus need to be cleaned well because of the natural secretions in these areas. If not properly cleaned, irritations and infections can occur. In women, to avoid infections, they should wipe front to back after urinating or defecating. Clean underwear should be worn after bathing.

Special Female Considerations

Many ladies do not feel completely comfortable when menstruating. This discomfort can be as a result of pre-menstrual tension or caused by the menstrual flow.

Technology offers sanitary pads or tampons to deal with the flow. The user has to decide what suits her best. Whatever the preference, bathing is important. Some women have the problem of odour during menstruation. Cleanliness and changing of sanitary pads or tampons as often as is necessary, reduces this problem. It is not advisable to use perfumed pads or tampons. In fact, using powder in the genital area is not recommended and should be discouraged.

For those who use tampons, the tampons should not be left unchanged beyond six hours because of the possibility of getting toxic shock. There seems to be a link between tampons and Toxic Shock Syndrome (TSS). TSS is caused by a bacterium called *Staphylococcus aureus*. It is marked by high fever, severe vomiting and diarrhoea. Approximately 1% of all menstruating women carry this bacterium in their vagina. Absorbent tampons provide the medium for them to grow and spread infection especially if left beyond six hours. Therefore, the importance of not leaving a tampon inside the vagina for more than six hours cannot be overemphasised.

Special Male Considerations

For uncircumcised male, a build up of secretions called ‘smegma’ can form under the foreskin. Therefore, the foreskin should be pulled back gently during a bath and cleaned with soap. However, the soap should be rinsed off the foreskin well. For circumcised men, the penis and testicles should be washed with soap and water during a bath and rinsed well.

For Travellers

When travelling, take special care if you're not sure whether the available water is safe. Suggestions include:

- Drink only packaged water, preferably bottled water.
- If you have no other water source, make sure the water is boiled before you drink.
- Wash your hands with clean water always before you eat.
- Wash fruits and vegetables with safe water before eating.
- Make sure any dishes, cups or other utensils used are totally dry after they are washed.
- Care must be taken to avoid inadvertently drinking some of the water when taking a bath
- If unsure of the water source, use packaged water or boiled water when brushing your teeth.

HAND WASHING

When to Wash the Hands

The hands should be washed thoroughly:

- Before preparing food.
- Before eating food and snacks.
- Between handling raw and cooked or ready-to-eat food.
- After going to the toilet or changing nappies.
- After using a tissue or handkerchief for blowing the nose.
- After handling garbage or working on the farm.
- After handling animals.
- After attending to sick children or other sick family members.
- After handling dressings, bandages or contaminated clothes or material from an infected person.
- After using chalk to write.

How to Wash the Hands Properly

To wash the hands properly, we need to:

- Wet them with water.
- Apply one dose of liquid soap and lather well for 15-20 seconds.
- Rub hands together rapidly across all surfaces of the hands and wrists to help remove dirt and germs.
- Ensure that the back of the hands, wrists, between fingers and under fingernails should not be forgotten.
- Wash the hands for at least 10 seconds.
- Rinse well under running water or under water poured by someone else. It must be ensured that all traces of soap are removed, as residues may cause irritation.

- Dry the hands with a clean towel or with air dryers.
- Ensure that rings and watches are be removed before washing the hands as they can be a source of contamination if they remain moist.
- Ensure that each family member in a household have his/her own towel which should be washed regularly.

Importance of Soap

Soap contains ingredients that will help to:

- Loosen dirt on the hands.
- Soften water, making it easier to lather the soap over the hands.
- Clean the hands thoroughly, leaving no residues to irritate and dry the skin.

Why Liquid Soap is Best

Generally, it is better to use liquid soap rather than bar soap, particularly in schools. The benefits of liquid soap include:

- It is hygienic - It is less likely to be contaminated.
- The right amount is dispensed per time - Liquid soap dispensers do not dispense more than the required amount (more is not better).
- Less waste - It's easier to use, with less wastage.
- Saves time - Liquid soap dispensers are easy and efficient to use.

The Problems with Bar Soap - Particularly in Public Places

There are many reasons why bar soap can be a problem, particularly if it is used by a lot of people. These problems include:

- Bar soap can sit in pools of water and become contaminated with many harmful germs.
- People are less likely to use bar soap if it is 'messy' from sitting in water.
- Contaminated soap may spread germs and may be more harmful than not washing the hands.
- Bar soap can dry out - People are less likely to use it to wash their hands because it is difficult to lather.
- Dried out bar soap will develop cracks which can harbour dirt and germs.

Task
A practical demonstration of hand washing should be done after this.
Time: 10 minutes

How to Take Care of the Hands

You can care for the hands by doing the following:

- Applying a water-based absorbent hand cream.
- Wear heavy-duty rubber gloves to wash clothes especially for those who wash on a commercial level - *washer men.*
- Wearing gloves when farming to prevent a build-up of ingrained soil or scratches.
- Consulting a doctor if a skin irritation develops or continues.

COMMON CONDITIONS CONTROLLABLE BY IMPROVING PERSONAL HYGIENE

Head Lice

Lice (Nits) are tiny insects that live on the human scalp and suck blood for nourishment. Lice make a pinprick-like punctures on the scalp, emit an anti-clotting substance and feed on the blood.

Lice thrive on unclean hair. Children are especially prone to lice infestation. Lice spread from one head to another when there is close contact as in school environments. The eggs produced by lice are wrapped in shiny white sheaths and these show up on the upper layers of hair as the infestation increases. They make the scalp itchy and are a cause of annoyance and embarrassment. If unchecked, they can cause scalp infection.

Anti-lice shampoos are available in the market, but in persistent cases a doctor's advice can be sought. Nit picking is painstaking and requires patience. A fine toothed comb and regular monitoring can get rid of the problem. Usually when a child is using an anti-lice shampoo, all members of the family are advised to use it too.

Dandruff

These are pieces of dead skin on the scalp which come off in tiny peels and can be seen as whitish flakes in the hair or on the shoulders.

Dandruff is associated with some disturbance in the tiny glands of the skin called the sebaceous glands. They excrete oil, but when there is too little oil, the skin becomes dry and peels. When there is too much oil, dandruff can also occur. It may have a slight yellow colour.

Washing of the hair with an anti-dandruff shampoo once to three times a week is necessary to get rid of the problem. Combs and brushes must be washed with soap. Hair should be brushed/combed regularly. A wholesome diet and overall cleanliness will help. Massage the scalp everyday to improve circulation.

Bad Breath

Poor oral hygiene and infection of gums often result in a bad odour emanating from the mouth. This is called halitosis. Smoking can make this worse. Proper brushing of the teeth and oral care can get rid of bad breath.

There can be other reasons for bad breadth e.g. colds, sinuses, throat infections or tonsil infections. Diseases of the stomach, liver, intestines or uncontrolled diabetes are also possible causes. Therefore, if bad breath persists despite good dental care, a doctor needs to be seen.

Body Odour

The body has nearly two million sweat glands. These glands produce about half a litre of sweat in a day. In tropical countries, naturally, more sweat is produced. The perspiration level increases with an increase in physical exertion or nervous tension.

Fresh perspiration, when allowed to evaporate does not cause body odour. An offensive smell is caused when bacteria that are present on the skin get to work on the sweat and decompose it. This is especially so in the groin area, underarms, and feet or in clothing that has absorbed sweat.

Regular baths and change of clothes should take care of the problem. Talcum powders, of the non medicated kind, can be used under the armpits. Deodorants can also be used. Most commercial deodorants contain an antiperspirant, such as aluminium chloride.

Perfumed soaps do not interfere with sweat secretion, but contain hexachlorophene which destroys the bacteria that cause body odour. If daily cleanliness routines do not reduce body odour, a doctor should be consulted.

Perspiration

The body perspires to keep the body temperature from rising. Sweat is 99% water. The remaining 1% comprises a small quantity of urea, salt and some other compounds. Some people sweat more, some less due to hereditary and body composition factors. If the body perspires more, especially in hot weather, a slight increase in the intake of common salt is advised, to make good what is lost through perspiration.

Excessive perspiration can lead to the scaling of the skin or inflammation (*Dermatitis*). This can also be a symptom of diabetes, anaemia or hyperthyroidism.

SUMMARY

Personal hygiene is one of the most effective ways of preventing diseases. All young persons must have a good mastery of correct grooming routines and proper hand-washing techniques. The health worker needs to reinforce these habits in the adolescent as frequently as possible.

EVALUATION

- What are some good grooming routines?
- Describe the steps involved in proper hand-washing?
- List some common conditions that can be controlled by improving personal hygiene.

MODULE FIFTEEN: SESSION 2
ADOLESCENT IMMUNIZATION

TIME: 1Hour 30 Minutes

LEARNERS' OBJECTIVES

By the end of the session, the participants will be able to:

- Analyse current issues in adolescent immunisation.
- Explain the benefits of adolescent Immunisation.
- Discuss recommended adolescent immunisation.

METHODS

- Lecture
- Discussion
- Brainstorming

MATERIALS

- Flip chart/markers
- Projector
- Vaccine samples

CONTENT

CURRENT ISSUES IN ADOLESCENT IMMUNIZATION

In 1997, the World Health Organization (WHO) Strategic Advisory Group of Experts (SAGE) for the Expanded Program in Immunization (EPI) indicated the need for expanded immunization activities beyond infancy. In response, the WHO released a review of strategies, policies, and practices for adolescent immunization in 1999. Almost a decade later, rates of adolescent immunization remained disappointing low.

Many vaccine-preventable diseases and infections, such as invasive meningococcal disease, pertussis, measles, mumps and Human Papiloma Virus (HPV) infections cause tremendous morbidity and mortality in the adolescent population or predispose them to cancer later in life. For example, invasive meningococcal disease kills ~10–15% of patients despite antimicrobial therapy and among survivors causes significant morbidity including neurological deficits and limb loss. In Nigeria – WHO estimated that about 14, 455 new cases of cancer of the cervix occurred in 2008, 8 out of 10 presenting with an advanced disease and with mortality rate of about 23%. Despite such morbidity and mortality, the availability of highly effective vaccines against these scourges, the recognition of vaccination as a key public health achievement of the 20th century, and the establishment of age-specific recommendations for vaccine administration in many countries, many adolescents remain unvaccinated.

This manual emphasizes the benefits of adolescent immunization programs and identifies current programmatic issues, such as adolescent vaccination acceptability among adolescents, parents, and healthcare providers, policy challenges including vaccine price and administration costs, lack of infrastructure and need for political will to support adolescent immunization programs. This session also aims to help identify key questions and proposes effective strategies to achieve the goal of vaccination of all adolescents.

Vaccinating adolescents offers three types of immunization opportunities: catch-up on missed vaccinations, boosting waning immunity (derived from prior childhood vaccinations), and achievement of primary immunization through administration of new vaccines best delivered during adolescence. New vaccines for adolescents, currently available in many countries, include the meningococcal conjugate vaccine (MCV4), the combined tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccine and, more recently, the bivalent and quadrivalent Human Papilloma Virus (HPV) vaccines. In the future, adolescence may also be the target age range for administration of some exciting prospective vaccines currently in development, including candidates to prevent human immunodeficiency virus (HIV) infection. The development and availability of the meningococcal conjugate vaccine (MCV4), Tdap, and HPV vaccines have revitalized interest in adolescent immunization.

A successful vaccination program may strengthen support for (and adolescents' participation in) preventive healthcare encounters, and thus, may increase opportunities for delivery of other evidence-based healthcare interventions.

Examples of successful Adolescent Immunisation programmes

The benefits of effective adolescent immunization implementation to both adolescents and society are substantial and worthy of investing in. For example, before launching its program in 1991, Italy was considered a country with medium HBV endemicity and it was hypothesized that the pool of chronic HBV carriers most likely arose from individuals infected in childhood. To decrease the number of susceptible children who were at high risk for acquiring chronic HBV infection, Italy adopted a program that included not only universal infant immunization but also adolescent immunization against HBV. In conjunction with social, behavioural, and demographic changes as well as other public health measures (e.g., universal precautions in medical settings), the program targeting infants and adolescents resulted in a dramatic decrease in the incidence of HBV especially among 15–24-year-old. No clinically overt hepatitis has been detected in vaccinated individuals and Italy is now considered to have low HBV endemicity.

Secondly, in the United States adolescents are at greater risk of death from invasive meningococcal disease than infants and children (case-fatality rates: 22.5% vs. 4.6%, respectively; p = 0.001). Adolescent pertussis infections, while causing significant morbidity to adolescents themselves, pose an even greater risk to society. Endemic disease in adults and adolescents is likely to be responsible for infections among unvaccinated or under-vaccinated children. In the United States, 20% of the 29,134 of pertussis cases occurring from1997 to 2000 required hospitalization, with estimated costs of US$5683 per adolescent or adult hospitalization and US$9586 per infant hospitalization. There are also costs associated with outpatient care and outbreak investigations including notification and treatment of contacts, and providing vaccination for indicated persons. In a recent cost-effectiveness study from the United States, Adolescent immunization clearly offers significant benefits to the vaccinee, their families and contacts, as well as society. This then begs the question—why are not more adolescents being vaccinated?

Barriers to Adolescent Immunization

Many barriers to adolescent immunization programs have been identified worldwide. Beyond lack of access to healthcare services, other factors contributing to low adolescent immunization rates include:

- Missed vaccination opportunities during preventive visits as well as those for acute care.
- Lack of population-based immunization registries that include adolescents.
- Low parental, peer/provider, and public awareness of vaccination recommendations.
- Limited healthcare provider endorsement for some vaccines.
- Misperceptions regarding vaccine safety.
- Lack of knowledge about the importance of immunizations and their health benefits.

Addressing the barriers to adolescent vaccination

Four barriers to overcome:

There is a need to address four key issues that are vital to the development of adolescent immunization programs.

- First, a better understanding of the healthcare needs of adolescents, including disease burdens and access to healthcare clinics, is required.
- Second, education of adolescents, parents, healthcare providers, and policymakers is needed to promote increased understanding of both vaccine-preventable diseases and vaccines.
- Third, infrastructure to support adolescent immunization needs to be developed.
- Fourth, the lack of sustained financing must be overcome. Multiple stake-holders are needed to overcome these barriers including public health organizations such as WHO, donors like the GAVI Alliance, national health ministries, healthcare professional organizations, and industry.

While multiple barriers to the implementation of a successful adolescent immunization program exist, countries who are committed to overcoming these barriers have realized positive results.

Currently recommended adolescent immunization

Vaccines recommended for adolescents address three key needs: helping "catch-up" young people who missed infant or childhood vaccinations, providing booster doses to bolster waning immunity, and providing primary immunity using recently available vaccines or vaccines with evidence of efficacy against infections affecting this age group. Table 1 provides selected information (e.g, disease characteristics, epidemiology) regarding vaccines currently available for adolescents. Table 2 shows selected strategies for vaccine delivery. For adolescents who missed childhood vaccinations, "catch-up" programs are used throughout the world. Evidence suggests that when children miss vaccinations, their risk for never completing immunization also increases.

"Catch-up" immunizations – They provide a direct individual benefit and a societal benefit through reducing transmission by enhancing herd immunity. Vaccines such as:

- Hepatitis B Vaccine,
- Measles Mumps and Rubella, and
- Varicella

are often recommended for adolescent catch-up vaccination.

A recent example of a successful adolescent catch-up program is the mass measles immunization campaign conducted nationwide in Nigeria in 2008. For diseases such as pertussis, the WHO recommends additional vaccinations in order to maintain or increase the duration of effective protection derived from prior childhood vaccinations. Adolescence is a strategically attractive opportunity for this "boosting", particularly in regions where immunization rates are high and the likelihood of "natural" boosting from exposure to the infectious agent may be low. In the case of pertussis, two vaccines specifically designed to boost waning immunity can be used to immunize

adolescents. Despite the continued endemicity of pertussis, few countries have implemented recommendations for these vaccines.

New vaccines -These are being introduced for the primary prevention of serious and life-threatening infections. Examples include:

- Meningococcal Conjugate Vaccine (MCV4),
- HPV vaccines that have been recently launched in the Nigeria.

For meningococcal and HPV respectively, adolescence marks a period of increased risk for infection. For some adolescents, vaccination programs poised at entry into various institutes (e.g., secondary or tertiary education, military training, etc.) offer an opportunity to vaccinate against STIs before the eventual onset of sexual activity. Despite the devastating effects of invasive meningococcal disease, a limited number of countries have conducted universal immunization programs and often they have been limited to high-risk groups or outbreak situations.

Human Papilloma Virus Vaccine (HPV vaccine)

Human Papilloma Virus (HPV) is a common infection that is often contracted soon after sexual debut. Currently, two HPV vaccines are available, which differ with regard to their composition of antigenic HPV serotypes.

- **Quadrivalent vaccine** - acts against HPV genotypes 6, 11, 16 and 18 – Gardasil - Merck &Co Inc.
- **Bivalent Vaccine** – acts against genotypes 16 and 18 - Cervarix –GSK.
- Vaccines safety profile is similar to other EPI vaccines.
- Recommended for **ages** 9-15 years.
- 3 doses – 6 months – (at 0, 1 and 6 months).
- **Cost** of the 3 dose regimen- $360.
- **Delivery Options** – School Based, Health Centre Based, and Outreach /community.

Other potential vaccines would target cytomegalovirus for the prevention of perinatal disease, *Chlamydia trachomatis*, hHerpes simplex two virus, and *Neisseria gonorrhea*. In addition, a number of candidates for universal primary prevention are also intended for adolescents.

Table 15.1: Selected vaccine-preventable disease characteristics and vaccines for administration to adolescents

Disease	Mode(s) of Transmission	Symptoms	Complication/ Long term risks	Global incidence	Global Mortality	Vaccines Available
Measles	Measles	High fever. Cough. Conjunctivitis . Exanthem .	• Otitis media • Bronchopneumonia (accounts for 60% of deaths).	580,287b	345,000b	• Combination vaccines comprise of measles, mumps,

Disease	Mode(s) of Transmission	Symptoms	Complication/ Long term risks	Global incidence	Global Mortality	Vaccines Available
		Maculopapular Rash	• Encephalitis (more common in adolescents and adults).			rubella, varicella (MR, MMR, MMRV). • One dose in adolescence for catch-up.
Rubella	Respiratory inhalation	Maculopapular or macular rash . Arthritis or arthralgia (adults).	• Thrombocytopenia • Encephalopathy	267,366b	NA	• Combination vaccines as per Measles or monovalent rubella. • One dose in adolescence.
Pertussis	Respiratory inhalation	**Phase I** catarrhal stage—cold-like symptoms. **Phase II** paroxysmal stage—cough with classical paroxysmal whoop often terminated with vomiting and exhaustion. **Convalescent Stage—** diminishing paroxysms.	• Pneumonia • Seizures • Encephalopathy	121,799b	NA	• Tetanus toxoid, reduced. • Diphtheria toxoid, and acellular • pertussis (Tdap) • One dose in adolescence
Meningococcal sepsis and meningitis	Respiratory secretions	Headache Meningeal signs Fever Purpuric rash	• Death if not promptly treated. • Neurological deficits. • Amputation	NA	NA	Quadrivalent conjugate One dose in adolescence Or Quadrivalent polysaccharide One dose in adolescence Or Monovalent serogroup C conjugate One dose in adolescence

Disease	Mode(s) of Transmission	Symptoms	Complication/ Long term risks	Global incidence	Global Mortality	Vaccines Available
Hepatitis B	Parenteral perinatal sexual	**Acute infection** —fever, malaise, anorexia, nausea, vomiting, abdominal pain, icteric symptoms of liver damage **Chronic infection** —mild or inapparent disease	• Primary Hepatocellular • carcinoma • Cirrhosis of the liver	NA	620,000c	Recombinant hepatitis B surface antigen (HBsAg) One dose in adolescence for catch-up. Or Two or three doses for adolescents not previously vaccinated
Typhoid fever	Fecal-oral	Headache Abdominal discomfort Constipation or diarrhea	• Peritonitis	21,650,974e	216,510e	Oral Ty21a live attenuated Four capsules over 7 days prior to travel to endemic areas Or Vi capsular polysaccharide antigen One dose prior to travel to endemic areas
Varicella	Respiratory or direct contact	Fever Maculopapular rash progressing to vesicles and crusting	• Bacterial superinfection • Interstitial pneumonia • Hospitalization • Post-herpetic neuralgia • Encephalitis (rare) • Reye syndrome (rare) • Scarring	NA	NA	Live attenuated One dose in adolescence as catch-up Or Two doses 3 months apart for those not previously vaccinated
Human papillomavirus	Sexual, vertical (very rare)	Incident and persistent infection with HPV are usually asymptomatic. Pruritis may be associated with genital warts.	• Primary cervical cancer • Anogenital cancers including vulvar, vaginal, anal, and penile. • Oropharyngeal cancer • Genital warts • Recurrent respiratory • Papillomatosis.	500,000f cases of cervical cancer Genital warts estimated at 1% of global population	250,000 deaths from cervical cancer	Quadrivalent (types 6, 11, 16, 18) Three doses in adolescence Or Bivalent (types 16, 18) Three doses in adolescence
NA: Global estimates not available.						

Disease	Mode(s) of Transmission	Symptoms	Complication/ Long term risks	Global incidence	Global Mortality	Vaccines Available
a - Readers are encouraged to consult their country-specific vaccination schedules for appropriate vaccine, dose, and administration protocol. This table is merely illustrative of the type of programs available and is not a comprehensive review of global vaccination recommendations. b - 2005 WHO estimates of reported cases and mortality . c - Based on model calculations. Available at: http://aim-e-learning.stanford.edu/en/vaccines/hepb/assessBurden/model/index.html. d - Recombivax HB two doses; Engerix B three doses. e - Estimated incidence in 2001 . f - GLOBOCAN 2002 estimates .						

Table 15.2: Vaccine implementation

Strategy	Example vaccine	Advantages for adolescent programs	Disadvantages for adolescent programs
Universal	Meningococcal conjugate (MCV4)	• Increased likelihood of achieving herd immunity • Decreased likelihood of inducing stigma around certain diseases such as sexually transmitted infections .	• The ability to achieve herd-immunity will be undermined if low vaccination rates occur. • Higher costs to society.
Targeted	Hepatitis B virus (HBV)	Reduced costs if every adolescent does not require vaccination. Reduced risk of adverse events in the whole e population. Reduced costs if every adolescent does not require vaccination.	• Target groups can be difficult to identify . • Adolescents may not perceive themselves to be high risk. • Adolescents may be unwilling to seek care if fear of judgment or lack of confidentiality exists especially for sexually transmitted infections. .Increased risk of stigmatization particularly for sexually transmitted infections .
School-based	Rubella (MMR, MR, or R)	• In countries with school-based programs, success has been mediated by the requirement to attend school and by a lack of private sector healthcare .	• School attendance by adolescents is low in many countries . • School-based healthcare infrastructure is generally directed at younger children; therefore, retention and/or creation of appropriate infrastructures in many countries will need to be developed for an adolescent program. • Future adolescent vaccines targeted at sexually transmitted diseases will necessitate integration with health promotion, especially sexual health Issues associated with absenteeism will require development of catch-up programs .

Catch-up	Pertussis (Tdap)	• Maintain immunity to prevent infection and subsequent infection of un-immunized individuals. • Reduced healthcare costs associated with decreased disease burden.	• Timing of catch-up programs will need to coincide. • with other preventive services in order to increase the likelihood of vaccination uptake.
Mass vaccination	Typhoid fever (Ty21a, Vi)	• Large number of individuals can be vaccinated in a rapid timeframe. • Excellent for outbreak situations. • Limited amount of resources can be mobilized.	• Suitable for single-dose vaccinations; however, less effective for multi-dose vaccines as the likelihood of individuals returning for subsequent vaccination decreases with each additional dose.

SUMMARY

Many vaccine-preventable diseases and infections, such as invasive meningococcal disease, pertussis, measles, mumps and Human Papiloma Virus (HPV) infections cause tremendous morbidity and mortality in the adolescent population or predispose them to cancer later in life. Adolescent immunizations to prevent these conditions are available and of immense benefit to both adolescents and the society at large. There is a need to address key barriers to adolescent immunization programs to ensure universal coverage with “catch up” and new vaccines.

EVALUATION

- List some of the benefits of adolescent immunizations.
- Discuss recommended adolescent immunizations.

MODULE FIFTEEN: SESSION 3
SELF BREAST AND TESTICULAR EXAMINATIONS

TIME: 1 Hour

LEARNER'S OBJECTIVES

At the end of the session, participants will be able to:

- Explain the importance of Self Breast Examination.
- Describe the essential steps for self breast examination.
- Describe the need for and process of conducting testicular examination.

SESSION OVERVIEW

- Importance of Self Breast Examinations
- Instructions for Self Breast Examination
- Practical Session on SBE
- Self Testicular examination`

METHODS

- Lecture
- Discussion
- Demonstrations

MATERIALS

- IEC Materials
- Mirror
- Bed and Pillow

CONTENT

IMPORTANCE OF SELF BREAST EXAMINATION

Regular breast examination helps clients to:

- Be accustomed to the normal look and feelings of her breasts.
- Detect any abnormalities in the breasts and go for medical assistance.

Teaching young people to examine their breasts monthly is therefore important to avoid the problems associated with breast.

Instructions for Self Breast Examination

1. Inform the client that it is best to examine the breast 3 days after cessation of the menstrual period when the breasts are less likely to be swollen or painful.
2. Although BSE can be performed at anytime of the day, doing so during bath will allow the hands to move easily over the wet skin.

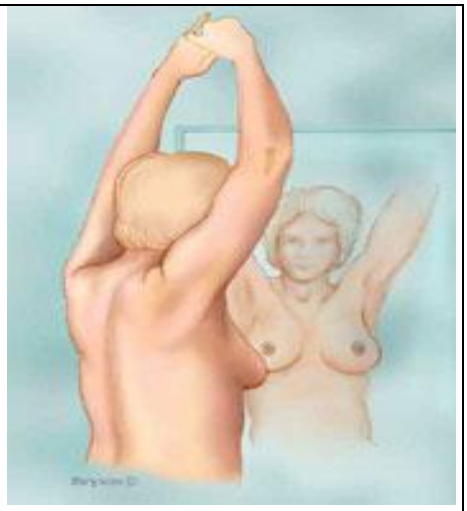
However, note that the breasts can be examined while standing up or lying down. When lying down, place a folded towel or pillow under the shoulder of the breast being examined.

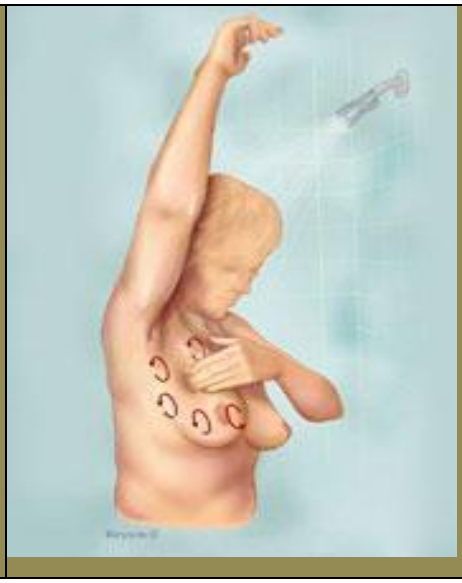
If your breasts are usually lumpy, note the number of lumps felt and their locations. Next month, note if there are any changes in the number, size or shape (smooth or irregular). Using the same technique every month will help you know if any changes occur.

PRACTICAL SESSIONS

TABLE 14.1: SELF BREAST EXAMINATION

STEPS	PROCEDURES	PICTURES
1	Begin by looking at your breasts in the mirror with your shoulders straight and your arms on your hips. Here's what you should look for: • Breasts that are their usual size, shape, and color. • Breasts that are evenly shaped without visible distortion or swelling. If you see any of the following changes, bring them to your doctor's attention: • Dimpling, puckering, or bulging of the skin. • A nipple that has changed position or an inverted nipple (pushed inward instead of sticking out). • Redness, soreness, rash, or swelling.	

2	• Now, raise your arms and look for the same changes.	
3	• While you're at the mirror, look for any signs of fluid coming out of one or both nipples (this could be a watery, milky, or yellow fluid or blood).	
4	• Next, feel your breasts while lying down, place a folded towel or pillow under the shoulder of the breast being examined. Use your right hand to feel your left breast and then your left hand to feel your right breast. • Use a firm, smooth touch with the first few finger pads of your hand, keeping the fingers flat and together. Use a circular motion, about the size of a quarter. • Cover the entire breast from top to bottom, side to side — from your collarbone to the top of your abdomen, and from your armpit to your cleavage. • Follow a pattern to be sure that you cover the whole breast. You can begin at the nipple, moving in larger and larger circles until you reach the outer edge of the breast. • You can also move your fingers up and down vertically, in rows, as if you were mowing a lawn. This up-and-down approach seems to work best for most women. • Be sure to feel all the tissue from the front to the back of your breasts: for the skin and tissue just beneath, use light pressure; use medium pressure for tissue in the middle of your breasts; use firm pressure for the deep tissue in the back. • When you've reached the deep tissue, you should be able to feel down to your ribcage.	

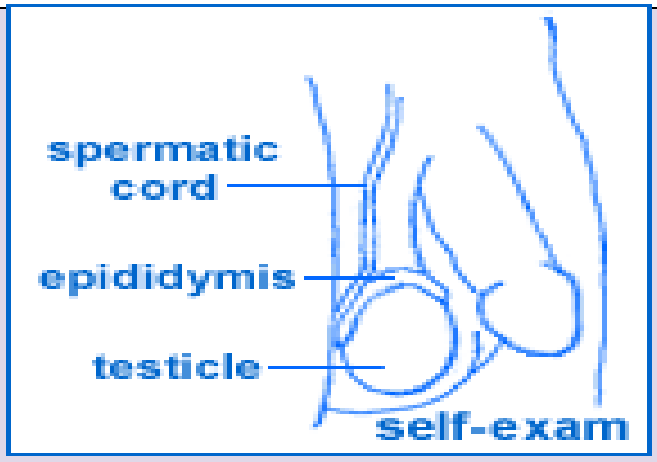
5	• Finally, feel your breasts while you are standing or sitting. • Many women find that the easiest way to feel their breasts is when their skin is wet and slippery, so they like to do this step in the shower. • Cover your entire breast, using the same hand movements described in Step 4.	

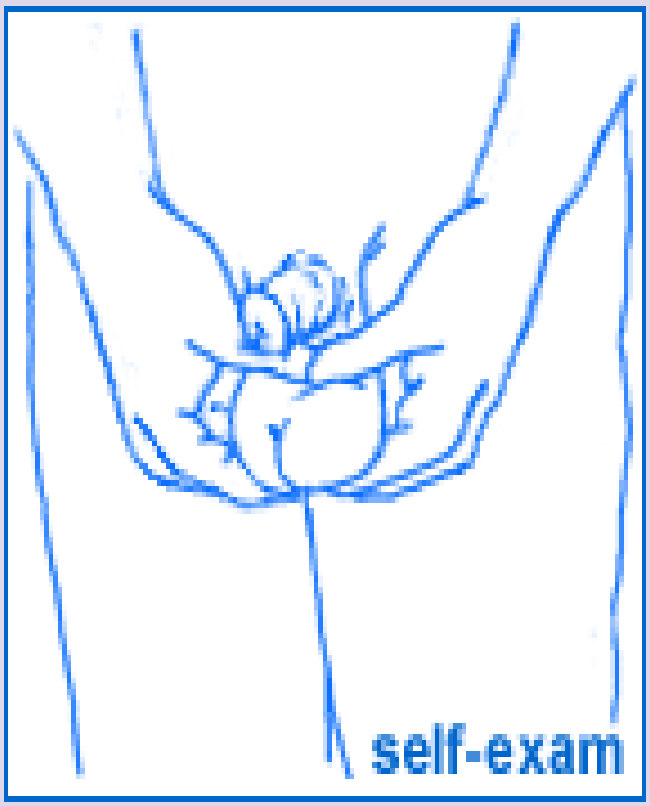
SELF TESTICULAR EXAMINATION

This is important for detecting testicular cancer at an early stage as many testicular cancers are first discovered as a painless lump or an enlarged testicle. It can also detect an undescended testis which has an increased risk of becoming cancerous later if not treated.

Although testicular cancer is rare in teenage guys, overall it is the most common cancer in males between the ages of 15 and 35. It's important to try to do a TSE every month so you can become familiar with the normal size and shape of your testicles, making it easier to tell if something feels different or abnormal in the future. Here's what to do:

TABLE 14.4: SELF TESTICULAR EXAMINATION

PROCEDURE	ILLUSTRATION
It's best to do a TSE during or right after a hot shower or bath. The scrotum (skin that covers the testicles) is most relaxed then, which makes it easier to examine the testicles.	
Examine one testicle at a time. Use both hands to gently roll each testicle (with slight pressure) between your fingers. Place your thumbs over the top of your testicle, with the index and middle fingers of each hand behind the testicle, and then roll it between your fingers.	

You should be able to feel the epididymis (the sperm-carrying tube), which feels soft, rope-like, and slightly tender to pressure, and is located at the top of the back part of each testicle. This is a normal lump.	
Remember that one testicle (usually the right one) is slightly larger than the other for most guys — this is also normal.	
When examining each testicle, feel for any lumps or bumps along the front or sides. Lumps may be as small as a piece of rice or a pea.	
If you notice any swelling, lumps, or changes in the size or color of a testicle, or if you have any pain or achy areas in your groin, let your doctor know right away.	
It's best to do a TSE during or right after a hot shower or bath. The scrotum (skin that covers the testicles) is most relaxed then, which makes it easier to examine the testicles.	

It's best to do a TSE during or right after a hot shower or bath. The scrotum (skin that covers the testicles) is most relaxed then, which makes it easier to examine the testicles.

- Examine one testicle at a time. Use both hands to gently roll each testicle (with slight pressure) between your fingers. Place your thumbs over the top of your testicle, with the index and middle fingers of each hand behind the testicle, and then roll it between your fingers.
- You should be able to feel the epididymis (the sperm-carrying tube), which feels soft, rope-like, and slightly tender to pressure, and is located at the top of the back part of each testicle. This is a normal lump.
- Remember that one testicle (usually the right one) is slightly larger than the other for most guys — this is also normal.
- When examining each testicle, feel for any lumps or bumps along the front or sides. Lumps may be as small as a piece of rice or a pea.
- If you notice any swelling, lumps, or changes in the size or color of a testicle, or if you have any pain or achy areas in your groin, let your doctor know right away.

Lumps or swelling may not be cancer, but they should be checked by your doctor as soon as possible. Testicular cancer is almost always curable if it is caught and treated early.

SUMMARY

Self-breast and Testicular examinations represent two useful skills that should be taught to all young persons. They require almost nothing to do these so they should to be encouraged to internalize the habit of monthly checking.

EVALUATION

- List different positions for self breast examination.
- Describe how to conduct self testicular examination.

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