

Commonwealth Youth Programme
Diploma in Youth Development Work

Module 12

Youth and Health

Commonwealth Secretariat
Marlborough House
London SW1Y 5HX
UNITED KINGDOM

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The Commonwealth Youth Programme's Mission

CYP works to engage and empower young people (aged 15–29) to enhance their contribution to development. We do this in partnership with young people, governments and other key stakeholders.

Our mission is grounded within a rights-based approach, guided by the realities facing young people in the Commonwealth, and anchored in the belief that young people are:

- a force for peace, democracy, equality and good governance,
- a catalyst for global consensus building, and
- an essential resource for poverty eradication and sustainable development.

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Introduction

Welcome to Module 12 *Youth and Health*. As you know, youth development workers have a key role to play in delivering a holistic approach to health promotion. This module is intended to assist you in your work.

The module starts by defining youth in the context of health. It continues by looking at why it is important to involve young people in the planning and implementation of any programme that targets them, and how to promote youth participation. You will also look closely at some of the contemporary health issues that affect young people, such as nutrition and diet, sexual and reproductive health and drug abuse.

You will look at the differences between the principles of youth development work and those of health professionals and educators, and explore the need for appropriate alliances with health agencies and non-governmental organisations (NGOs). The module also looks at how to enable practitioners to recognise the different roles they have, and how to foster effective working relationships.

Module learning outcomes

Learning outcomes are statements that tell you what knowledge and skills you should have when you have worked successfully through a module.

Knowledge

When you have worked through this module, you should be able to:

- identify the major health issues affecting young people
- outline health promotion strategies (particularly preventative strategies)
- describe the specific role of youth development work in health promotion
- describe the roles of other agencies in this field.

Skills

When you have worked through this module, you should also be able to:

- acquire appropriate techniques to respond to health issues raised in the course of your youth development work
- develop specific programmes of health promotion
- use the distinctive methodology of youth development work within the environment of a primary health care agency
- work within complex partnerships created to achieve key objectives in the field of health promotion.

About this module

Module 12 *Youth and Health* is divided into six units.

Unit 1: Defining youth and health

In this unit you will review different approaches to defining youth and examine health-related issues that affect young people and where in the health system youth development workers can most effectively work. The unit also describes the physical and emotional changes that occur during adolescence and reproductive anatomy and physiology.

Unit 2: Involving young people

This unit discusses the importance of youth participation in planning and implementing health programmes, the skills young people need to participate and how youth development workers can promote effective programmes.

Unit 3: Nutrition

This unit will provide you with valuable information about nutrition and diet, for your own understanding and for you to refer to and use in any health prevention or promotion activities that you might wish to facilitate or get involved in.

Unit 4: Sexual and reproductive health

This unit discusses health issues such as contraception and abortion. In this unit you will recognise the value of family planning and some of the dangers traditional, cultural practices sometimes cause to the sexual and reproductive health of young people, especially young women.

Unit 5 STDs and HIV/AIDS

In this unit you will gain essential knowledge about sexually transmitted (STD) and HIV infections, prevention and counselling. You will also explore the psychological and social issues involved in STDs and HIV/AIDS and identify some of the root causes of the increasing rates of infection and the specific impact on young people. In addition you will learn about approaches to living positively with HIV/AIDS.

Unit 6 Mental health and drug abuse

In this unit you will learn about why young people use drugs, the health risks associated with drug abuse and how best to intervene.

This table shows which units cover different learning outcomes.

| Module 12 Units Learning outcomes | 1 | 2 | 3 | 4 | 5 | 6 |
|---|----------|----------|----------|----------|----------|----------|
| Knowledge | | | | | | |
| 1 Identify the major health issues affecting young people. | x | | | x | x | x |
| 2 Outline health promotion strategies (particularly preventative strategies). | | | x | | x | x |
| 3 Describe the specific role of youth development work in health promotion. | x | x | | | | |
| 4 Describe the roles of other agencies in this field. | | x | | | x | x |
| Skills | | | | | | |
| 1 Acquire appropriate techniques to respond to health issues raised in the course of your youth development work. | | x | x | x | x | x |
| 2 Develop specific programmes of health promotion. | x | x | x | | x | x |
| 3 Use the distinctive methodology of youth development work within the environment of a primary health care agency. | x | x | | | | |
| 4 Work within complex partnerships created to achieve key objectives in the field of health promotion. | x | x | x | x | x | x |

Assessment

Each module is divided into a number of units. Each unit addresses some of the learning outcomes. You will be asked to complete various tasks so that you can demonstrate your competence in achieving the learning outcomes. The study guide will help you to succeed in your final assessment tasks.

Methods

Your work in this module will be assessed in the following three ways:

- 1 A written report of about 2000 words on a small-scale practical project in the field of health care promotion (worth 50 percent of the final mark).
- 2 A review of the learning journal you keep (worth 20 percent of the final mark).
- 3 A written examination set by the institution in which you are enrolled for this Diploma programme (worth 30 percent of the final mark).

If the university or college at which you are enrolled does not set an examination, a further assignment will be required in the form of a second written report, of around 1,000 words.

You will also do activities throughout this module that will help you prepare for your major assignment, as well as for the final examination. You will find full details of the assignment at the end of the module.

Note: We recommend that you discuss the study and assessment requirements with your tutor before you begin work on the module. You may want to discuss such topics as:

- the learning activities you will undertake on your own
- the learning activities you will undertake as part of a group
- whether it is practical for you to do all of the activities
- the evidence you will produce to prove that you have met the learning outcomes – for example, learning journal entries, or activities that prepare for the final assignment
- how to relate the assignment topics to your own context
- when to submit assignments and when you will get feedback.

Learning journal

Educational research has shown that keeping a learning journal is a valuable strategy to help your learning development. It makes use of the important faculty of reflecting on your learning, which supports you in developing a critical understanding of it. The journal is where you will record your thoughts and feelings as you are learning and where you will write your responses to the study guide activities. The journal is worth 20 per cent of the final assessment. Your responses to the self-help questions can also be recorded here if you wish, though you may use a separate notebook if that seems more useful.

Again, we recommend you discuss the learning journal requirements with your tutor before you begin, including how your learning journal will be assessed.

Self-test

Take a few minutes to try this self-test. If you think you already have some of the knowledge or skills covered by this module and answer 'Yes' to most of these questions, you may be able to apply for credits from your learning institution. Talk to your tutor about this.

Note: This is not the full challenge test to be held by your learning institution for 'Recognition of Prior Learning'.

Put a tick in the appropriate box in answer to the following questions:

| | Yes | No | More or less |
|---|--------------------------|--------------------------|--------------------------|
| Can you describe the major health issues affecting adolescents and youth in your local communities and worldwide? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Can you describe a range of health promotion strategies, particularly preventative strategies? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Can you explain the specific role of youth development work in health promotion? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Can you outline the role of other agencies in this field? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Can you describe appropriate techniques to respond to health issues raised in the course of your work? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Can you design and deliver specific programmes of health promotion? Can you produce evidence of this work? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever worked within the environment of primary health care as a youth development worker? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Learning tips

You may not have studied by distance education before. Here are some guidelines to help you.

How long will it take?

It will probably take you a minimum of 70 hours to work through this study guide. The time should be spent on studying the module and the readings, doing the activities and self-help questions and completing the assessment tasks.

Note that units are not all the same length, so make sure you plan and pace your work to give yourself time to complete all of them. For example, Unit 3 has a heavy reading schedule.

About the study guide

This study guide gives you a unit-by-unit guide to the module you are studying. Each unit includes information, case studies, activities, self-help questions and readings for you to complete. These are all designed to help you achieve the learning outcomes that are stated at the beginning of the module.

Activities, self-help questions and case studies

The activities, self-help questions and case studies are part of a planned distance education programme. They will help you make your learning more active and effective, as you process and apply what you read. They will help you to engage with ideas and check your own understanding. It is vital that you take the time to complete them in the order that they occur in the study guide. Make sure you write full answers to the activities, or take notes of any discussions.

We recommend you write your answers in your learning journal and keep it with your study materials as a record of your work. You can refer to it whenever you need to remind yourself of what you have done. The activities may be reflective exercises designed to get you thinking about aspects of the subject matter, or they may be practical tasks to undertake on your own or with fellow students. Answers are not given for activities. A time is suggested for each activity (for example, 'about 20 minutes'). This is just a guide. It does not include the time you will need to spend on any discussions or research involved.

The self-help questions are usually more specific and require a brief written response. Answers to them are given at the end of each unit. If you wish, you may also record your answers to the self-help questions in your learning journal, or you may use a separate notebook.

The case studies give examples, often drawn from real life, to apply the concepts in the study guide. Often the case studies are used as the basis for an activity or self-help question.

Readings

There is a section of Readings at the end of the study guide. These provide additional information or other viewpoints and relate to topics in the units. You are expected to read these.

There is a list of references at the end of each unit. This gives details about books that are referred to in the unit. It may give you ideas for further reading. You are not expected to read all the books on this list.

Please note: In a few cases full details of publications referred to in the module have not been provided, as we have been unable to confirm the details with the original authors.

There is a list of Further Reading at the end of each module. This includes books and articles referred to in the module and are suggestions for those who wish to explore topics further. You are encouraged to read as widely as possible during and after the course, but you are not expected to read all the books on this list. Module 4 also provides a list of useful websites.

Although there is no set requirement, you should aim to do some follow-up reading to get alternative viewpoints and approaches. We suggest you discuss this with your tutor. What is available to you in libraries? Are there other books of particular interest to you or your region? Can you use alternative resources, such as newspapers and the internet?

Unit summary

At the end of each unit there is a list of the main points. Use it to help you review your learning. Go back if you think you have not covered something properly.

Icons

In the margins of the *Study Guide*, you will find these icons that tell you what to do:



Self-help question

Answer the question. Suggested answers are provided at the end of each unit.



Activity

Complete the activity. Activities are often used to encourage reflective learning and may be a practical task. Answers are not provided.



Reading

Read as suggested.



Case study

Read these examples and complete any related self-help question or activity.

Studying at a distance

There are many advantages to studying by distance education – a full set of learning materials is provided, and you study close to home in your own community. You can also plan some of your study time to fit in with other commitments like work or family.

However, there are also challenges. Learning at a distance from your learning institution requires discipline and motivation. Here are some tips for studying at a distance.

- 1 **Plan** – Give priority to study sessions with your tutor and make sure you allow enough travel time to your meeting place. Make a study schedule and try to stick to it. Set specific days and times each week for study and keep them free of other activities. Make a note of the dates that your assessment pieces are due and plan for extra study time around those dates.
- 2 **Manage your time** – Set aside a reasonable amount of time each week for your study programme – but don't be too ambitious or you won't be able to keep up the pace. Work in productive blocks of time and include regular rests.
- 3 **Be organised** – Have your study materials organised in one place and keep your notes clearly labelled and sorted. Work through the topics in your study guide systematically and seek help for difficulties straight away. Never leave this until later.
- 4 **Find a good place to study** – Most people need order and quiet to study effectively, so try to find a suitable place to do your work – preferably somewhere where you can leave your study materials ready until next time.
- 5 **Ask for help if you need it** – This is the most vital part of studying at a distance. No matter what the difficulty is, seek help from your tutor or fellow students straight away.
- 6 **Don't give up** – If you miss deadlines for assessment pieces, speak to your tutor – together you can work out what to do. Talking to other students can also make a difference to your study progress. Seeking help when you need it is a key way of making sure you complete your studies – so don't give up!

If you need help

If you have any difficulties with your studies, contact your local learning centre or your tutor, who will be able to help you.

Note: You will find more detailed information about learner support from your learning institution.

We wish you all the best with your studies.

Unit 1: Defining youth and health

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Unit introduction

Welcome to Unit 1 *Defining youth and health*.

This first unit begins by looking at a definition of ‘youth’ and explains the importance of understanding the concept of adolescence and youth. It discusses the meaning and different concepts of ‘health’ and describes the contemporary socio-economic and political context of health.

Next, the unit discusses the concept and importance of primary health care, particularly in relation to youth development. The unit describes the main physical and emotional changes that occur during youth and adolescence.

The unit ends with an outline of a basic programme of self-care for the young people you will work with.

Unit learning outcomes

When you have worked through this unit, you should be able to:

- define ‘adolescence and youth’ and ‘health’
- describe the social context of primary health care programmes
- describe the physical and emotional changes that occur during adolescence
- explain to young people how to practise good personal hygiene.

Defining youth

In earlier modules of this diploma you have examined different ways of defining youth. In this unit we return to the idea that the concept of 'youth' varies widely from country to country within the Commonwealth, and may even vary widely within a given country. This is largely because the definition of 'youth' is determined socially and culturally, as well as biologically.

However, there are some characteristics that all young people share, worldwide. Young people:

- constitute the largest age group of the population in most developing countries
- have a greater need for acceptance, co-operation and consultation than any other age group
- are skilful, energetic, industrious, adventurous and willing to learn in order to become socially valuable
- face a far greater proportion of problems than any other age group, especially unemployment, delinquency, and unwanted pregnancy
- have the potential to initiate action and can be empowered to do so
- can and should be empowered to manage their own health.

In this module we will adopt the United Nations' definition of a youth, which is: 'an individual female or male aged between 15 and 24 years'. Individuals below 15 years are defined as children, while those above 24 years are defined as adults. The term 'youth' then includes adolescents; those aged between 15 and 19 years. Therefore the state of being a youth is a transitional stage, prior to the status of adulthood, and it is a time of quite rapid growth and change.

Members of this group are usually engaged in exploring the potential of their minds, bodies and environments. And because they are actively engaged in constructing personal and social identities, within the range of possibilities in their societies, they may experiment and take risks, such as having casual sex or trying out psychoactive drugs. All these things pose special health problems for this age group.

Before we discuss these problems in detail, let's look at why it is important for you to understand the meaning of adolescence and youth.

There are at least five reasons why it is important for you to have a clear understanding of the concepts of adolescence and youth in the context of health.

- 1 Adolescents and youths have special social, economic and health needs that require youth specific approaches.

- 2 Adolescents and youths constitute a large segment (around 50 per cent) of the total population of many poor countries in the world, including many Commonwealth countries, in Africa in particular.
- 3 Most adolescents and youths are not able to live independently. Some are still in school. Some of those who are out of school are unemployed; some still live with their parents or extended family members, while others are on the streets engaged in various activities to earn a living and/or just to pass time.
- 4 Adolescents and youths make up a vulnerable group. The poor socio-economic situation prevailing in most Commonwealth countries has a more negative effect on adolescents and youths than other groups. As a result, these countries' youths are particularly at risk of the problems associated with poverty, such as malnutrition, unwanted pregnancy and sexually transmitted diseases.
- 5 Few countries, developed or underdeveloped, have a significant amount of access to specialised, youth specific health services. Yet for poor developing countries youths are the most critical group from the point of view of developing the human resources and achieving any kind of economic take-off.

This list is not necessarily exhaustive. You may think about other reasons yourself.

Defining health



Activity 1.1

(about 5 minutes)

Before you read the following section, write down in your journal what you think the word 'health' means.

You may have heard or read about other definitions. In this module we will use the World Health Organisation's definition, which is: 'health is a state of complete wellbeing, physical, social, mental and spiritual, not just the mere absence of disease.'

This definition is an ideal against which to set targets to aim for. Therefore, given the nature of the real world, it is important to turn to the sorts of real world definitions used by social scientists. Social scientists argue that, while the labels 'health', 'disease' and 'illness' are used as if they are precise, objective descriptions of people's biological states, they are partly subjective but largely socially constructed concepts.

A judgement about a person's health is influenced by what is considered normal in a particular society. As norms and values change, the concepts of health, disease and illness also change. For example, in a society where there are relatively few older people, the elderly who become ill are less likely to consider themselves ill, because they will expect old age to bring the onset of disease. However, in an ageing society, where there is a lot of health provision for older people, and a lot of knowledge about health, older people will recognise symptoms early, and, having learned to recognise the onset of illness, will define themselves as ill, and will seek medical help.

Before any further discussion of the meaning of 'health', let's briefly examine and clarify two concepts that are related to the subject, namely disease and illness. Social scientists argue that disease and illness are usually used in different ways and can often be considered as two distinct concepts. You can have a disease without being ill. For example:

- a person with heart disease may not know that they have heart disease until they suffer a heart attack
- a person who has contracted HIV may not know until they become seriously ill with AIDS years after the virus was contracted.

Health is a socially constructed concept

We can argue that health is a socially constructed concept and that different social groups have different ideas about being healthy and being ill. With young people, this matters a lot in terms of what they feel to be acceptable behaviour. In Pakistan for instance, as in many developing countries, the tobacco firms, whose markets in the rich world are diminishing, have made a gigantic effort to persuade young people to smoke more. They sponsor many sports, notably cricket, and consequently many young people must already be in a state of early, smoking-related disease. However, these young people may at some level feel that they are healthier than they would be if they did not smoke, because of the association of cigarettes and sport.

Several years ago, the Pakistan government initiated a major anti-smoking health campaign, using cricketers such as Wasim Akram as models, because the government, too, realises that health is socially constructed within a framework of certain norms and values that television advertising is particularly good at exploiting.

Again, powerful criminal subcultures, almost as dangerous to health as the tobacco, oil and alcohol companies, have begun to exert a powerful cultural influence on young people without career prospects. For example, in the Caribbean, many young, unemployed people are drawn into criminal activity such as selling narcotics, with all the known health risks that those have. The young people become involved in this not only as a way of surviving, but also because

association with the gangs or groups that have recruited them may provide them with a sense of purpose and belonging. In such cases it may even become a status symbol to use and sell narcotics.

If you want to get a clear understanding of the real nature of health and illness, it is important to treat the whole subject as a socially constituted as well as a physical phenomenon. This requires an understanding not only of the biology of health and illness, but also of the way that health and illness are integrated with social structures and processes, and how health is directly linked to the economic well being of a country. We look at this in the sections that follow.

Health is an economic resource

Health is an economic resource, just as knowledge or machinery are, for example. If a society invests in the physical and mental health of its people, it is likely to have a financial payoff, especially in the long term. Agricultural, industrial and commercial production will be more efficient with a healthy workforce than with an unhealthy one. Studies show that working below par, or having time off for sickness, are major costs in production. Preventive health is considerably cheaper in the long run than curative health; therefore preventive health strategies are excellent social investment strategies.

The UK National Health Service was set up after the Second World War as part of the effort to enable Britain to create a modern industrial state capable of paying off war debts and rebuilding the country. This would have been impossible without a health service 'free at the point of delivery', so that people were not kept out of work for long periods through treatable illnesses. In Britain and Europe, the emphasis is now on health education and prevention as the cost of public health systems increases.

Of course, many Commonwealth countries, under pressure from the lending agencies, do not have the basic resources to set up such a system. Nevertheless, the importance of a health-promotion and illness-prevention programme should be clear from the economic devastation caused by HIV/AIDS. This issue has now become so clear that the leaders of the rich countries (the G8) set up a pilot scheme in February 2006, called the Advance Market Commitment (AMC), to develop a vaccine to combat a few specific diseases throughout the developing world. If the pilot scheme works, then £3.4 billion will be put into each of three AMCs, which will be used to tackle malaria, HIV/AIDS and tuberculosis. The leaders of the G8 know that if poor countries can raise their production levels, then they will also become greater purchasers of G8 goods, and that this should lead to a positive cycle of trade and development worldwide, in which both the wealthy and poor countries will benefit.

This now leads us to the discussion issue of investment in health. You have probably used this phrase in some of your discussions related to your work.

The issue of investment in health

The issue of investment is complicated when it applies to social goods such as education or health. Capitalism is praised for the efficiency with which it allocates resources to the right people i.e. those who can use them well. However, because of the way the market works, spending on health is not treated by the market as an investment but as a form of consumption, with an emphasis on the costs rather than on the future benefits.

There is already pressure on the G8 from some economists to spend their money buying vaccines and other medicines from the established pharmaceutical companies rather than developing the three new specialist vaccines. But that strategy has not so far achieved much for developing countries. The AMCs at last seem to be an initiative to deal with the problems of world health in a planned way by an international body, rather than relying on private companies and the market to do everything, though they will surely have an important role.

For states that have to survive in the global market, and therefore continually to adjust their economies structurally, adapting all their spending in response to market forces, reduction of spending on health is an obvious strategy. This is done by:

- simply cutting health budgets
- efficiency measures such as cutting expenditure on expensive drugs in favour of simpler and cheaper drugs
- cost recovery methods, such as persuading people to invest in their own health through healthy diets and exercise or, where possible, paying for private medical treatment.

In this way, however, socially disadvantaged groups are deprived of resources that might be made available to them if health care were under properly funded public control, and allocated according to people's needs rather than their buying power. In other words, like all resources (consumer goods, property, money, education), health is distributed unequally by the market and usually needs the state's intervention in the market to distribute health resources equitably. If you lack money and social power, it is that much more difficult for you to access not only health resources but educational resources as well.



Activity 1.2

(about 10 minutes)

As a way of reflecting on what you have read so far, answer the following questions:

- 1 What is the meaning of 'youth'?
- 2 What are the general characteristics of young people?
- 3 Why do you need to know about adolescence and youth?
- 4 What is the difference between disease and illness?
- 5 How is health related to economic development?

Write your answers in your learning journal.

You may wish to check your answers by going through the earlier sections at a later stage. For now, it is important for you to remember the following:

- The concept of youth varies widely, within and across countries, because of different social and cultural contexts as well as the biological changes associated with the concept.
- Despite the different definitions of 'youth' that you may come across, young people share some key characteristics that you ought to know about.

Different groups of people may have different concept of 'health'.

Health is important for economic development.

On the other hand, a country's economic status may have a negative impact on health provision. The next section illustrates this point.

Economic recovery programmes and health

You are probably familiar with economic recovery programmes in your country. You may know that because of strategies developed in response to global market pressures – such as the debt and economic adjustment programmes for Highly Indebted Poor Countries (HIPC) – it has become increasingly difficult for the state to intervene in health matters, especially in the poorest countries. As a result, non-governmental organisations (NGOs) have filled more of the gaps than they used to. For example, many African countries which formerly provided a range of free medical services are now implementing health reforms including cost-sharing schemes and national health insurance schemes which require government, private sector, NGOs and communities to co-finance the health sector. In these reforms, the public is now expected to pay user fees for health services instead of receiving free health care.

The effect of economic recovery measures is illustrated by the case study that follows. As you read it, try to reflect on what we have discussed so far on the relationship (both positive and negative) between economic development and health.



Case study 1.1

The effect of structural adjustment on health provision in Zambia

In a slum area of the capital (of Zambia), Lusaka, I met a young woman called Florence. Prior to the debt crisis, she would have been regarded as one of the better-off. Now she is one of the new strata, the *nouveaux pauvres* (new poor), and she was close to breaking point. For four years, prices of basic foods had been rising rapidly and it had become more and more difficult to survive on her husband's salary as a junior clerk in a government office. Often, they had to survive on just one meal a day and they could only afford the luxury of meat on pay day.

Her two children became prone to diseases, and in November the smallest developed an acute respiratory infection. The doctor prescribed a course of medicine but the clinic had run out of the drug because the government could only afford enough foreign exchange to import one-seventh of the country's requirements of essential drugs. She managed to find a chemist's shop which could sell her the medicines she needed but at an exorbitant black-market price. The family's food allowances for the week went in a stroke: she had to borrow.

At about this time she discovered that she was pregnant. This should normally of course, have been a happy time: they wanted a third baby, but she couldn't stop worrying about how the family was going to survive. A week later her husband came home with the news that, due to the IMF austerity programme, introduced to rescue the economy, the price of maize meal, the staple food, was going to double.

“When my husband told me I just could not believe it,” she said. “Then I looked into his eyes and saw that it was true. Suddenly, it occurred to me that we just wouldn't survive. We would all go hungry. And then I just burst into tears.”

Florence, with tears of desperation streaming from her eyes, is the human face of the debt crisis. In the event, the price rise only lasted a few days. Thousands of the urban poor in Zambia took to the streets and rioted. The government brought back the food subsidy, restoring maize meal to its previous price. Its decision caused tension, however, between the government of Zambia and the IMF, who questioned the commitment of the government to rescuing the economy.'

(Clark, J, in J. Vickers, 1991, p.16.)



Self-help question 1.1

(about 10 minutes)

The case study about Zambia shows how poverty makes people prone to diseases and how the problem can be overcome. Read the case study again, then answer these questions:

- 1 What is the crisis described in the case study?
- 2 Why are young people, particularly women, especially vulnerable?
- 3 As a youth development worker, what might you do about this situation?

Compare your answers with those provided at the end of the unit.

Models of health

The effect of the social and cultural context on the definition of health has been discussed in an earlier section of this unit. You will also remember that in Module 2 you learned about the social construction of youth – how local culture and beliefs define how young people are perceived. Also, in Module 3 you learned about the various models of youth work, and how these different approaches are based on different social theories. Our mental constructions of social phenomena determine how we think about them. Therefore this applies to health.

We will now examine different models related to health.

The medical model of health

The dominant model of health throughout the developed world is the ‘medical’ model. In this model, the development of medical science is presented as a series of spectacular breakthroughs. Each new discovery is constructed as one more step in medical progress which will eventually result in the victory of science over nature. This model requires massive social spending on training of health professionals, pharmaceutical products and medical technology. However, researchers like McKeown and Lowe (1974) have shown, for example, that the really dramatic breakthroughs that occurred in disease control in Britain through the development of good water management and sewage systems took place well before clinical medical intervention was established there. This therefore brings us to the social dimension of health.

The social model of health

The social model of health acknowledges that health is determined by social and environmental conditions. A social model of health looks at creating the conditions that promote good health and make illness and disease less likely. Work such as that of McKeown and Lowe (1974) suggests that, in order of importance, infectious diseases are most effectively treated by:

- improved living standards, especially better food
- behavioural changes, better personal hygiene, less overcrowding
- improved public health, especially water and sanitation
- clinical medical intervention.

Preventive health policy

A health policy aimed at the first three of the strategies suggested by McKeown is a preventive health policy, and is likely to involve a variety of social agencies such as government, private providers, NGOs and communities.



Activity 1.3

Read the case study about Zambia and the two models of health again, then briefly write your responses to the following questions in your learning journal. Discuss them with others (friends, family, tutorial group).

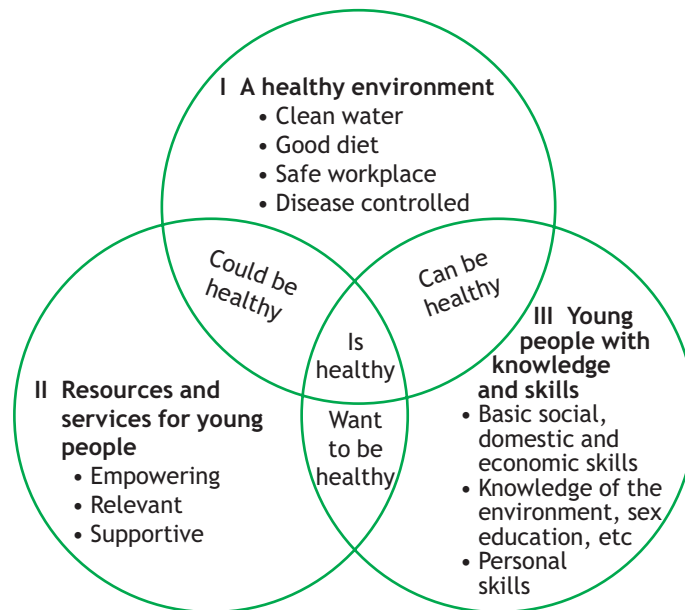
- 1 Which of the two models of health do you think is more relevant/important for your country?
- 2 Does your country have a preventive health policy? If yes, describe (in one paragraph) your country's health policy.
- 3 Is your government, or are any other agencies, initiating any of the four strategies suggested by McKeown and Lowe (listed above)? List the agencies involved.
- 4 Give some examples of how preventive health strategies have helped in improving the health of poor people in your community or country at large.

Whatever your answers to the first question in Activity 1.3, you may be interested to know that similar to McKeown and Lowe, the Commonwealth Youth Programme (1995) specifies three core components for guaranteeing the health of young people.

These are:

- a healthy environment – with clean water and a good diet, safe workplaces, controlled diseases, personally and socially supportive in culture.
- resources and services – these should be empowering, relevant and supportive.
- a knowledge and skill base – good basic social skills, domestic and economic skills, good knowledge of sexual and lifestyle issues, environmental issues and so on.

The diagram below shows the three core components for guaranteeing the health of young people:



This is a primary health care programme. As part of the process of continuous structural adjustment now being required of every country in the world, official UK health policy (like that of other European countries) has now begun to turn more and more towards primary health care to save money.

Primary health care



Activity 1.4

(about 15 minutes)

Before you read the next section, spend about 15 minutes writing down in your journal what you understand by 'primary health care'. Compare what you have written with what you read in the next section.

Health care is often referred to in stages of care – primary, secondary or tertiary. These stages refer to the type of medical or health-related service and where it is provided.

Primary health care (PHC) refers to services provided at the community level, for example by doctors, nurses, counsellors and other health professionals in community clinics, schools, workplaces or in the homes of patients. Often, primary health care is a team-based approach, and it provides good opportunities for preventive health care – promotion of good health practices and prevention of injury and disease. This is where youth development workers could be very effective.

The World Health Organisation (WHO) gives the following definition of primary health care:

“Primary health care is the principal vehicle for the delivery of health care at the most local level of a country’s health system. It is essential that health care is made accessible at a cost the country and community can afford, with methods that are practical, scientifically sound and socially acceptable. Everyone in the community should have access to it, and everyone should be involved in it. Besides an appropriate treatment of common diseases and injuries, provision of essential drugs, maternal and child health, and prevention and control of locally endemic diseases and immunisation, it should also include at least education of the community on prevalent health problems and methods of preventing them, promotion of proper nutrition, safe water and sanitation.”

(WHO, 1978)

Secondary health care refers to services that may be provided in community hospitals by specialists, for example obstetricians. 'Preventive health care' may also be provided in this setting.

Tertiary health care refers to services provided in major hospitals by specialist teams, for example in a coronary or spinal care unit.



Now turn to Reading 1: David Werner’s article from Third World Guide 1993–94: 'The World As Seen By the Third World'.

The health objectives of youth development are similar to those achieved in the countries described in Werner's article. The direction of youth activity should be towards those objectives. What one usually finds in most developing countries is a situation with some of the determinants of good health developed to some extent, though often to a very small extent. As a youth development worker, you need to assess your situation and to evaluate what is possible next. Primary health care is a very important initial step in achieving health care.



Activity 1.5

(about 20 minutes)

Consider the four determinants of good health at low cost mentioned by Werner:

- 1 Political and social commitment to equity.
- 2 Equitable distribution and access to public health care, beginning at the primary level and reinforced by secondary and tertiary systems.
- 3 Uniform access to the educational system with a focus on the primary level.
- 4 Availability of adequate nutrition at all levels of society in a manner that does not inhibit indigenous agricultural activity.

How does your country measure up to the four determinants of good health at low cost?

What do you think should be your role as a youth development worker within this model?

Discuss each of the four determinants in relation to your own region with friends, family or your tutorial group.

Write your responses in your learning journal.

In the next three sections, we examine the importance of the social model of health and its relevance to youth development work. We also highlight the importance of health promotion.

Primary health care and the social model of health

Primary health care (PHC) has been influenced by research based more on the social model of health than the medical model of health. It acknowledges that health is mainly socially and environmentally determined and therefore seeks to create the conditions that make illness or disability less likely. Primary health care is a policy that has been more or less universally adopted in developing countries, and,

because structural adjustment is forcing countries to try to save money, in developed countries as well.



Primary health care and youth development work

What makes primary health care a particularly appropriate setting for youth development work is that it requires a proactive approach. Primary health care does not accept the prevailing health situation and wait for illness or disability to strike. Instead, it makes use of the available health-related research, and mobilises the resources of the community to develop conditions that are favourable to good health. When bad health occurs, such as an epidemic, then primary health care has access to a range of resources that it can select from, rather than expensive drugs and medical expertise alone. This is where health promotion strategies become important and necessary.

Health education and promotion

You must have heard about and have probably participated in health education and promotion programmes. A crucial feature of primary health care is to provide maximum public understanding of why ill health develops, by using a range of health education and health promotion strategies. It aims at empowering communities to identify and prioritise health-related problems that affect them, and to design the most appropriate and cost-effective solutions to address those problems.

Health education, which aims to inform people of health risks and ways of avoiding them, is not always enough on its own. For example, one of the main strategies used in the developed world to prevent HIV/AIDS is public information using television. This does not appear to have been particularly successful as a strategy for behavioural change, which indicates that educating people on health issues and promoting public health may be much more complex than they appear.

You should now read Case study 1.2, which illustrates that when powerful lobby groups such as tobacco companies are involved in health issues, legislation may be necessary in addition to education.



Case study 1.2

Smoking and women's health

'... smoking kills over half a million women each year in the industrialised world. But it is also an increasingly important cause of ill-health amongst women in developing countries... Young girls and women need to be protected from inducements to smoke – smoking is declining in many industrialised countries.

To maintain profits, tobacco companies need to ensure that at least 2.7 million new smokers, usually young people, start smoking every year. Women have been clearly identified as a key target group for

tobacco advertising in both the industrialised and developing worlds. Billions of US dollars each year are spent on promoting this lethal product specifically to women. *Women only* brands, widespread advertisements depicting beautiful, glamorous, successful women smoking, free fashion goods, and the sponsorship of women's sports and events (such as tennis and fashion shows) are all part of the industrial global marketing strategy aimed at attracting and keeping women smoking...

Research in industrialised countries has shown the subtle methods used to encourage girls to smoke. The impact of such methods is likely to be even greater in developing countries, where young people are generally less knowledgeable about smoking hazards and may be more attracted by glamorous, desirable images of the female smoker.

That is why the WHO, together with other national and international health agencies, has repeatedly called for national legislation banning all forms of tobacco promotion, and for an appropriate high price policy which would slow down the enthusiasm of young women for tobacco consumption.

Several countries have developed integrated school and pre-school health education programmes which have successfully reduced girls' smoking rates, but this education should not be restricted to what happens in school. There are many other examples of effective cessation programmes in the workplace and primary health centres. Unfortunately, many women do not have the opportunity to be involved in such programmes, and programmes have generally been less successful with women than men.

In countries where smoking has decreased, the rate of decline has usually been lower in women than men, and least amongst women with low education and income ... But what can be done to tackle this problem? Community health workers can develop health education programmes for young girls. Primary care workers can ensure that all women receive information, advice and support to help them refrain from smoking and/or give up the habit.

Governments, national and international NGOs, and the WHO in particular, can act as advocates for women's health to ensure that the issue of women and tobacco is put high on the political agenda, by pressing for action to protect women ... Only by exposing the previously hidden problem of women and tobacco, only by putting women in the picture, will we be able to secure major improvements in the health of women world wide.'(Amos, 1990)



Self-help question 1.2

(about 10 minutes)

Now that you have read Case study 1.2, answer the following questions.

- 1 Why do you think women are being so heavily targeted by tobacco companies and why are they so susceptible to advertising of this type?
- 2 The two methods being stressed for coping with this problem are health education (specific programmes to inform people of the danger and ways to resist tobacco addiction) and health promotion (political campaigns and publicity aimed at getting mainstream attention to the issues). Given the hints in the report about the way tobacco campaigns operate, how effective do you think these strategies will be?

Compare your answers with those at the end of the unit.

From the answers you have given and from what you have read so far, it should be clear to you that health promotion is a wider approach that may involve a range of strategies such as education, advertising, consciousness-raising drama activities, campaigning, legislation as well as technological innovations. Some of these strategies are also appropriate to youth development work.

In the next section we return to the concepts we mentioned earlier in the unit 'adolescence' and 'youth'.

Adolescent and youth developmental changes

Developmental changes

The period of adolescence and its basic characteristics were described in Module 2 *Young People and Society*. Now, we will review the various changes that occur during adolescence and youth.

Young people have many needs. These vary over developmental stages, between countries, areas and social classes. However, the factors that define the health-related needs that young people may have can be broadly grouped under these four categories:

- 1 Physical development – including oral health, nutrition, sexual and reproductive health needs.
- 2 Psychological changes – related to the transition from childhood to adulthood, which may create disturbances ranging from minor transient emotional problems to grave psychiatric disorders.

- 3 Behavioural changes – manifested in experimentation and risk-taking as young men and women develop their identities and personalities based on their own judgements, as well as those of peers, parents, families and teachers. Risky behaviour that is more common in this age group includes dangerous driving, alcohol or drug abuse, smoking, attempted suicide, violence and risky sexual activity.
- 4 Social, economic and political situations in which young people find themselves – for example, war or civil unrest, occupational hazards, unemployment and exploitation.

Some of these problems will be more severe in developing countries than in developed countries.



Activity 1.6

(about 20 minutes)

Below is a list of some of the health-related problems that young people face. Discuss the list with others (friends, family, your tutorial group, etc.). Then, in your learning journal, draw up a table like the one below.

- 1 Identify which category discussed above (1, 2, 3 or 4) each belongs to. You may identify more than one for each.
- 2 List at least one need that relates to each problem. Ask yourself, ‘What do they need to do to get help with this problem?’ Try to generate as many ideas as you can.

The first one has been completed as an example. What do you think a youth worker can do about the needs you have identified?

| Category/ categories | Problem | Need |
|-------------------------|---|--|
| 1 and 4 | Poor nutrition. | Access to healthy food, education about nutrition. |
| | Mood swings due to hormonal changes. | |
| | Poor dental health. | |
| | Physical stress and/or other work-related health risks. | |
| | Unwanted pregnancy. | |
| | Endemic disease. | |
| | Psychological trauma. | |

| | | |
|--|---|--|
| | Emotional adjustment. | |
| | Group competitiveness. | |
| | Poor self-concept and social confidence. | |
| | Experimenting or risk-taking, e.g. driving fast, drug/alcohol abuse, casual and/or unprotected sex. | |
| | Risk of violence from war, urban unrest, crime, confrontation with other youths. | |
| | Inadequate education and/or unemployment. | |
| | Exploitation by others. | |
| | Being alone, i.e. abandoned, orphaned or alienated from family. | |

You must have seen some young people experiencing some of these problems. Do you remember experiencing any of the above problems yourself?

To end this unit we will now look at physical development and at some physical changes that occur during adolescence.

Physical development

As adolescents, we experience physical changes. To help you recall these changes, work through the self-help exercise below.



Self-help question 1.3

(about 10 minutes)

- 1 List the physical changes you know that take place in girls during puberty.
- 2 List the physical changes you know that take place in boys during puberty.
- 3 What are the changes (physical, social and emotional) that occur in adolescence?

Compare your answers with those provided at the end of the unit.

It is important for you, as a youth development worker, to have basic knowledge of good health and hygiene. The next section looks at the basics of personal health and hygiene as it applies to young people.

The basics of health and personal hygiene

Young people may suffer from diseases and illnesses because they don't know about the basics of personal health and hygiene. The information given below provides an introduction to the subject. You should encourage the young people you work with to talk to appropriate people (for example, yourself) about any questions or concerns they may have about their health. The tips provided below are divided into those which apply to all young people, those which apply only to women, and those which apply only to men.

General health and hygiene

Keeping clean

Frequent bathing and showering is important to keep clean and free of odour. Where this is not possible, then local washing can be used instead of all over cleansing.

Using soap is necessary even with regular bathing. Bathing regularly and wearing clean clothes keeps a person smelling clean and fresh. Sweat glands become more active during adolescence and some people like to use a deodorant and/or anti-perspirant product. Deodorants are designed to cover up natural body odours; anti-perspirants are designed to absorb perspiration in the armpit and therefore reduce underarm wetness.

Pimples and acne

Using a facial soap or cleanser can help prevent blackheads and pimples. Blackheads occur when pores in the skin become clogged. If blackheads are not removed, oil may continue to back up in the oil gland below the pore, causing pressure and inflammation. If germs get into the pore, pimples can develop. Teenagers who have blackheads may find that using a gentle abrasive soap or cleanser will help. Such a soap has tiny cleansing grains that scrub the blackheads loose and remove them. Washing the skin twice a day with regular soap is enough. It is important not to use products that are too strong.

Acne, a condition where the skin may become inflamed, may be caused by hormonal activity and excess washing will only make the condition worse. A good diet may help but, unfortunately, there may be little that the young person can do but wash normally, look after their general health and wait until they grow out of it. It is important that young people do not assume that the fact they have acne means they are not clean – this is not true.

STD testing and treatment

Being tested and treated for sexually transmitted diseases (STDs) can protect young people and their partners from further infection. STDs can only occur if there has been sexual contact with another person. Any adolescent who has engaged in sexual intercourse of any kind may be infected with an STD. Many STDs have no symptoms, especially in females, and can only be detected by a medical examination or after they have caused damage to a woman's reproductive organs. Testing is important to keep STDs from infecting internal reproductive organs and from spreading to another person. Treatment is usually very effective and teenagers can normally be treated in private or government health facilities without a parent's permission.

(Unit 5 looks in detail at STDs.)

Masturbation

Masturbation is a normal, healthy way to relieve sexual tension. Myths about it include that it can cause blindness, insanity, weakness, excessive hair growth, warts, acne (and so on). None of these things is true. People of both sexes and all ages masturbate, including people who have sexual partners, because it feels good. It can be a good way for teenagers to release sexual tension without risking pregnancy or disease. Young people who masturbate are normal, and so are young people who do not.

Female health and hygiene

Avoiding non-sexually transmitted vaginal infections

Sharing of infected clothing and poor personal hygiene may also contribute to vaginal infections. Some vaginal infections, like yeast infections, are common among adolescent girls. The first sign of a vaginal infection is generally a change in a woman's discharge. This may be accompanied by itching around the private parts. All women and adolescent girls have a normal vaginal discharge; this is nature's way of cleansing the vagina regularly. The normal discharge is usually clear or cloudy and has no unpleasant odour, as long as a woman's vagina is free of infection.

Infections can often be avoided by practising good health habits:

- keeping the vulva clean and dry by bathing and showering frequently and wear cotton underwear
- wiping from front to back after using the toilet, to keep bacteria from faeces away from the vaginal opening
- avoiding tight fitting clothing such as nylon underwear or tight jeans, especially in warm climates.
- avoiding irritating chemicals such as commercial douches, bubble baths, hygiene sprays and deodorised tampons.

Dealing with menstruation

Tampons are thin rolls of cotton and/or other fibres that are placed in the vagina to absorb menstrual flow. Attached to one end of the tampon is a string that extends through the vagina and hangs outside the vulva. The string is gently pulled to remove the tampon after use. Pads should also be used if there is a heavy menstrual flow. Tampons, pads and cotton wool should all be changed at least every four hours. It is particularly important to change tampons frequently. If left, they may absorb germs which can cause 'toxic shock syndrome' (TSS), a serious condition (characterised by fever), which requires medical attention.

Breast checks

Teenagers rarely get breast cancer, but getting into the habit of doing breast self-examination once a month is a good idea.

Young women should be taught that it is normal for women's breasts to change in size and how they feel due to menstrual cycles, pregnancy, and weight gain or loss. All women should be aware of how their breasts feel.

Generally, changes in a breast are normal, but occasionally changes can be found which can be the early signs of breast cancer. Most lumps or changes are not caused by cancer, but any changes that a woman find in her breasts should always be checked by a doctor as soon as possible. Early detection of breast cancer is the key to successful treatment and survival.

How to do a breast check:

- Feel each breast from the collarbone at the top to the bra-line at the bottom, and from midway between your breasts to an imaginary line down from the middle of your armpit.
- When you are feeling your breasts, use the flat part of your fingers including the sensitive finger pads. Move your fingers in small circles at every spot you touch.
- Start from your armpit and work up and down in vertical strips across your whole breast. The time this will take will depend on your breast size.
- You should use two different levels of pressure, both light and firm.
- To feel lightly, put your fingers together and flat and make the first circle with light pressure, firm enough just to make a slight dent in the skin. This will enable you to feel anything just below the surface.
- At the same spot make a second circle pressing quite firmly so that you can feel any deep lumps in your breast. Press as firmly as you can without any discomfort.

The following changes may not be due to breast cancer, but it is important that a woman sees her doctor straight away if she finds any of these changes.

- a breast lump
- a skin rash or itching
- changes in the colour of the skin
- puckering, roughness or dimpling of the skin
- retraction (pulling in) of the nipple
- discharge or leaking from the nipple
- pain anywhere in the breast
- any change from the usual look of either breast
- swelling or discomfort in the armpit.

Having a regular medical check-up

Examination of the breast and the pelvis at regular intervals is important to ensure that sexual organs are normal and healthy and to detect early signs of infections or other medical problems. Digital or instrumental pelvic examination is not indicated in virgins. A health practitioner should instead recommend other forms of medical imaging e.g. ultrasound or X-ray if any abnormality is suspected. Many girls are nervous about having their first pelvic exam, but the exams need not be painful and are very important for maintaining reproductive health. During a pelvic exam, the health practitioner first examines a woman's external pelvic area and genitals, then inserts a speculum – a plastic or metal instrument that gently spreads apart the walls of the vagina – to see the lining of the vagina, the cervix and the lower part of the uterus. The nurse or doctor wipes a plastic or wooden spoon across the cervix to take a pap smear – a test for cervical cancer that saves thousands of lives each year. To take charge of their own reproductive health and lives, all women should make an annual medical check up a part of their routine health care.

Male health and hygiene

Male circumcision

Some communities who practise circumcision do so because they believe that circumcision is necessary for male health and hygiene. In many European countries it may be done soon after birth. It is also done in some countries as a part of an initiation rite around the age of 12–14 years. Male circumcision does not affect sexual or reproductive health. A fold of skin called the foreskin is removed from around the top of the penis. Male circumcision is not necessary if the man practises good personal hygiene. Uncircumcised boys and men need to gently pull the foreskin back and wash the head of the penis when bathing.

Testicular self-examination

Cancer of the testes is not common and treatment is usually very successful. It is more common in boys or men who had an undescended testis (i.e. the testis had not descended into the scrotum, and needed to be operated on to bring it down). This cancer is usually found by men checking their own testes. Regular monthly checks are recommended, and if a man finds a change or a lump, he should go to his doctor as soon as possible. Most lumps are not cancer and most do not need treatment. The doctor will be able to tell if the lump is something to be concerned about, and if any more tests are needed.

Steps to follow

- 1 It is ideal if the self-examination is done after a warm bath or shower. The heat tends to make the testes hang lower so they are easier to feel and find anything different.
- 2 Stand in front of a mirror and look for any swelling of the skin around the testes.
- 3 Feel each testicle with both hands. Both the index and middle fingers should be placed under the testicle while the thumbs are placed on the top.
- 4 Gently roll the testicle between the thumbs and fingers. It is normal for one testicle to be larger than the other.
- 5 Find the epididymis (the soft tube-like structure at the back of the testicle that collects and carries the sperm). Do not mistake this for an abnormal lump.

What to check for:

- a lump in either testicle
- a testis being larger than it was, or tender to touch
- pain or tenderness
- a heavy feeling in the scrotum
- an ache in the lower abdomen (groin).

Check that you are familiar with these tips for promoting good health and hygiene among young people. Think about how you could get this information across to young people, individually, in groups, or as part of youth development activities.

Unit summary

In this unit, you have covered the following main points:

- there is a distinction between adolescents and youth, and both categories of young people constitute a transition from childhood to adulthood.
- adolescents and youth constitute the majority of in many developing countries and in most African populations and have special characteristics, some of which are positive and some of which makes them dependent and vulnerable.
- adolescents and youths are at risk and need special attention because of their rapid physical, emotional and behavioural changes.
- the social model of health is most relevant to youth and health.
- youth development activity can be crucial, but it requires a considerable understanding of how healthy situations can be created.
- the only economically feasible general approach must be based on primary health care. Youth development workers must try to ally their growing knowledge of social processes and illness patterns to a mode of working that links together some of the relevant agencies in the community.
- it is essential that young people are involved in primary health care projects that address their health problems.

To check how you have got on, look back at the learning outcomes for this unit and see if you can now do them. When you have done this, look through your learning journal to remind yourself of what you have learned and the ideas you have generated.

In Unit 2 we discuss the importance of youth participation in planning and implementing health programmes, the skills young people need to participate and how youth development workers can promote effective programmes.

Answers to self-help questions

Self-help question 1.1

See how many of the points below you included in your answer to this self-help question.

The crisis was the agreement of the Zambian government to a programme of structural adjustment of the economy. This was on the advice of the International Monetary Fund which threatened to withdraw financial support for the government unless it began to balance the books. Loss of IMF money would have brought the country to ruin. In other words, Zambia had to cut government spending to service its debts to international banks. This debt is a consequence of international bank lending policies in the 1970s and 1980s, and the inability to pay arose because of increasingly unfair terms of trade for poor countries. In Zambia, this led to a substantial drop in the price of copper.

Another serious problem is the heightened economic activity caused by growing globalisation of the world's economy, which attracts available capital to where the best rates of profit are to be found. Young people are particularly vulnerable because they are among the poorest people, and young women are poorer than young men. Directly or indirectly, we have to pay for health. Health is not just an issue of access to medicines or doctors. Good health is produced more by the quality of your environment or the quality of your food than by conventional medicine. Florence's children have become sick because they are malnourished: the problem of the scarce drugs would not have been an issue had they had enough proper food.

Let us look at what was done by development workers to help the situation in Florence's community: youth development workers could ally themselves with such work. An organisation that OXFAM supports, called the Human Settlements of Zambia, set up a clinic for preventive health and supplementary feeding of the growing numbers of malnourished children. They also started a kitchen garden scheme. Women like Florence were supplied with seeds and shown how to grow a range of quality vegetables on whatever waste ground they could find. Florence grew enough to feed her family and even to sell in the local market.

While youth development workers are unlikely to have the sort of medical knowledge to take the place of doctors, they should have the managerial knowledge and skills to organise the community resources that are available. If they know how health is socially constituted locally, they can intervene at the critical points. There will always be some medical professionals, environmental and diet specialists willing to give part of their time for nothing to act as advisers on preventive health, but the organisational problems on the ground need analysing beforehand and this can be done by youth development workers, who can also use networking to contact the right sources of help.

Self-help question 1.2

How do the following points compare with what you wrote in your journal?

- 1 Women are being so heavily targeted because they are becoming wealthier in the parts of the world where modernisation is taking place. Of course, in most countries it will only be women in certain social strata, such as those who have the skills to find work in the offices and factories of large, transnational companies, or work for the state in health, education, and so on. Women fall for this kind of 'hype' because the people who devise the advertisements are experts in manipulative psychology: the images and messages used are based on fundamental physical, emotional and social psychological needs, very carefully located in the specific cultures where the advertising takes place. It is particularly effective because many women are undergoing a major shift of role, and the tobacco drug is used to reassure them that they belong in these new, dominating roles.

The report shows clearly that, like all large capitalist companies, the tobacco companies are desperate for new markets and can afford to stop at nothing, providing it is legal, to gain them. They will fight for selling space and advertising space, and for agricultural control for growing tobacco, right across the developing world. At the moment their largest market is China, but the state in China is fast realising the terrible financial and human cost of their people's extraordinary addiction to tobacco, and may well drive the tobacco companies to rely even more on the developing world. So they will spend an enormous amount on image-making and on attacking people's insecurities at the subconscious level.

- 2 Health education, which is based on making knowledge available to ordinary young people, is valuable but limited in effect. This is because of the limited power of purely rational argument on human action. Human action is driven by very deep emotional and social forces, and the advertisers tap into these forces very cleverly.

Health promotion is wider and is aimed at more than consciousness-raising among the general public. While it uses techniques of health persuasion to persuade individuals to quit smoking, it is also prepared to fight for legislative action for health. A dramatic result of this is that in the UK parliament approved a ban on smoking in all places where the public gather, to take place from the summer of 2007. There is also personal health counselling for health for individuals and community development for health which is aimed at groups.

This at least indicates that within the field of health promotion there is now some awareness of the complexity of the challenge laid down by the global culture and the global economy. Whether

this can be successful in relation to women smoking is anybody's guess. There is a difficult battle to fight, but what we do know is that public health legislation, accompanied by health education and promotion of health, has been successful in lowering educated men's propensity to smoke. The possibilities are there to make serious changes around the whole Commonwealth.

Self-help question 1.3

You may have included the following changes in your answer.

Physical changes that occur during adolescence

| Boys | Girls |
|---|---|
| Enlargement of the testes and penis. | Onset of menstruation. |
| Growth of underarm, pubic and facial hair. | Development and growth of breasts and pubic hair. |
| First ejaculation. | Growth in body height. |
| 'Wet dreams'. | Weight gain. |
| Gain in muscular strength. | Voice changes. |
| Growth in body height and weight gain. | Skin problems (acne) may develop. |
| Voice change. | Body shape takes on characteristic adult pattern. |
| Body shape takes on characteristic adult pattern. | Acne may develop. |
| Acne may develop. | |

Social and emotional changes

There are several social and emotional changes that take place as well. These include:

- establishing independence from parent or other adults
- accepting oneself as a worthwhile person worthy of love
- behaving according to a shifting peer code (this means values and behaviour may change during the adolescent years when trying to conform with peer norms)
- adopting an adult set of social values (this means accepting and behaving as adults do)
- resolving problems in a responsible manner

- changing from concrete thinkers to abstract thinkers who are able to associate their actions with possible consequences
- learning appropriate outlets for sexual feelings.

You may also have included other ideas.

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Unit 2: Involving young people

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Unit introduction

Welcome to Unit 2 *Involving young people*.

This unit begins with an explanation of the role of youth development work in health promotion. We describe the essential youth development and health services and identify the key agents in health promotion and preventative work. We also look at how to enhance the quality of health programmes by encouraging the participation of young people. In addition, we consider the skills that young people need to develop so that they can participate fully in the health issues and programmes that concern them.

Unit learning outcomes

When you have worked through this unit you should be able to:

- identify the role of youth development work in the field of health promotion
- assess the role of other agencies in this field
- use appropriate techniques to respond to health issues in the course of your work
- help young people to acquire the knowledge and skills they need to participate in the environment of a primary health care agency.

Development

In Unit 1 we looked at the social model of health, in particular McKeown's four ways of dealing with infectious diseases. You may ask yourself what the particular role of youth development workers in this area should be. How might they intervene to improve the health of young people?

The following suggestions derive from the methodological underpinning of youth development theory:

- 1 **Improve standards of living** (a preventive health strategy). As we saw in Case study 1.1 (in Unit 1), Florence's living conditions were greatly improved by growing vegetables on waste ground in Lusaka, Zambia. Youth development workers can help build up a data bank of knowledge about food production and processing, diet and housing that can be used to underpin a range of specific health projects. There are many NGOs that have these kinds of data, and access to experts around the world is available increasingly via the internet.

There are many wealthy people operating in the global market who are as worried as the rest of us about the effects of the blind operations of the global bond markets. They are, therefore, willing to support 'supply side' improvements for poor people, although unwilling to give aid as handouts because of the ineffectiveness of this within global market conditions. Supply side improvements are improvements in efficiency and skill through better knowledge and organisation. For example, poor young people need support to develop modern sector or entrepreneurial skills so that they can earn a living. Having more money and knowledge will help to improve their health by enabling them to buy better food and improved housing.

The problems created by the world economy are now so massive that such improvements may seem tiny in comparison, but they are at least going in the right direction.

- 2 **Promote behavioural changes.** Better personal hygiene and less overcrowding (which fit into the category of preventive health care) are at least partly in the general area of improved knowledge and skill. If young people understand the conditions that support the growth of infectious diseases and lifestyle health problems, then they have the basis for making real choices. However, they also require the skills to change their habitual patterns of behaviour.

Habitual practices can become deeply ingrained, until they seem automatic and naturalised, even when those who use these practices are aware that they are harmful. We learn our place in society as much through our bodies as through our consciousness, and thus these practices are less accessible to

deliberate change. For example, where young men have habitually considered the symbol of manhood to be the number of women they have sexual relationships with, it is going to be a difficult process to change that. It may necessitate the empowerment of young women to resist young men through such strategies as assertiveness training.

Overcrowding is even harder since poverty and population patterns are involved, but improved earnings through entrepreneurial roles and/or modern sector work are shown to bring about a downturn in birth rates. Again, knowledge of the consequences of overcrowding can help people to avoid it, as far as possible.

- 3 **Improve public health, especially sanitation** (preventive health care). This is an obvious area for youth development workers to effect change, since small-scale public health projects are well within our scope. Quite often, the essential need is for somebody to take responsibility for the financial and operational management of such a scheme: for example putting in a cesspit or arranging a sewage pipe and flushing water.

Clean water may only require a simple cleansing system using gravels and sand in layers and a long pipe run. Technical knowledge can be brought in via the network of volunteer experts and the NGOs. The key to such problems is really at the human level more often than not. (Module 8 *Project Planning, Monitoring and Evaluation* may be helpful in understanding this.)

- 4 **Clinical medical intervention** (secondary and perhaps tertiary health care, but most efficiently used in primary health care). An essential part of the solution for women like Florence was the clinical dimension of the primary health care approach. In fact, the ideal for primary health care is a team-based approach, typically using:

- a volunteer base of low-skilled young people
- social agents such as teachers and health care workers
- a food and diet specialist
- local authority environmental specialists
- a few health care professionals.

The youth worker's main role, then, is in the organisation and management of part of this team – the volunteer youth base. This requires excellent social and communication skills, for not only will the youth worker need these with young people but also with all the other members of the primary health care team. This is crucial for the success of the programme.



Activity 2.1

(about 20 minutes)

Select some of the examples of youth development work mentioned above that you think might improve the health of young people in your neighbourhood.

What would be the primary role of the youth development worker?

Use the following headings to focus your ideas:

- 1 Improved living standards.
- 2 Behavioural changes.
- 3 Improved public health.

For each of these, consider who, from your own community, might become involved in a primary health care team (for example, other agencies, health practitioners, engineers, agriculturalists, dieticians, etc.). Explain why and how you feel they should be involved.

Write your notes in your learning journal.

Did you include young people among those who should get involved in primary health care, and explained why? Compare your responses with the next section.

Involving young people in health care

You may already know from experience that both youth development work and primary health care aim to empower people. It is therefore essential that young people participate in primary health care projects. We need to listen to the views of young people, and we need to use their insights and energy to make projects relevant and of a style that young people will respond to positively.

In order to make their participation more productive, young people should be treated as 'partners in action'. They can be involved as active participants in the definition of the problems, and in the creation and implementation of the solutions. Young people are realistic about the problems they face, they have initiative, energy and ideas, and can organise themselves to take action. You will learn more about this, and other related issues, in the next reading.



Now turn to Reading 2: 'Young people – partners in action on youth health' from *Youth Health – Analysis and Action* by the Commonwealth Youth Programme.

This paper outlines the active role young people can play in improving youth health, with suggestions for programmes and action.



Activity 2.2

(about 10 minutes)

List some of the reasons given in Reading 2 for including young people in primary health care teams. What qualities and skills do you think that you personally might bring to such a team?

Make notes about this in your learning journal.

The issue of wider participation in health care is further highlighted in the Alma-Ata Declaration (WHO Document 22, 1978), which argues that:

“... primary health care should involve and co-ordinate people from throughout the health sector as well as all related sectors of national and community development, particularly agriculture, animal husbandry, food, industry, education, housing, public works, communications ...”

“From the health sector it relies, at local and referral level, on health workers, including physicians, nurses, midwives, auxiliaries, and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed needs of the community.”

“It also recognises that ... health is rooted in the social structure as well as the environment; it requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources, and to this end develops through appropriate education the ability of communities to participate.”



Activity 2.3

(about 10 minutes)

Reflect on what you have read in Reading 2 and the extract above from the Alma-Ata Declaration, then answer the following questions.

- 1 In what ways does poverty create health problems?
- 2 How can a youth development worker intervene to improve the health of young people?
- 3 Why is primary health care so important?

Compare your answers with those provided at the end of the unit.

Youth development and health services

The health of a nation's youth is determined by the way that different strata of young people fit into that nation's social structure, with the poorest groups suffering the most ill-health. This is in turn influenced by the structure of the social and economic global system.

For example, a country like Sri Lanka, which developed a degree of prosperity with textiles and other related industries, faced the loss of jobs for thousands of textile workers when the Multi-fibre Arrangement came to an end in 2005 and removed the protected market share. Unless the textiles industry in these countries can create new niche markets, for high quality expensive textiles, then that will create new areas of poverty, which as we said earlier is statistically damaging to the health of the poor. Their governments will need to redress that problem through public health measures.

In order for youth development workers to be able to work in the same direction as the progressive forces in a given social system, rather than struggling against them, it is important that they first determine what the possible linkages between youth development activities and the local systems of public health are.

While most countries in the world are increasingly adopting the primary health care approach, the management of health education and promotion varies greatly from region to region, depending on the local culture and the political and economic structure of a region, as well as on the health and disease patterns and local primary health care policies.

The Commonwealth Youth Programme (1995) suggests that an analysis of health provision in a specific situation should begin with the consideration of three factors:

- whether health services for young people exist inside a service specifically allocated to health, such as a health centre or a drug unit, or happen to be located within broader community development services, such as the criminal justice system or education
- whether the service in question is being used by young people alone or by the population in general
- whether the service in question is a specialist service, for example relevant to smoking or sexually transmitted diseases, or whether it has a broader (more holistic) emphasis, being concerned with the wider context of young people's health.

It is therefore important for you to know the way in which the local health service fits into these broad groupings, as youth development workers need to mobilise aspects of these services to meet identified needs. You need to be aware of the way each service operates, its organisational objectives and how each service varies according to the

way it is located in the general system. Now let's look at the various categories of services for young men and women.

Categories of services

The Commonwealth Youth Programme further describes four categories of service for young men and women:

- youth development services
- youth health services
- general health services
- community development services.

Youth development services

As you may know from your own experience, these are not normally a part of specific health-centred services, as they tend to deal with more general matters to do with young people. They aim to develop the social and personal lives of young people and to serve vulnerable groups of young people. They provide a range of services available in one location, including the following:

- youth councils
- multipurpose youth centres – recreation, primary health care, advice on reproductive health; skills training
- 'youth for youth' and 'peer education' projects
- youth task forces
- 'youth sport for health'
- life-skills and health education projects (in-school)
- out-of-school and unattached youth projects, such as enterprise schemes
- youth homelessness projects
- outreach work in bars and shops.

Youth health services

These are youth-centred, specific health services based in a location, and they may focus on particular health issues affecting young people, or may work on young people's general health:

- peer education health projects such as anti-smoking and HIV/AIDS campaigns
- youth health action projects such as 'safer sex' workshops
- youth counselling projects
- youth health clinics and drop-in projects for family planning
- young women's health advice centres

- youth disability projects
- units, wards and services designated for the treatment of young people.

General health services

These are services designed to be used by all age groups within a population. They may focus on particular issues or vulnerable groups, or provide a general health service in one location:

- community health clinics
- hospitals
- psychiatric units
- health education and promotion projects
- marriage guidance
- health professionals such as doctors and nurses
- general anti-smoking campaigns.

Community development services

Community development services are general services outside the specific health service that young people may use. They work with vulnerable groups of people to develop particular aspects of their lives, or they may aim to work with people generally and to provide a complete range of services in one location:

- community centres
- community theatre groups
- anti-poverty projects
- nutrition projects
- women's health projects
- enterprise schemes
- adult education projects
- literacy schemes
- environmental health services
- sex workers' rehabilitation community projects
- drug users' rehabilitation community projects.



Activity 2.4

(about 25 minutes)

In your tutorial group or with your colleagues, explore the range of services available in your community and country and compare them with the list of services mentioned above.

Which health services are available to you in community and country? Do you know how to access them? Which would you most like to have in your community, and why?

Are there other services in your country or community that are not mentioned here?

Write this information in your learning journal and keep it for reference.

Now that you have explored the range of services available in your community and country, let's look at how to prepare to work with young people in the area of health.

Working with young people in youth health

The next activity will help you begin to develop a small youth health project, or become involved with an existing one. As you continue to develop or become involved in such a project, try to focus on just *one* relevant area that you have identified as a significant local need. Start out small, or you will end up being very unfocused, and you may not achieve very much. Once you have one success (however small it is), you can build on that work, perhaps expanding the team's work to address other needs.

Units 3, 4, 5 and 6 will provide you with specific information about nutrition, sexual and reproductive health, STDs and HIV/AIDS, and drug abuse. You do not need to focus on all of these areas for your project, and will find it more effective to deal with just one of these. Or you might choose another, health-related issue such as youth empowerment, through activities that develop:

- access to information
- communication skills
- entrepreneurship
- a supportive environment.

In the next section of this unit you will look at these health-related issues, and the importance of involving young people.

(Note: Whatever you decide on for your project, all of the information that is covered in Units 3–6 will be valuable to you as you progress in your role as a youth development worker. Please read all the material carefully and complete all the activities.)



Activity 2.5

(about 20 minutes initial planning, but allow plenty of time for the group work and preparation for it)

- 1 In the context of developing preventive strategies for health, identify the health-related problems and needs of young people in *your* community.
- 2 Identify a group of young people (youth group, high school group, sports group, etc.) whom you would like to involve in a primary health care project for young people.
- 3 Set up an opportunity to discuss health-related problems with the group of young people. Think carefully about how you will set up this opportunity and what youth development strategies you will use (role-plays, peer learning, games, etc.)
- 4 Ask the group to identify what *they* consider to be the health-related problems that face young people in their community. (Was your list different from theirs? You might like to discuss your different perspectives.)
- 5 As a group, generate a list of needs; group and prioritise them so that you can focus on the one or two that are most important.
- 6 If you wanted to set up a primary health care project team to address the problem(s) you have identified, who or what services from your local community would you want to involve, why and how? Ask your group to think about this also.

As you become involved with health services, you may find that you and your group of young ‘partners in action’ can work within existing primary health care projects, perhaps by adding a youth specific element. This approach is acceptable for your project and final assignment.

Write the information you gather in your learning journal.

This activity will be of use in your final assignment. There are more activities that will help you with your project and assignment in the following units.

The role of young people in health

In the previous section we discussed how young people should be involved in health projects. In this section we will look at how youths can be empowered with knowledge and skills to assume more responsibilities in managing their own health needs and improving their quality of life. However, many programmes for youths tend to consider them as passive, not active participants.

In general, youth programmes do not make enough effort to stimulate participation of the young people in the planning, decision-making, policy development, monitoring and evaluation of programmes designed for them.

Sometimes youths are symbolically involved in the activities that are targeting them. An example of the symbolic involvement of young people is the common practice of inviting one or two youths to a large national and/or regional conference or workshop where adults are discussing important youth-related issues, or where findings about research conducted on youths, without their participation, are being discussed.

In the next two sections we examine why and how youths should be involved in promoting their own health.

Why involve young people?

Young people can and should be part of the solution to global and local health problems that affect them and their communities. Their role as agents of change in promoting health and development enhances their competencies, as highlighted by UNDP (2003):

“Youth should be actively involved in the planning, implementation and evaluation of development activities that have a direct impact on their daily lives. This is especially important with respect to information, education and communication activities and services concerning reproductive and sexual health, including the prevention of early pregnancies, sex education and the prevention of HIV/AIDS and other sexually transmitted diseases.”

(ICPD Programme of Action (1994), paragraph 6.15)

Both youth development work and primary health care aim to empower people. It is therefore essential that young people participate in primary health care projects. We need to listen to the views of young people, and use their insights and energy to make projects relevant and of a style that they will respond to positively.



Turn again to Reading 2: ‘Young people – partners in action on youth health’ from *Youth Health – Analysis and Action* by the Commonwealth Youth Programme.

This time, concentrate on identifying the programmes and actions that you think would be most valuable in your situation.



Activity 2.6

(about 15 minutes)

Reflect on what you have read, then answer the following question.

What key action points do you recommend to promote the development of youth programmes in your community, and why?

Write your response in your learning journal.

From Reading 2, it should not be surprising to you that in recent years it has become widely recognised that there is a need to involve youths at all stages of programmes intended for them. According to the International Centre for Research on Women (www.icrw.org), the active participation of youths in their own programmes:

- facilitates the co-operation of young people
- catalyses community responses to identified needs and problems
- fosters sustainability of the programmes.
- enhances research and programme outcomes
- increases utilisation and promotes ownership of programmes.

We also saw in Reading 2 that another important reason for involving young people is that they form a very large segment of the world population, especially in developing countries. Youths are the major human resource that can be mobilised against threats to health for the whole population.

Young people are usually very close to the changing culture of the times and therefore have special sorts of experience, knowledge and skills that they can bring to programmes. They must therefore be able to participate in the design and management of every stage of the programmes that are particular to them.



Activity 2.7

(about 20 minutes, allowing extra time for discussion)

Discuss with a group of young people the practical ways and specific areas in which they feel that they should be involved in the design and management of youth health programmes.

Write the ideas down in your learning journal for reference.

The next section explains how young people should be involved in programmes aimed at improving their own development and health status.

How can young people be involved?

Young people can obviously take an active part in research or review activities of the programmes designed for them. They can contribute to the development of research instruments (consulting existing information/reports, observing and interviewing, surveys and focus group discussions), take part in data collection, the discussion of data in data analysis, and in decisions about how research findings should be used. Moreover, involving youth in the review of health issues that affect their lives will lead to conclusions that are more workable, and recommendations that are more likely to achieve the desired outcomes when put in practice.

They can participate as community education agents. For example, the peer education (defined as “*the sharing of information for the purpose of educating, between individuals who are not professionally trained instructors, but who share similar backgrounds, experiences or behaviours*”) and counselling approach in STDs/HIV/AIDS awareness and condom promotion has proved successful in some communities. Peer education among young people is therefore a vital element in achieving successful changes to attitudes and behaviour (Harden *et al*, 1999).

Youths can make very useful contributions to the decision-making and planning processes of interventions designed for them. There are both formal and informal mechanisms that enable young people to participate in the decision-making process. To maximise the effectiveness of their participation, the following key questions should be asked:

- Are young men and women represented at all levels in the decision-making systems?
- Are young men and women given adequate support and training to articulate their views and experiences at every level?
- Are the mechanisms for electing or selecting young people as representatives widely known and appropriate?

- Are the young people who are involved representative of young people generally – do they reflect the diversity within the youth population?
- Are their representatives effective at consulting and reporting to young people?
- Do informal mechanisms for consultations exist and are they used fully?

Formal mechanisms include youth councils and youth assemblies, peer education projects and campaigns, youth run and managed activities and school forums. Informal mechanisms include talking in youth centres, meeting in the street, correspondence in magazines and meeting in the playground.

The main decision making structures can therefore be identified as:

- youth forums
- youth representation
- everyday consultation
- young people talking to each other (Commonwealth Youth Programme, 1995).

Youths can form a strong, united voice to advocate for the formulation of programmes to address their own problems and needs, such as those identified in this module. Remember that there is strength in unity. However, unity will only be possible if the principles of participation are upheld.



Activity 2.8

(about 20 minutes, allowing extra for the visit and discussions)

Visit a community programme that targets young people in your community and talk to the organisers and participants. (This need not be just a health programme.)

Find out the ways in which young people are involved in the organisation of the programme.

In your learning journal, list the activities that the young people do. Have they been involved in the development and implementation of the programme? If not, why not? What effect has that had on the programme and the participants?

From your visit to the community programme, you may have noticed some positive changes in the community that have been brought about by the involvement of young people.

In the next section, we look at how young people in various parts of the Commonwealth have contributed to the fight against HIV/AIDS, through the Commonwealth Youth Programme (CYP).

Young people making a difference: CYP's role

The work of the Commonwealth Youth Programme (CYP) on HIV/AIDS has formed the main plank of the Youth Participation Strategic Programme. The Youth Ambassadors for Positive Living (YAPL) Programme was expanded to the Asia (India) and the Caribbean (Guyana) regions respectively.

Consultation has gone on in the Pacific region to implement the project. A group of young people from the Pacific region participated in a CYP/UNICEF study tour programme to assess the incidence of HIV/AIDS in Africa. These young people are leading the dialogue on HIV/AIDS in the Pacific region.

The Ambassadors for Positive Living participated in the 4th Commonwealth Youth Forum in Nigeria and a press conference on World AIDS Day was organised for ambassadors to share their views during the Commonwealth Heads of Government Meeting.

The visit of an Ambassador for Positive Living from India to the Commonwealth Secretariat and the UK in November 2003 received wide media coverage by the BBC (international radio and television programmes) and other international networks. This media coverage generated a lot of publicity for the Commonwealth initiative.

The 'Play It Safe' HIV/AIDS initiative is evolving as an innovative project to raise awareness on HIV/AIDS in St Vincent and the Grenadines. The project uses sports (cricket, soccer and netball) as a medium for reaching unattached young people in rural communities and galvanising them into action against HIV/AIDS. The project possesses the potential to evolve as a model of best practice in this area of work.

Case study 2.1

1 Youth Ambassadors for Positive Living (CYP Caribbean Region)

The Commonwealth Youth Programme Caribbean Centre enhanced its HIV/AIDS intervention activities with a workshop in Guyana, involving participants from a number of NGOs across the country to determine the gaps in HIV/AIDS programmes in the country. With assistance from CAREC, UNAIDS in Guyana, representatives of a local HIV/AIDS Network and a Canadian Intern, the workshop agreed that CYPCC's focus should be on 'Positive Living' and should use young people who have been diagnosed as both HIV/AIDS positive and negative, to spread the message of 'Positive Living'. This is meant to help:

- contain the spread of HIV/AIDS through positive lifestyles by young people who are HIV-positive

- encourage young people who are HIV-negative to choose healthy life styles and as a result reduce their chances of being exposed to the HIV virus.

On September 11th 2003, the Commonwealth Youths for Positive Living, a team of 21 HIV/AIDS positive and negative youths, now referred to as the CYPLs, was launched and has been conducting Positive Living Workshops in schools and communities. A procedure manual has been drafted to assist other countries in the region that wish to establish CYPL groups.

The CYPL is based on similar objectives to the YAPL. The Caribbean Centre opted for CYPL as a means of branding the intervention and to bring into focus the commitment of the CYP to positive youth intervention.

2 Youth in Jamaica

In Jamaica, the performing arts are applied in relation to social issues by an award-winning ensemble called by a Yoruba word meaning "the strength, power and talent within": ASHE. With a diverse repertoire, ASHE draws on songs and dances with roots in Afro-Caribbean traditional, folk, gospel, reggae and popular dancehall music. Its original educational musicals address such issues as HIV/AIDS, drug abuse, the environment and children's rights.

The ensemble features 25 full-time professional performers. ASHE's academy has enabled many hundreds of young people between the ages of 9 and 25 to receive training in singing, dancing, acting and drumming. Among its many activities, ASHE has produced a music video, "Choices", advocating the empowerment of young women and their right to say "no"; also a musical event entitled "Solid" that tells the story of a family confronted by teenage drug abuse and pregnancy; and "VIBES in a World of Sexuality", dealing with HIV/AIDS and other STDs.

(Interactive Population Centre)

3 CYP Africa Region - Youth Health, YAPL

The Commonwealth Youth Programme Africa Centre (CYPAC), in collaboration with the Government of Seychelles, through its Ministry of Education and Youth, held a workshop in Mahe, Seychelles, from 26th to 28th July 2004. The theme of the workshop was the crucial and challenging issue of 'The Integration of Youth Issues and Youth Participation in HIV/AIDS Planning and Programming in the Eastern African Countries of Kenya, Tanzania, Uganda, including the Commonwealth Countries of Seychelles and Cyprus.'

Forty-five participants, comprising senior policy makers, representatives of civil society organisations and young people from Kenya, Seychelles, Tanzania and Uganda, attended the meeting.

The workshop recognised that one of the major weaknesses of many youth programmes is that they do not sufficiently involve the young people themselves in programme planning, development and implementation. It is important to ensure that young people actively participate in their own programmes because such an involvement guarantees, among other things, sustainability of the programmes.

An important lesson from these examples is that programmes that *do not* involve the intended users usually fail to meet their objectives. Often such programmes:

- do not address the felt needs
- use strategies that are not appropriate or acceptable to the target group and/or are not perceived by the community or participants as useful for them, but as owned by someone else or by an institution.



Turn to Reading 3: 'Best Practice Initiatives: Youth to Youth in Health', from the Secretariat of the Pacific Community.



Activity 2.9

(about 10 minutes)

Now that you have read Reading 3, answer the following questions. Write your responses in your learning journal.

Why was the programme started? What are the main objectives?

Would you want to have such a programme in your country? If so, why? If not, why not?

In the previous sections we have looked at the need for, and importance of, involving young people in developing and managing community/youth development and health promotion programmes. For young people to participate productively and actively, they need some skills as explained in the next section.

Developing skills and information

To participate actively in the planning, development and implementation of youth health programmes, young people need good communication skills and information about health issues and health services in their community. As a youth development worker trying to involve young people in their own health programmes, you will need to help young people to develop their communication skills in order to get the information they need to participate fully.

Communication skills

Young people need to be empowered with communication skills so that they can:

- identify their own individual and group needs, such as local health problems, gaps in youth health services, etc.
- generate solutions and make practical decisions about their own wellbeing
- articulate their needs to other people such as peers, parents, teachers, policy makers/planners and programme implementers
- negotiate effectively to have their needs met, in order for example, to access family planning services and contraceptives, to gain access to services that support new behaviours and prevent relapses into old behaviours, as in the case of alcoholics and other drug abusers.

Involving young people in youth health programmes should begin with free and open discussion. You can use relevant activities, such as peer to peer talks, drama and role-playing. You should encourage a trusting atmosphere where this can take place. In Module 1, you learned about Paolo Freire's 'conscientisation' model, which describes strategies utilised to raise the awareness and develop the communication skills of poor peasant families. These are the types of strategies that are very useful in developing communication skills, so that youths can be empowered to participate in health care programmes.

Information

Young people need information about what health services exist, what services they have access to and what is missing. They also need to be able to make informed decisions about using existing health services.

Utilisation of services designed for youths, as with any other target group, depends on several factors:

- **Affordability.** Can youths pay for the service if there is a fee?
- **Acceptability.** Are the services and/or approaches used to deliver the services socially and culturally acceptable to youths?
- **Accessibility.** Are the services socially and geographically within reach?
- **Quality.** Is the standard and quality of the service assured?
- **Relevance.** Do the young people have the information and knowledge needed to use and/or benefit from the services?

To facilitate the dissemination of information about community health programmes, it is useful to develop a youth health directory. To be of value, such a directory needs to be updated regularly.

Format for a youth health directory

Well-designed youth community programmes can be in place, but if young people are not aware of them, they will remain under-utilised. Therefore, it is important that relevant information about the programme be available to young people.

Information dissemination should make use of well designed, community specific and appropriate (informal and formal) communication channels, if the young people are to be empowered with the knowledge and skills to acquire relevant information. Simple but useful information about available programmes should include:

- Name of institution/project.
- Location – exactly where can the programme be accessed and where is it located?
- Objectives of the institution/project.
- Type of activities/services offered by the institution/project.
- Target group – who are the services intended for?
- Contact information – geographical location; mailing address; telephone; fax; e-mail.
- Costs for using services.
- Operational schedule. Are services offered every day or not? What are the operational hours for the service? Is the service available 24 hours a day, or just during normal working hours?
- Relevant policy matters such as a ‘confidentiality statement’, ‘non-discrimination policies’ on the basis of sex, race or statements about ‘other factors’ such as marital status.
- How targets are identified.



Activity 2.10

(Time will vary and will depend on your discussions and on how detailed you make the activity)

Based on the format suggested above, and drawing on some of the results of your work in Activity 2.4, develop an inventory of youth related programmes or health services in the town/city where you live. Organise the information according to these categories:

- youth development services
- youth health services
- general health services, and
- community development services.

If no youth specific programmes exist, talk to health service personnel about the possibility of adapting existing services to incorporate a youth specific programme. It may be possible to initiate a youth specific programme that piggy-backs on an existing one. You could consider this for your project and final assignment.

Note: If you have identified lack of information about youth health services as one of the problems in your community, this activity could form the basis of your project and final assignment.

Read the details about your final assignment at the end of this module before you go any further. This will help you to plan your project. Remember that there will be other ideas to choose from throughout the module.

Record your ideas and your findings in your learning journal.

Clearly, the acquisition of skills and information are important in promoting youth participation in programmes. However, there are other factors that determine youth participation.

Factors affecting participation

You will have noted that participation is a recurrent theme that is discussed in most, if not all, 13 modules. In this section, we look at factors that can facilitate or inhibit youth participation in the local environments that the young people live in. There are also some strategies that can improve the chances of youth participation.



Look again at Reading 2: 'Young people – partners in action on youth health' from *Youth Health – Analysis and Action* by the Commonwealth Youth Programme.



Activity 2.11 (about 10 minutes)

List some of the approaches mentioned in Reading 2 that will encourage youth participation.

Identify any barriers that need to be overcome in order for youth development workers in your country to participate more fully in promoting youth health.

Make notes about this in your journal.

You may have identified a number of barriers to youth participation. We will proceed by looking at the factors that facilitate participation, before we look at those that inhibit it.

Some of the factors that facilitate youth participation in health issues that affect them are:

- recognition that a problem affects them personally
- willingness to address the problem and also to take action
- knowledge and skills related to the identified problem and the availability of possible solutions to the problem
- availability of local/external resources
- support from the community or relevant institutions.

Some of the factors that inhibit youth participation in health issues that affect them are:

- an unsupportive environment (i.e. communities/adults not giving youths opportunities to take charge of issues that directly affect them)
- failure to recognise that the problem is important to them
- lack of knowledge and skills needed to take action
- lack of resources.

Having looked at the factors that facilitate and inhibit youth participation in health and development programmes, it is important to explore how youth participation can be improved.

Improving youth participation

We should begin the discussion of this subject by repeating a point made earlier in the unit: young people should not be seen as problems, but as agents of change. However, their ability to be involved in change is hampered because they rarely have much organisational or institutional power. We can begin to empower young people by providing them with access to relevant information and good communication skills, but that is only the beginning of the process.

It is very important to develop strategies to shift the balance of power in the community so that we can create an environment where youths act as participatory power holders. Activities that help to create a supportive environment with parents, teachers and religious leaders will facilitate youth involvement in their own health concerns.

Participatory Learning Appraisal (PLA)

You probably have heard or read about the PLA approach to developing community development programmes. Don't worry if you haven't. PLA refers to the way things are done in the community determines the way power distribution works or is allowed to work. PLA is a pivotal process for involving young people in activities that define the distribution of power, because it is a community process used to:

- identify and prioritise community problems
- make a plan of action
- and create a relevant budget based on available local/external resources.

Some of the advantages that PLA has for empowering youths are that it:

- offers young people as participants a direct experience of participating in all stages of the programme, from problem identification, planning and implementation to monitoring and evaluation
- offers an opportunity to participants to have a better understanding of the nature and magnitude of the real problems faced by the community
- can enhance commitment from all stakeholders to devise community solutions
- fosters group solutions and shared ownership of policies/programmes

- teaches skills that can be transferred to other community situations and problems
- facilitates sustainability of programmes because of the strong commitment generated.

Income-generating activities (entrepreneurship)

One major problem affecting young people is lack of money to meet their basic needs (i.e. food, clothing, shelter, education and health) because of the problem of unemployment. Their lack of financial resources means that, even when they feel the need to seek health care or address other reproductive health needs, they find themselves unable to afford the costs. The link between poverty and poor health is clear, therefore programmes that develop income generating skills can contribute significantly to improvements in youth health and youth participation



Now turn to Reading 4: ‘The Commonwealth Youth Credit Initiative’ from the Commonwealth Secretariat journal *In Common*, and then do the activity that follows.



Activity 2.12

(about 10 minutes)

What do you think are the main advantages of the Commonwealth Youth Credit Initiative described in Reading 4?

Make notes in your learning journal.

A supportive environment for health communication

We have already highlighted the need for, and importance of, creating a supportive environment for facilitating the participation of the youth in promoting their own health. We will now look at a case study of how cultural and religious norms limit communication.



Case study 2.2

The effect of cultural and religious norms on communication

Local African cultural and religious norms limit communication about issues related to sexuality and abortion in Zambia. Because abortion is not discussed openly, it does not find itself on the policy agenda. Further, inability to talk about sexuality results in irrational teaching to children and youths – *no to sex before marriage* and *no to abortion* are the usual messages to youths, yet their lives dictate that they learn more about these issues.

Premarital pregnancies and induced abortion suggest that there is high unprotected sexual activity among youths and that youths have little access to services and information about conception, contraception and the reproductive process.

(Ahlberg *et al*, 1993)

In cases like this, which are widespread, local initiatives to open the dialogue through existing and innovative structures are needed: parents, teachers, religious leaders of both sexes ought to take a lead in the re-education process. For example, up-to-date information and education could be targeted at church institutions, which have the moral and social authority to modify their messages to youths to facilitate informed and up-to-date sexual practices.

For example, instead of focusing exclusively on messages of sex within the realm of marriage and abstinence outside of marriage, which anyway seems to have little effect on large groups of young people, the church could also teach that unprotected sex and failure to use family planning may lead to STDs/HIV infection, abortion and death.

Intervention by religious and cultural elders and leaders to empower parents to communicate more openly with young people, especially about sexual matters, is needed urgently. Young people have indicated that they would like their parents to educate them about sexuality at an early age (Macwan'gi, 1993).

Effective health communication involves the transformation of health knowledge into health messages that are readily understood by the audience and accepted – both culturally and socially, and can be acted upon by the audience to promote healthy behaviour and improve the health status of the whole community, particularly youths.

Effective preparation and communication

Being clear about what you as a youth development worker (and your group of young volunteers) want to achieve through a health care project requires careful preparation and effective communication.

You need to:

- define what knowledge or behaviours are required to deal with the identified health problem and set them as objectives
- decide which specific group of youths you are trying to influence and identify them in your objectives
- find out whether the new health behaviour requires new skills, and if so, set the new skills as objectives
- find out about the present knowledge, beliefs and behaviour of the target group of young people and those around them
- find out if the behaviour you intend promoting has already been tried in the community and whether it is working or not
- find out where people get their health information from
- select communication channels that best reach your target group, e.g. using radio, television, newspapers, cassettes, leaflets, peer group activities, religious forums, community drama groups
- design your messages so that they are: easy to understand, culturally acceptable and socially appropriate, practical, brief, relevant, factual, true and sensitive to the concerns of those people interacting with the youths and health workers (such as teachers and parents)
- test your messages and materials
- integrate your education with other development activities
- check whether people are getting the messages and are using them
- repeat and adjust your messages depending on the response of the audience over time.

Check that you understand what is required for effective preparation and communication, and think about what this would mean in practice for your work.

Unit Summary

In this unit, you have explored a number of issues concerning the involvement of the youth in development and health programmes purposely designed for effective intervention.

You have covered the following main points:

- the role of youth development in the field of health
- youth development and health services, with possible links between youth development activities and the local health system
- the role of young people in promoting their own health and how young people are making a difference
- developing skills and information for youth
- how to encourage participation.

To check how you have got on, look back at the learning outcomes for this unit and see if you can now do them. When you have done this, look through your learning journal to remind yourself of what you have learned and the ideas you have generated.

Unit 3 focuses on nutrition, and provides information about nutrition and diet for use in any health prevention or promotion activities that you might be involved in.

Answers to self-help question

Self-help question 2.1

- 1 Poverty creates health problems in many ways. For example:
 - good, adequate food is important for improved living standards, but poor people often cannot meet the basic food requirements of their families
 - because of inadequate food of acceptable quality and substandard alternatives, poor families tend to be prone to diseases
 - in many countries, basic health services are not entirely free and poor people find it difficult to buy basic medicines or to pay for basic health services.

- 2 Youth development workers can play an important role in promoting the health of young people in a number of ways. For example, they can:
 - assist in developing projects through which information about food production and processing, diet and housing can be made accessible to poor families
 - assist in developing educational programmes/activities aimed at improving behavioural changes and better personal hygiene
 - help in mobilising and co-ordinating NGO activities to improve public health
 - take part in team-based strategies for health promotion, e.g. primary health care activities involving volunteers, environmental specialists, health care professionals and local authorities.

- 3 Primary health care is important because it is:
 - health care in the community, therefore it provides opportunities for voluntary support from the community, including young people
 - a team-based approach, which at its best involves the sharing of expertise and resources from specialists and non-specialists: this means that youth development workers can be involved at a grassroots level, drawing together community resources and expertise specifically to focus on the health of the young sector
 - where preventive health care, especially health education and promotion, takes place

- it is based on a social model of health and takes action to improve the causes of poor health (poor living standards, lack of education, poverty, etc.).

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Unit 3: Nutrition

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Unit introduction

Welcome to Unit 3 *Nutrition*.

This unit will provide you with valuable information about nutrition and diet, for your own understanding and to use in any health prevention or promotion activities that you might facilitate. It begins with the definition of 'malnutrition'. We look at the mandate of the World Health Organisation (WHO) in the promotion of nutrition, after which we look at the world food supply. We then discuss the challenge of balancing food supply and demand, and finish with a detailed discussion of various aspects of human nutrition.

One of the simplest and most effective ways of improving anyone's health is to guarantee that they are getting an adequate diet that satisfies their nutritional needs, and a good supply of fresh, clean water. Of course, to be completely healthy also requires a healthy emotional and mental life, and good nutrition may satisfy some of the requirements of that as well.

However, in many countries people have given up being self-sufficient in food production as a main goal of agricultural production, because global market pressures, combined with policies of structural adjustment, are causing a shift of resources towards production of those things that give a country a comparative economic advantage. There is consequently a huge superfluity of food available for rich countries, but unfortunately this unequal distribution may well contribute to the many disastrous consequences of the enormous income imbalances between rich and poor countries.

Youth development workers can do little in the short term about the terrible income imbalances even between well-off and poor people in their own countries, but they can help poor people achieve important marginal improvements in their health, by educating them about nutrition, and helping communities towards whatever measure of nutritional self-sufficiency can be achieved.

Unit learning outcomes

When you have worked through this unit, you should be able to:

- describe the nutritional dimension of major health issues affecting communities locally, regionally and world wide
- discuss the nutritional issues underpinning a range of health promotion strategies, particularly preventative strategies
- use relevant knowledge of food production and distribution to respond to health issues raised in the course of your work
- design and deliver specific programmes of health promotion, in a way informed by nutritional knowledge and insight
- use relevant knowledge to work within the environment of a primary health agency, using the distinctive methodology of youth development work
- acquire essential knowledge for working within complex partnerships created to achieve key objectives in the field of health promotion.

Malnutrition



Activity 3.1

(about 10 minutes)

You must have heard and read about malnutrition. What is your understanding of the meaning of this term? Is malnutrition a serious problem in your community or country?

Make notes in your learning journal.

In this unit, malnutrition is defined as any condition in which a person suffers from ill health or less than optimal wellbeing because of a poor diet. The term includes:

- under-nourishment
- over-nourishment
- conditions related to inadequate intake or balance of essential nutrients.

Malnutrition can also result from improper absorption or utilisation of nutrients due to infections or other causes. Poor growth in children due to nutrient deficiencies is also a form of malnutrition.

Malnourishment can be found in both developed and developing countries. Nutritionists have estimated that 10 million American children suffer malnutrition in such forms as anaemia, obesity, or under-nutrition. The World Health Organisation (WHO) estimates that at least 600 million people suffer from under-nutrition in the developing nations.

The most common manifestation of under-nutrition in children is protein-energy malnutrition, which includes nutritional *marasmus*, resulting from insufficient food and calories, and *kwashiorkor*, due primarily to a deficit protein intake. Other prevalent forms of malnutrition are iodine deficiency leading to goitre and cretinism, and vitamin A deficiency which is a leading cause of childhood blindness.

The World Health Organisation (WHO) mandate

The importance of malnutrition has been recognised at a very high level in the United Nations system. Because of the fundamental role of nutrition to good health, and the worldwide magnitude of malnutrition, the WHO's mandate has always included the promotion of nutrition. The importance of nutrition in the attainment of good health has been stated and re-stated, as shown below:

- Article 2 of the *WHO Constitution* (1948), specifically includes the improvement of nutrition as part of the WHO's functions.
- The *Primary Health Care Declaration of Alma Ata* (1978) includes promotion of food and nutrition as one of the eight essential elements.
- *Health for All* (1981) had nutrition as one of its cornerstones, with three of its twelve monitoring indicators nutrition-related.
- *The World Summit for Children* (1990) identified eight nutrition goals for the year 2000.
- *The World Declaration and Plan of Action for Nutrition* (1992) with its nine goals and nine action areas, was endorsed in its entirety by the World Health Assembly.
- The *48th World Health Assembly* (May 1995) identified nutrition as one of the WHO's priority areas.
- *Health for All in the Twenty-First Century* (1998) includes malnutrition (stunting), iodine deficiency and vitamin A deficiency among its specific targets for the year 2000.

It should be clear to you that these are serious efforts, at international level, to address the problem of malnutrition and to promote good nutrition. We will now discuss the importance of nutrition in one's life.

The importance of good nutrition was recognised as far back as 400 BCE when Hippocrates said, 'Let food be your medicine and medicine be your food.' This simply means that having a proper diet is a cornerstone of health.

Proper food and good nutrition are essential for survival, physical and mental growth and development, and good health across the entire life-span – from the earliest stages of foetal development, at birth, through infancy, childhood, adolescence, pregnancy and lactation, throughout adulthood and into the elderly and old stages.

In fact, UNICEF views nutrition as a basic human right, articulated in numerous human rights instruments, from the Convention on the Rights of the Child to the Universal Declaration of Human Rights.

Key questions

In order for you to address issues of nutrition with respect to young people and therefore make a significant contribution to the promotion of good nutrition, you need to ask some key questions:

- How healthy are the respective diets of different groups of young people?
- What cultural factors promote healthy or unhealthy diets?
- What changes are taking place in the traditional diets of your country and how will these changes affect young people's health?

As a youth development worker, your response to these questions may take the form of specific actions, including:

- Information gathering on the actual eating habits of young people and the probable impact on their health.
- Investigation into what motivates young people to eat particular foods and not to eat others.
- Producing materials that challenge stereotypes about how young people (particularly young women) should look.
- Developing and launching a youth-centred campaign to promote a diet that is healthy.

(CYP, 1995)

Now that we have looked at some key questions and identified some of the specific actions we need to take to promote good nutrition, we will discuss, in greater detail, some priority areas for action.

Six priority areas for action

The WHO has a commitment to the goals and action-oriented strategies of the *World Declaration and Plan of Action for Nutrition* (1992), which were reinforced at the *World Food Summit* (1996). Accordingly, WHO identified six priority nutrition areas for action:

- 1 **Protein-energy malnutrition:** its assessment, monitoring, management, prevention and reduction.
- 2 **Micronutrient malnutrition:** assessment, monitoring, prevention, reduction and elimination of:
 - iodine deficiency disorders
 - vitamin A deficiency
 - iron deficiency and anaemia
 - other specific and trace element deficiencies.
- 3 **Obesity and other diet-related non-communicable diseases:** their epidemiology, prevention, management and control.
- 4 **Developing and implementing national policies and plans of action for nutrition:** including monitoring and implementing national nutrition plans, household food security, caring for the nutritionally vulnerable.
- 5 **Promoting and protecting infant and young child feeding:** including the Baby-friendly Hospital Initiative, implementing the International Code, and complementary feeding.
- 6 **Managing nutrition in emergencies:** including preparedness and nutritional assessment, management, monitoring and evaluation in emergencies.



Activity 3.2

(about 10 minutes)

Reflect on the following questions

- Why is nutrition considered to be a human right?
- What are the effects of poor nutrition?
- What actions do you need to take to promote good nutrition in your community?

Make notes in your learning journal.

World food supply

In the introduction to this unit, we mentioned that the global market pressures have had an effect on food production and supply. In the next section we will explore the issue of world food supply because of its relevance to nutrition.

Food production

The total supply of food is mainly a function of land area (primarily cropland) and yield per unit. Increasing the food-producing area is possible in many situations, but the economic feasibility and environmental sustainability of such a procedure is often questionable.

Among developing countries, increases in food production may be largely cancelled out by an increase in population. The number of people that have to be supported directly and indirectly by land in poor countries can run as high as 10–15 people per hectare. However, it is not just the rapidly growing world population that has led to the extent of hunger and malnutrition that we are witnessing today. Other factors, such as methods of food production, food distribution, food availability, and food loss or wastage also contribute. Food availability is also influenced by the percentage of cereals and legumes produced that is fed to animals (for meat production) rather than being eaten directly by people. To illustrate points raised in this section we present a quotation from one of the writers on the subject:

Nearly 800 million people in the developing world (20 percent of the total population) are chronically undernourished. At least 2 billion suffer from vitamin and mineral deficiencies. Yet since the mid-1970s, the world has produced enough food to provide everyone with a minimally adequate diet.

The poorest and most food-insecure people are disproportionately in Africa. The largest number of chronically

undernourished people lives in the Asia-Pacific region, although the number dropped from 762 million in 1970 to 540 million in 1990 (from 40 to 20 percent of the population). However, hunger remains especially severe in South Asia (Figure 2). In Sub-Saharan Africa, the number of hungry people rose from 94 million in 1970 to 175 million in 1990. Growing poverty, debt, economic decline, poor terms of trade, rapid population growth, unfavourable weather, war, and governmental collapse have all contributed to the continent's food problems. hunger in wealthy nations is neither as severe nor as widespread as in developing countries.

(Cohen and Reeves, 1995)

Dealing with the problem

Having highlighted the problems associated with world food supply, we will now look at how the problem can be addressed in a variety of ways, related to food production, especially, distribution, birth control and other strategies.

As you have read in the introduction of this unit, the major challenge is to balance food supply and demand, on the one hand and to improve equity and reduce poverty, and on the other, to ensure adequate quantities of food for all people. You will probably agree that the most important starting point in addressing the challenge is to improve food production.

Improving food production

Even when there is plenty of land, primitive techniques and the use of inefficient and/or simple human labour mean that production levels of basic food will tend to be mainly for family consumption, leaving those without family land having to buy basic food at market prices from large producers. There is then no incentive to innovate and raise small farm production levels unless there is an economic incentive to do so.

Such an incentive might come from, say, an increase in the supply and storage of water, facilitating the development of market garden food production which, if not sold by large producers, could be sold at profitable rates in local markets, increasing the supply of vegetables and complex carbohydrates. Such a scheme has been developed by USAid in Pakistani Kashmir's Suketer Water Management Scheme in the Mirpur region. The method is to construct small dams on farms in the lower areas of the Himalayan ranges, to collect the considerable runoff during monsoons. The dams hold water for year round food production and are also able to be stocked with fish, supplying valuable protein to farm families and to the market, raising the overall supplies of protein to the local communities which have been shown to suffer from protein deficiency. A number of young, university educated men and women are employed in or work voluntarily in this scheme.

Another method of increasing the supply of protein in the Mirpur region has been government sponsorship of research and development into private production and deep-litter management of chickens both for egg production and, of course, mature birds for sale. This stemmed from the initiative of a young trained specialist working for the government.

Solving distribution problems

More than enough food is now produced worldwide to provide sufficient calories for all humans, but distribution is both inadequate and inequitable. Cash crops, such as fine beans or cut flowers can be harvested and flown from Naivasha in Kenya to London and Paris within hours. If this distribution problem can be solved, why can't basic foods be distributed to the malnourished?

It's obvious that the incomes of the buyers are as crucial as the existence of the appropriate infrastructure, but there's little doubt that a new road creates its own distribution network. Once the road exists, then small producers immediately look for ways they can use it to distribute their goods to market. Anthropological research has shown that Malawi had a thriving market economy before the coming of the colonialists who disrupted it for their own purposes, and, when new roads were built in the Shire Valley for multinational companies, villagers quickly took the opportunity to carry their huge sacks of grains and vegetables to Blantyre, often as many as twenty or more people in the back of one of the huge number of privately owned pickup vans meant for five or six.

One of the ways in which educated youth workers have helped these people is in the dissemination of simple scientific knowledge and techniques for eradicating the infestation of worms in the intestines of villagers, by teaching the use of latrines so that intestinal worms are not left in places where cattle feed. This releases the men from the expense of drugs and recurrent sickness so that they can do sustained work in food production, and their wives so that there is no disruption to selling their produce in the market at Blantyre.

Improved food production alone is not sufficient. High population growth rates can disturb the balance between food supply and demand in any country. This has been the case in many developing countries. You will read about other necessary measures in the sections that follow.

Controlling the birth rate

The concept of birth control is usually misunderstood. We normally think that this must mean reducing the birth rate in developing countries, but at the private level not necessarily, since in many countries the only surety for welfare in old age is from the children you have brought up and who are bound to you in some way. Moreover, you may require a lot of cheap and reliable labour to work on your farm or manage your distribution outlet. Nevertheless, if

your farm or business is inherited through partible succession, a large family eventually causes inheritance problems, and a rapidly growing population causes national problems.

It is therefore important to take steps to enable families to control their birth rates, particularly in the developing countries. This must be managed through education and public awareness programmes that target both men and women and must make accessible up-to-date information on birth control methods. This is not an easy task and involves complex social, ethical, health, economic and political considerations.

Using food energy efficiently

It is far more energy efficient for humans to consume plants than to consume herbivores (e.g. by eating beef). Although many of the world's people emphasise plants and plant products in their diets, dietary preferences in the developed countries have resulted in high per capita consumption of animal products. Much of this food is derived from extensive grain feeding of the animals.

If more people relied less on animal protein, the substantial reduction of grain feeding and use of cattle feed made from fish meal could significantly increase the efficiency of food energy conversion and the carrying capacity of croplands. Humans do have protein requirements but the protein requirements of people can be met partly by the protein in bread, eggs and so on, and particularly by the high protein content of many pulses.

Protecting the environment

A primary requirement for increasing the food yield of plants and animals is to inform humans about how easily the environment can be degraded, often in invisible ways, and about how best to protect that environment. The motive of exploitation of the environment, even for the production of basic food, must give way to recognition of the limits of the earth's carrying capacity, and to embrace those practices that will maintain or enhance this capacity.

Efficient cropland use necessitates soil conservation and soil building, using forage crops in rotation with grains. These pasture and cropland forages, together with waste products from grains and other sources, can be used to feed animals. The resulting meat, eggs, and milk products can provide food that is high in essential amino acids and specific vitamins commonly low or lacking in plant food.

The greatest increases in food production efficiency have resulted from scientific and technological advances, primarily in the areas of nutritional quality, plant and animal genetics, disease and pest control, and alteration of the environment.

However, many of the advances in food production must be evaluated against the environmental damage created by monoculture farming techniques, and the use of pesticides, herbicides and chemical

fertilisers. (There is more about ways we can protect our environment in Module 13.)



Activity 3.2

(about 15 minutes)

- 1 What is the food situation in your community?
- 2 What, if any, sorts of food are plentiful?
- 3 Where does the food come from?
- 4 Do people produce any of their own food?
- 5 Is some of it imported?
- 6 Do any of the local farmers or small holders grow cash crops?
- 7 When did this start and why?
- 8 Can your community get a balanced diet of fresh fruit and vegetables, pulses, cereals and animal products?
- 9 If not, what is missing?

Now try also to write responses to the three questions from the WHO mandate section above:

- How healthy are the respective diets of different groups of young people?
- What cultural factors promote healthy or unhealthy diets?
- What changes are taking place in the traditional diets of your country and how will these changes affect young people's health?

Write your findings in your learning journal and discuss them with others. You might decide to use some of this information for your project and assignment, so ensure that you keep it.

In the first part of this unit we have looked at nutrition in terms of supply of, and demand for, food. We will now examine nutrition in terms of its scientific nature.

Human nutrition

Nutrition is a science that deals with nutrients and other food substances, and with how the body assimilates them. The extremely complex processes that nutrients undergo in the body – how they affect one another, how they are broken down and released as energy, and how they are transported and used to rebuild countless

specialised tissues and to sustain the overall health of the individual – are understood only approximately.

Nevertheless, important nutrition decisions need to be made for the health of individuals, and of particular groups with special needs, such as the very young, pregnant women and the very old. Also, there are special problems for large groups suffering from malnutrition.



Activity 3.4

(about 5 minutes)

In your learning journal write or draw what comes into your mind when you use or hear the word ‘nutrition’. It could be a statement, something you read somewhere, a series of words, and part of an advertisement - whatever comes to mind.

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We will now examine nutrition in the context of what scientists recommend as requirements for good nutrition. Scientists have established recommended daily allowances for essential human nutrients. These are given for an average individual, with variations identified for differences in age, gender, activity, body structure, and geographical location. Before you read further, please work through Activity 3.5, which opens our discussion of the function of human nutrients.



Activity 3.5

(about 10 minutes, not counting the research)

Find out what your local health service, or a local doctor or nurse recommends as the essential daily allowances of nutrients for good health, especially for adolescents and young adults. Look for pamphlets or other information that you might want to use in a health promotion campaign or project.

Write your findings in your learning journal and discuss them with others (your tutorial group if you have one, friends, family and peers).

In the next section, we discuss the function and effects of nutrients in our bodies.

Nutrients and their effects

The composition of food is made up of various nutrients. Nutrients are the essential food factors required for health and growth. They are the substances in food which supply energy and nourish the body.

You will remember from an earlier section that recommended daily nutrients vary. This is largely because many things affect our nutrient requirements. They include:

- age and stage of development
- gender
- activity levels
- lifestyle
- general health.

We have been talking about nutrients in general terms. We now need to identify the nutrients that are important for our health.

Essential nutrients

There are six essential or 'key' nutrients for health, growth and development. They are:

- proteins
- carbohydrates
- fats
- minerals
- vitamins
- water.

Carbohydrates

There are two groups of carbohydrates: available (can be broken down and used in the body) and unavailable (cannot be broken down by human digestive enzymes). The available carbohydrates include starches (complex carbohydrates) and sugars (simple carbohydrates).

Simple carbohydrates require no digestion and are readily absorbed from the intestinal wall directly into the bloodstream. They are also referred to as monosaccharides, or 'simple sugars'.

Complex carbohydrates are composed of many carbohydrate units (or single sugar units) and are also called polysaccharides. They must be reduced to simple carbohydrates (monosaccharide) before they can be absorbed into the bloodstream.

The unavailable or indigestible carbohydrate is dietary 'fibre' such as cellulose, an essential non-nutrient whose function is to pass virtually unchanged through the whole of the digestive and waste systems, clearing out potentially toxic debris.

Vitamins

Vitamins can be divided into two groups according to their solubility. This means that they tend either to dissolve in water (water-soluble vitamins) or in fat (fat-soluble vitamins):

Water-soluble vitamins (C, B complex) are found in watery parts of cells and foods. They are more readily lost in cooking water or destroyed by heat than fat-soluble vitamins.

Fat-soluble vitamins (A, D, E and K) are found in fatty parts of cells and foods. They are more stable than water-soluble vitamins and are not as easily lost in cooking or in storage of food.

It is very important for you to know that all nutrients have specific functions, are found in different healthy foods and can have an effect if one takes too much or too little of them. For example, protein promotes growth, maintenance, repair of body tissues. However, too much protein adds to body fat, while too little can cause irritability and lower resistance to infections. In Reading 5 you will be able to see:

- some functions of some of these nutrients
- examples of their healthy food sources
- some of the effects that can result from having too much or not enough of these nutrients in your diet.



Now turn to Reading 5: 'Table of Nutrients' by the module authors. After you have read the table, work through Self-help question 3.1.



Self-help question 3.1

(about 5 minutes)

Choose the best answer to each of the following five statements:

- 1 Vitamins that regulate energy and metabolism are:
 - (a) magnesium folacin, and iodine
 - (b) thiamine, niacin, and riboflavin
 - (c) calcium, phosphorus and iron
 - (d) iron, pyridoxine and calcium.
2. The best sources of vitamin A are:
 - (a) peas, bananas apples
 - (b) cherries, turnips, chicken
 - (c) beans, liver, broccoli
 - (d) rice, beans, corn
3. Milk and dairy foods are good sources of:
 - (a) calcium, riboflavin, protein
 - (b) vitamin C, iron, thiamine
 - (c) niacin, magnesium folacin
 - (d) pyridoxine, copper, zinc
4. Bread and cereals are good sources of:
 - (a) thiamine, phosphorus
 - (b) complex carbohydrates, thiamine, niacin, pyridoxine
 - (c) protein, vitamin B12
 - (d) fats, vitamin C, vitamin K, calcium
- 5 Foods that contribute to growth and bone strength are:
 - (a) bananas, tomatoes, prunes
 - (b) almonds, bread, oranges
 - (c) butter, peanuts, strawberries
 - (d) milk, fish, eggs

Check the nutrient table to help you with your answers.

Compare your answers with those provided at the end of the unit.



Activity 3.6

(about 10 minutes)

Having read Reading 6, indicate the main functions of nutrients by completing the following table.

| Nutrients | Main function |
|---------------|---------------|
| Proteins | |
| Minerals | |
| Vitamins | |
| Carbohydrates | |
| Fats | |

So far we have discussed the functions of nutrients, the effects of their deficiencies, the effect of oversupply and their food sources.

Many people do not find it easy to know when they are having a balanced diet because there are many food sources of nutrients. To make it easier for you, the next section sets out how food sources are categorised.

The five food groups

There are various ways of determining that a diet has a variety of nutritionally sound foods that meet the recommended nutrient requirements. One such method that is commonly used divides food into five main groups from which to draw our daily nutritional needs.

The five groups are:

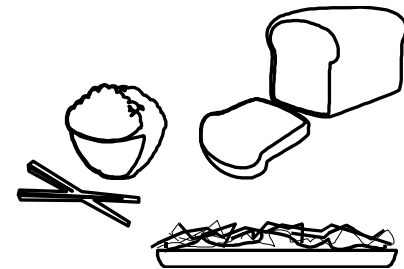
- **Fruit and vegetables**



- **Meat, fish, poultry, eggs, pulses and nuts**



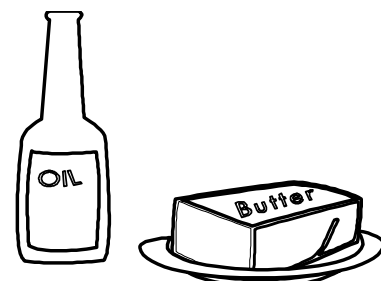
- **Cereals, bread, pasta and rice**



- **Milk and milk products**



- **Fats and oils**



A healthy diet is one that contains foods from each group in varying amounts. The amounts required by an individual will mainly be dependent on their age and stage of development, gender, activity levels and state of health. Before you read the next section, which

gives tips on how to maintain a balanced diet, ask yourself about how many times in a week you eat foods from each of the five groups.

Dietary guidelines

It is important to note that while general guidelines can be provided on what constitutes a healthy diet, individual requirements will be determined by various factors (such as disabilities and allergies, among others).

- 1 **Eat plenty of breads, cereals, vegetables (including legumes) and fruits.** Vegetables and fruit are much more nutritious when they have just been harvested. The longer the time between when they were picked and when eaten, the more nutrient loss there will be. It is best to buy whatever is in season. Not only is it likely to be at its peak nutritionally but it will also taste better and cost less.

Vegetables and fruit are generally much more nutritious when eaten raw. Heat reduces some of the nutrient content. Cooking in a lot of water can also cause nutrients to be leached out of the fruit or vegetables. Steaming food is better.



Self-help question 3.2

(about 5 minutes)

Name one nutrient that is likely to be destroyed by heat.

Give two examples of food sources of this nutrient that are likely to be cooked.

How would you prevent or cut down the nutrient loss?

Compare your answers with those provided at the end of the unit.

- 2 **Eat foods that are low in fat and in particular, low in saturated fat.** Fats should normally constitute no more than 30 per cent of dietary calories. Some fat is essential for good health because it provides energy and is a structural component of cells; it is an important source of energy for young children. From about five years of age onward, too much fat, particularly saturated fat, can lead to health problems.

Fats

Before we proceed we should explain what we mean by saturated fat and why it is of particular concern to health. First, you need to know that there are three types of dietary fats. These are:

- saturated fats - found mainly in meat and dairy products
- monounsaturated fats - found in olive oil and avocados
- polyunsaturated fats - found in fish and vegetable oils.

Saturated fats tend to increase the amounts of bad cholesterol (low-density lipoprotein) in our blood, and this is associated with coronary artery disease. The body makes enough cholesterol for its own needs and taking saturated fats is unnecessary. Monounsaturated and polyunsaturated fats have the opposite effect to saturated fats.

Saturated fats are the solid fats such as:

- butter, cream and cheese
- the fat of meat
- dripping from meat
- coconut oils.

Unsaturated fats can be converted to solid fats in manufacturing by a process known as hydrogenation. An example of this is the conversion of liquid vegetable oils into solid margarines and other cooking fats. As of February 2006, this is now considered to be a dangerous way of refining foods, producing 'transfats', which may raise cholesterol levels and form plaque on the walls of arteries, reducing blood flow and leading to strokes and heart attacks.

While it is the saturated fats that put health most at risk, a high fat intake of either saturated or unsaturated fats can affect health negatively, for example through gains in body fat and weight, particularly in older children, adolescents and adults.



Activity 3.5

(about 10 minutes, not counting the research)

Find out what your local health service, or a local doctor or nurse recommends as the essential daily allowances of nutrients for good health, especially for adolescents and young adults. Look for pamphlets or other information that you might want to use in a health promotion campaign or project.

Write your findings in your learning journal and discuss them with others (your tutorial group if you have one, friends, family and peers).



Self-help question 3.3

(about 5 minutes)

- 1 Some fats in foods are very obvious, like the fat on meat or chicken. What other examples of fat in food can you think of?
- 2 The fat content is not so obvious in some foods like cakes, sweet or savoury pastries and so on. You can think of it as 'invisible' fat. Can you give some other examples of foods with invisible fats?

Compare your answers with those provided at the end of the unit.

- 3 **Avoid sugar and only eat moderate amounts of foods that contain natural sugars.** Natural sugars from vegetables and fruit are fine in moderate quantities and take time to be absorbed so that the body's insulin production response is slower and more controlled. Sugars such as granulated sugar have been refined and they are immediately absorbed from the gut and therefore produce a dramatic insulin response, which can set up a reaction that can be dangerous over the long term. They do not contribute any major nutrients and therefore should be limited in our diet, particularly the diet of children. It is better to satisfy a sweet tooth with a piece of fruit because it contains other valuable nutrients.

One of the disadvantages in eating a lot of sugary foods is that these foods are often replacing more nutritious foods in the diet. You should be aware of the fact that the quality and quantity of our daily food consumption are important factors that can contribute to obesity, dental decay and behavioural problems.

Sugar comes hidden in many foods. It can be found in most convenience foods, even many savoury foods like tomato sauce. Sugar can be identified by a variety of terms on the list of ingredients on food labels:

- sucrose
- fructose
- dextrose
- glucose
- corn syrup
- raw sugar
- brown sugar
- honey.

Did you realise that these are all sugars?

- 4 **Choose low salt foods, avoid adding salt and check for salt in processed foods.** An adult only needs about 200mg of sodium (salt) a day. That is equivalent to just one tenth of a teaspoon of salt.

Many people, especially in developed countries, consume 20 times more salt than the body requires each day. This can lead to health problems such as high blood pressure, increased risk of heart disease, stroke and kidney failure.

- 5 **Eat foods containing calcium.** Calcium is important for everyone for strong bones and healthy teeth. It is especially important that growing children and pregnant women get adequate amounts.



Activity 3.7

(about 10 minutes)

Re-read from the nutrient table in Reading 5 the function of calcium and its healthiest food sources.

What are four food sources of calcium?

Write your answers in your learning journal.

- 6 **Eat foods containing iron.** Most babies are born with a store of iron. Breast milk and cow's milk contain little iron. Thus by the time an infant is about four months old its iron store is usually running low. This is one of the reasons why the first food that is introduced to infants tends to be iron-enriched cereal.

Iron must be absorbed to be useable. One of the nutrients required for efficient iron absorption is vitamin C. Good sources of iron tend to be foods of animal origins such as liver and other organ meats and red meats. Although iron can come from plant sources such as wholegrain cereals, dried beans, some fruit and dark green leafy vegetables it is not as rich a supply. Absorption can be increased by eating a small amount of meat and taking a vitamin C source of food with the meal.



Activity 3.8

(about 5 minutes)

Turn back to the nutrition table in Reading 5 and find the list of vitamin C sources, which help the iron to be absorbed. Write them in your learning journal.

You should now have a good idea of how to maintain a balanced diet. However, you may want to know how to avoid eating too much or too little of given foods. We can check this by using the 'healthy diet pyramid'.

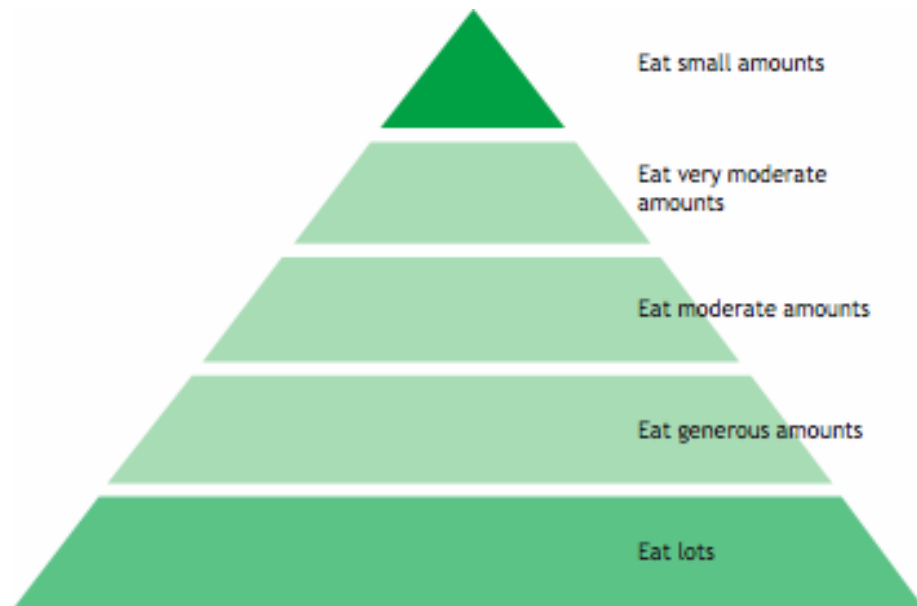
The healthy diet pyramid

The healthy diet pyramid gives us an easy way of focusing on which foods we should eat more of and which we should resist. It is an easy-to-remember guide and is useful to use in education programmes. You might like to use it if you decide to do a small promotional programme on nutrition for your project.



Self-help question 3.4

(about 10 minutes)



Try to work out in which section of the pyramid for a healthy diet you would place the following foods: milk, salt, bread, fish, fruit, vegetable oil, butter, yoghurt, cereals, eggs, water, sugar, cheese, legumes, pasta, lean meat, rice, vegetables.

Compare your answers with those provided at the end of the unit.

We have shown that one of the main sources of nutrients is meat. However, there are many people who, for various reasons, do not eat meat and rely on a vegetarian diet. The next section looks at the types of vegetarian diets.

Vegetarian diets

There are several different categories of vegetarians. They include:

- semi-vegetarians, who eat fish, poultry, milk and milk products, eggs, vegetables, fruit, breads, cereals and nuts, but do not eat meat
- lacto-ovo vegetarians, who eat milk and milk products, eggs, vegetables, fruits, breads, cereals and nuts, but do not eat meat, fish or poultry

- ovo-vegetarians, who eat eggs, vegetables, fruit, breads, cereals and nuts, but do not eat meat, fish, poultry, milk or milk products
- lacto-vegetarians, who eat milk, milk products, vegetables, fruits, breads, cereals and nuts, but who do not eat meat, fish, poultry or eggs
- vegans, who eat vegetables, fruits, breads, cereals and nuts, but do not eat meat, fish, poultry, milk, milk products or eggs.

There is no doubt that one can live a healthy life on a vegetarian diet. However, as you may know, vegetarian diets commonly lack some of the essential nutrients.

If you check the nutrient table and the types of foods missing from any vegetarian diet (because they all lack meat), you will notice that the main nutrients that could be lacking are:

- protein
- calcium
- iron.

Proteins are made up of smaller units known as amino acids. There are 22 amino acids, of which eight are known as essential amino acids. The eight essential amino acids cannot be made by the cells (as the other 14 can) and thus must be supplied by food in the diet.

Foods containing generous amounts of the eight essential amino acids are known as 'complete' or 'high-quality' proteins. These complete proteins are mainly from animal food sources.

Most plant proteins are incomplete proteins, but with attention to the combination of vegetable proteins they eat, it becomes easy for vegetarians to ensure that essential nutrients are obtained. It is important for vegetarians to eat an adequate mixture of vegetable protein each day, for example vegetables with rice, pulses such as lentils with cheese or milk and so on. Pulses, which are the seeds of legumes, are good sources of protein but do not contain ideal amounts of all the amino acids necessary for growth and tissue strength, so should be eaten with plant foods and whole grains such as rice or bread. However, soya beans are classed as a source of high-quality protein.

The main foods rich in calcium and iron also tend to be from animal origins. It is important if a person has a vegetarian diet to ensure that these mineral requirements are supplied in the food they eat, such as milk, milk products, sesame products, peanut butter and cereals. Iron is obtained from wholegrain breads, cereals and pulses (dried peas, beans, lentils). Iron from these foods is best absorbed if a food or drink containing vitamin C is consumed at the same meal. Calcium is available from nuts such as almonds, dark green leafy vegetables, sesame or sunflower seeds.

People who follow strict vegan diets (without milk) also risk insufficient vitamin D intake, but careful selection of foods can

ensure an adequate supply. Vegan diets can also lead to a deficiency of vitamin B12, which causes *megaloblastic anaemia*, though the vitamin can be synthesised from yeast extracts.



Activity 3.9

(about 10 minutes)

In your learning journal, list everything you eat and drink over a three-day period, including a weekend, if possible.

- 1 Think about your food and drink intake in relation to the dietary guidelines and healthy diet pyramid. What do you think are your good and bad eating habits?
- 2 Suggest changes that could be made to your own diet to improve its nutritional value.



Activity 3.10

(Two one-hour sessions, plus time for research, planning and preparation)

This activity is part of your preparation for the module assignment.

Train (or enlist the help of a health practitioner to train) your group of young people to work with other young people (senior high school students, unemployed youth, participants in youth programmes etc.) to raise their awareness of nutrition. Draw on local expertise where you can.

The following suggestions for session titles might help you to get started.

Session 1: A healthy diet

You will be able to use much of the information from this unit for the first session, but remember, your local dietary preferences will be of most interest, so try to draw on local examples to illustrate what you are talking about.

Encourage the group to explore local deficiencies in food supplies for discussion in the second session. Ask them to think about possible solutions.

Session 2: Growing your own food

In this session, introduce the group to simple gardening techniques. You might need to ask for help or gather information from someone with expertise in this area. Talk to local health services to find out who might be able to help you.

You might even find some local elders who have the skills and knowledge you are looking for, who would be willing to help demonstrate setting up a small vegetable garden.

Note: You can extend this activity into your small-scale project if you choose to.

If you choose to focus on nutrition for your project, remember to:

- enlist the help of young people
- list the desired outcomes of the project
- identify what resources you will need and where you might find them
- identify any skills that your group need to develop to take the lead in this project
- discuss what help you will need and form alliances with other agencies or practitioners (at least one from the health field) who are willing to help with expertise or resources
- plan for fund-raising, promotion, etc.

Re-read the details of your assignment before you continue.

Unit summary

In this unit, you have explored various aspects of one of the most important subjects in human life – nutrition. You have covered the following main points:

- the concept of malnutrition
- the mandate of the World Health organisation in promoting good health and priority areas for action
- issues related to world food supply, including food production and distribution and environmental issues
- human nutrition, including information about nutrients and guidelines for a balanced diet
- how to apply what you have learned to raise young people's awareness of nutrition

To check how you have got on, look back at the learning outcomes for this unit and see if you can now do them. When you have done this, look through your learning journal to remind yourself of what you have learned and the ideas you have generated.

You are now ready to advance to Unit 4, which discusses key issues related to youth sexual and reproductive health.

Answers to self-help questions

Self-help question 3.1

- 1 (b)
- 2 (c)
- 3 (a)
- 4 (b)
- 5 (d)

Self-help question 3.2

Heat destroys water-soluble vitamins (C, B complex). These are found in fruit and more likely to be cooked in vegetables, cereals, eggs, meat, and fish. To preserve the value of these vitamins, eat raw fruit, vegetables and cereals where possible. (NB Some cereals have to be cooked or soaked before eating.) Steam them if necessary, rather than boiling. Try to avoid prolonged cooking of eggs, meat and particularly fish – cook them just enough to destroy bacteria and to tenderise the meat.

Self-help question 3.3

- 1 Fat is present in nuts, eggs, milk and milk products (cream, butter, yoghurt, cheese), margarine, cooking oils.
- 2 Custard (made with full cream milk), quiches, pastries, puddings, creamy sauces, cheese dishes, sausages, meat or fish patties. Many foods have 'invisible' fat in them.

Self-help question 3.4

The healthy diet pyramid:

- 1 Eat small amounts of salt, sugar, butter.
- 2 Eat very moderate amounts of vegetable oil, cheese, milk, yoghurt.
- 3 Eat moderate amounts of lean meat, fish, and eggs.
- 4 Eat generous amounts of fruit, vegetables, legumes.
- 5 Eat lots of bread, pasta, rice, cereals and water.

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Unit 4: Sexual and reproductive health

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Unit introduction

Welcome to Unit 4 *Sexual and reproductive health*. In this unit we look at the concept of responsible sexual behaviour in the context of the World Health Organisation's (WHO) definition of sexual health and explain the various components of reproductive health. The unit will help you to understand the risks of unprotected sex (unintended pregnancy, abortion, and STDs including HIV/AIDS). We will also give you directions on how young people can avoid such risks.

We will then describe the main contraceptive methods and explain why education about contraceptives is important. Each of the methods is discussed in detail, explaining what it is, how it works, its advantages and benefits, the characteristics of users, how to use it, possible side-effects and follow-up health care. In addition, we discuss issues of reproductive rights and abortion, giving reasons why young people terminate pregnancies and describing the main types of abortions, and their prevention and management. We will end by looking at some harmful traditional practices such as female genital mutilation (FGM).

Unit learning outcomes

When you have worked through this unit, you should be able to :

- identify the key aspects of sexuality
- explain what sexuality is and how it affects behaviour
- define the various components of reproductive health
- explain how to prevent an unwanted pregnancy and how to use the various contraceptives available
- explain the social and health consequences of early pregnancy
- describe the dangers of procuring an illegal or unsafe abortion, and learn how to ensure safe abortion
- explain why FGM (female genital mutilation), wife inheritance and early marriage continue to be practiced in some communities
- explain the social and health effects of harmful traditional practices, especially on girls.

Defining sexuality



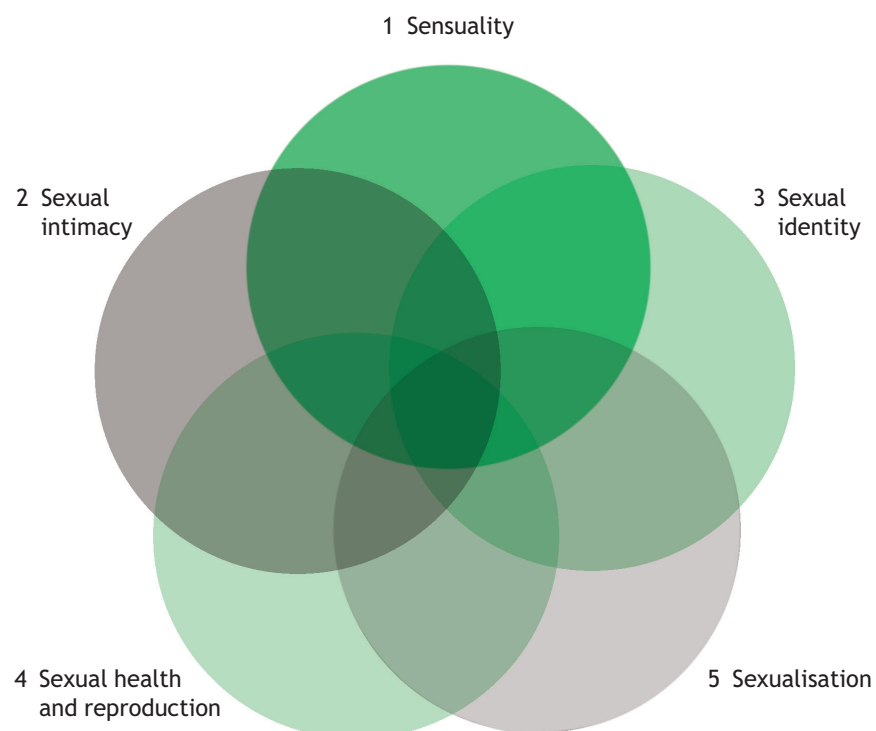
Activity 4.1

(about 5 minutes)

Before you read any further, take your learning journal and write down what you understand by the word 'sexuality'.

As you work through this unit you will see that sexuality is much more than sexual feelings or sexual intercourse. It is an important part of how a person defines who they are and what they will become. It includes all the feelings, thoughts and behaviours of being female or male, including work, social status, being attractive and being in love, as well as being in relationships that include sexual intimacy and physical sexual activity. Sexuality begins when a person is born and ends when they die. On the other hand, the term 'sex' is used to refer to one's reproductive system and one's gender behaviour as male or female. It has to do with biology, anatomy, physiology and the reproduction of children. It is a crucial element in everyone's sexuality.

Circles of sexuality



As the diagram shows, there are five key components of sexuality, which are interlinked. These are:

- 1 **Sensuality:** Awareness, acceptance of and comfort with one's own body, physiological and psychological enjoyment of one's own body and the bodies of others.
- 2 **Sexual intimacy:** The ability and need to experience emotional closeness to another human being and have it returned.
- 3 **Sexual identity:** The development of a sense of whom one is sexually, including a sense of maleness and femaleness.
- 4 **Sexual health and reproduction:** Attitudes and behaviour related to producing children, care and maintenance of the sex and reproductive organs, and health consequences of sexual behaviour.
- 5 **Sexualisation:** The use of sexuality to influence, control or manipulate others.

Let's look in detail at what the circles of sexuality mean. Everything related to human sexuality fits into one of these circles.

Circle 1: Sensuality is an internal mental awareness and feeling about your own body and other people's bodies, especially the body of a sexual partner. Sensuality enables us to feel good or bad about how our bodies look and feel, and what they can do. Sensuality also allows us to enjoy the pleasure our bodies can give us and others. This part of our sexuality affects our behaviour in several ways:

- It helps us to feel physical attraction for another person, and helps us realise that the centre of sexual attraction is not in the genitals, but in the brain.
- It satisfies our need for physical closeness – to be touched and held by others in loving and caring ways.
- It helps us to experience pleasure and release from sexual tension.
- It helps us to have fantasies about sexual behaviours and experiences.
- It interacts with the image we have of our bodies: whether we feel sexually attractive to others and proud of our own bodies, or not.
- It emphasises the need to understand how our bodies function, anatomically and physiologically.

Circle 2: Sexual intimacy is the ability and need to be emotionally close to another human being and to have that closeness returned. Sharing intimacy is what makes personal relationships rich. While sensuality is about physical closeness, intimacy focuses on emotional closeness. Aspects of intimacy include liking or loving another person. To have true intimacy with others, a person must open up and share feelings and personal information. As sexual beings, we can have intimacy with or without engaging in sexual intercourse.

Circle 3: Sexual identity is a person's understanding of who she or he is sexually, including the sense of being male or female. Sexual identity can be thought of as three interlocking pieces, that together affect how each person sees themselves. These 'pieces' are:

- gender identity – the degree to which you feel that you are male or female and the degree of uncertainty
- gender role – knowing what it means to be male or female or what a man or woman can or cannot do because of their gender
- sexual orientation – this is a measure of whether a person's primary attraction is to people of the same gender (homosexuality), the opposite gender (heterosexuality) or both genders (bisexuality). In the vast majority of cases a person's primary attraction is predominantly to the opposite gender (heterosexuality). However, it is generally accepted in the developed world that homosexuality is a significant and widespread aspect of normal sexual variation. There are also several minor variations of sexual orientation that individuals, families and social groups may also find psychologically difficult to cope with because of social norms and values: an example might be that of the cross-dresser, or the person who desperately wants a sex change. Both of these are becoming accepted in many parts of the developed world as simply variations of sexual orientation.

Circle 4: Reproduction and sexual health are the capacity to produce children successfully, as well as the behaviours and attitudes that make sexual relationships healthy, physically and emotionally. Specific aspects of sexual behaviour that belong in this circle are:

- factual information about sexual reproduction
- feelings and attitudes towards fatherhood and motherhood
- understanding and developing skill in sexual intercourse
- information on the prevention and control of STDs
- responsible sexual practices and contraceptive information.

Circle 5: Sexualisation is using sex or sexuality to influence, manipulate or control other people, which is of course one of the most widely used of human abilities. Behaviours include flirting in a wide range of social situations, seduction, withholding sex from a partner to 'punish' the partner or to get something you want, offering money for sex and sex for money, selling products using sexual messages, sexual harassment, sexual abuse and rape.

We now examine another important concept – reproductive health, which is the main focus of this unit. You will have read or heard about the concept of reproductive health in your work. Compare the knowledge you already have with what is described in the next section.

Defining reproductive health

The World Health Organisation (WHO) defines reproductive health as a *'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'*, in all matters related to the reproductive system and its functions and processes. Reproductive health therefore entails people being able to have a satisfying and safe sexual life, and the capability of reproducing children, together with the freedom to decide if, when and how often to do so (UNFPA, 1995: 7).

This broad definition of reproductive health suggests that individuals or couples have the right to:

- regulate their fertility without risk to their health
- have safe pregnancies and births when they choose to have children
- have sex safely, without the fear of sexually transmitted disease (STDs).

Implicit in this last condition are:

- the right of all people young and old, particularly women, to be informed of any risk
- the right to have access to safe, effective, affordable and acceptable methods of family planning of one's choice
- the right to have access to other methods of one's choice for the restitution of fertility, providing these are not against the law
- the right of access to appropriate health-care services that will enable women to go safely through pregnancy and child birth and to fulfil for those involved the WHO definition of reproductive health.

Unfortunately, many developing countries lack policies and programmes, let alone funds, to address the specific reproductive health needs of young people. This is despite the fact that in most countries a large number of youths are sexually active. For example, today, most young people in the developing world are aware of the need to use contraceptives or other methods to prevent pregnancy, but few have access to family planning services, especially in rural areas and among poor communities. Where family planning services are available, they are generally tailored to meet the reproductive health needs of married adults.

The reproductive health needs of young people, who in most countries comprise the largest segment of the population, are not adequately addressed. Furthermore, young people are usually not involved in the planning, design and implementation of reproductive health programmes.

Young people have particular health problems no matter where they live, but the nature of and responses to these problems may differ from country to country because of social, economic and cultural factors. For example, teen pregnancy may not be perceived as a major problem in countries where early marriage is culturally accepted, while teen pregnancy may be classified as a major problem in countries where girls' further education and professional employment are emphasised.

Similarly, engaging in early and unprotected sex may occur for a variety of reasons. In some societies, youths may engage in early sex to experience and explore their bodies and/or exercise their freedom. However, for others, for example for girls from poor families or communities, early sex may be an economic survival strategy due to limited employment opportunities. According to one secondary school student in Kenya:

It is not so hard for a girl not to have sex while still at school, but the big temptations come after she leaves. If she cannot get a job, she is seen as a burden to her parents. She has no money, but wants to go out and buy nice things. When a man offers her money to buy those things if she will be his girlfriend it is hard to say no.

(From Commonwealth Secretariat, 2001)

Reproductive health covers a broad field and includes ethical and epistemological questions about reproductive rights, across the whole field. In this unit, we will cover four main areas that are relevant to the health of young people:

- contraception
- abortion
- sexually transmitted diseases
- HIV/AIDS.

Clearly, you are not expected to be medically expert in any of these areas, but it is essential that you have a basic general understanding of the main medical issues so you can be more effective in this aspect of your work.

Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproductive and sexually transmitted diseases.

(WHO, 1998)

The components of reproductive health care services include:

- safe motherhood, including antenatal, safe delivery and post-natal care especially breast feeding, infant and women's health
- family planning
- prevention and treatment of reproductive tract infections (RTI), including sexually transmitted diseases (STD), and HIV/AIDS
- prevention and treatment of infertility
- management of cancers of the reproductive system, including breast, testicular and prostatic cancers, prevention and management of cervical cancers
- responding to concerns about menopause
- discouragement of harmful traditional practices that affect the reproductive health of men and women, such as female genital mutilation
- information and counselling on human sexuality, responsible sexual behaviour, responsible parenthood, pre-conceptual care and sexual health.

The most important reproductive health issues for young people are issues regarding prevention of unwanted pregnancies, contraceptives, abortions, STDS and HIV/AIDS. We will look at these in some detail.

Contraception



Activity 4.2

(about 10 minutes)

Using your experience, reflect on what you have read in the preceding sections and write your responses to these questions in your learning journal.

- 1 What are the risks of unprotected sex?
- 2 Name as many methods of contraception as you can.
- 3 Which ones are most effective?
- 4 Which ones would young people be most likely to use and why?
- 5 How would you feel about getting these methods from a family planning clinic, health centre or hospital?
- 6 Where would you like to get access to these methods?
- 7 From whom would you want to learn how to use them properly?

Contraception is the practice of using traditional or modern methods of preventing and controlling pregnancies, whether by married people or single people. This requires that young single people or couples have adequate information about methods of contraception and access to appropriate resources. This will enable them to make considered choices about:

- prevention of pregnancy
- what methods suit them best
- the number of children they want to have
- how to space their children's births to maintain the family's quality of life.

According to a United Nations Economic Commission for Africa (UNECA) publication, over 50 per cent of youths from eleven of the Sub-Saharan African countries, which conducted the Demographic and Health Survey (DHSS), have experienced sex. In Kenya, the average age at which young people have their first sexual experience is 14 years for both boys and girls.

As we have already mentioned, young people need information about contraception. This should be given in an organised manner.

Education about and access to contraception has proved to be an effective approach to improving the existing living standards and quality of life for people of many nations. It is a significant aspect of empowering young people to live healthy lives.

About half a million women die every year from problems related to pregnancy or childbirth throughout the world. Most of these deaths occur in women in high-risk categories for pregnancy, for example:

- they are too young, too old, or too ill
- they already have too many children
- the births of their children are too close to each other.

Almost 90 per cent of these deaths occur in the developing world, including sub-Saharan Africa, South Asia and the Pacific.

Education about contraception and effective use of family planning methods can also help in the reduction of the population growth rate, and can enable governments to deal with national development problems.

Consequences of unprotected sex among young people

Rising fertility and unprotected sexual activity among young people have various socio-economic and medical consequences:

- Adolescents who become pregnant are likely to drop out of school, and many are not able to continue their school after delivering the baby. This reduces their opportunities for

employment and personal development and consequently their ability to contribute to national development.

- Lack of support to care for the child usually stresses the teen mother and her child and this may force her into premature marriage, which may end up in divorce and its associated social and economic problems.
- Youths who are not well informed or prepared for sexual activity are at risk of STDs, including HIV/AIDS. Although most STDs, apart from HIV/AIDS, are treatable, the stigma attached to STDs, lack of youth-friendly services, and economic constraints, restrict youths from benefiting from available STD/HIV/AIDS services. As a result, youths are likely to suffer from STD complications.
- The major causes of death among females in the 15–19 year age group are related to unsafe abortion, complications in pregnancy and delivery. Teenagers are more likely to die from problems related to pregnancy and delivery than adults. Some common complications teenage mothers experience include ectopic pregnancy (where the foetus develops outside the protection of the uterus), early or premature labour, vesico-vaginal fistula and recto-vaginal fistula (abnormal passages from the internal organ to the outside of the body), and secondary infertility. These problems, if not promptly and effectively treated, have a long-lasting emotional, physiological and physical impact.
- Children born of poor teenage mothers are more likely to die, and those who survive are more likely to suffer negligence.
- Early sexuality and fertility among adolescents and youths also has the potential to increase population, which has largely negative effects on the socio-economic development of many poor countries, especially in Africa. Unplanned children can create additional socio-economic burdens on parents, families, communities and the country as a whole, and help to undermine development efforts, thereby contributing to a poverty dominated cyclic pattern.

The above points are illustrated by the Zambian situation described in Case study 4.1. As you read through it, reflect on the situation in your own country.



Case study 4.1: The importance of family planning.

In most African countries the population is growing at a very fast rate of between 2.6 and 3.2 per cent per annum. In Zambia (2005 estimated) it is 2.12 per cent, lowered by a high death rate due to AIDS. At this rate the populations will double within 20 years, which means that African governments will have to more than double their infrastructures (i.e. schools, hospitals, housing, food production, new

jobs, etc.) in order to meet the basic needs of communities. Population growth has already outstripped existing resources and compromised the capacity of social facilities to deliver services, causing a serious decline in the quality of life for most Zambians, especially vulnerable groups, youths and females.

The direct pressures of population on African economies have manifested themselves in rising unemployment rates (especially for youths) and rapid urbanisation. If the economic growth and job creation rates are not consistently greater than the population growth rate, the unemployment rate for African countries will continue to rise, causing severe economic hardships for individuals, families and the country. In Zambia in 2003, the unemployment rate in Lusaka was 30 per cent, and in the industrial Copper Belt it was 25 per cent. The CIA in 2005 estimated the combined unemployment and underemployment rate in Zambia as 50 per cent.

The majority of Zambians are subsistence farmers, though there is a high relative level of urbanisation due to industrial development. Among Zambian women of reproductive age, there is a high level of literacy (at least 75 per cent estimated in 2003) and knowledge of modern contraception (approximately 90 per cent know about methods), but a low rate of usage (i.e. 16 per cent modern and 9 per cent traditional use of family planning methods). Only 15 per cent of women in Zambia use a modern method of family planning. Urban women are twice as likely to use contraception and five times more likely to use modern methods than rural women.

Children under 15 years of age and women of childbearing age (15–49) make up nearly 75 per cent of the population. An early study found that 31 per cent of girls aged 17 in Zambia were sexually active, and contraceptive use was lowest among women aged 15–19. By the age of 17, one third of Zambian girls had become pregnant (Zambia Demographic and Health Survey, 1992).

In addition to the problem of high fertility, Zambia suffers from a high prevalence of HIV/AIDS. 17 per cent of adults aged 15 to 49 are infected with AIDS (UNFPA, 2005), 34 per cent of urban clinic attendees are HIV positive. One in five births in Zambia occurs less than 24 months after the previous birth and about 40 per cent of mothers aged 15–19 had birth intervals of less than 24 months. UNFPA (2005) have found that 15–20 per cent of families say that they experience an unmet need for family planning in regard to spacing of children.



Activity 4.3

(about 15 minutes)

Reflect on Readings 7 and 8 and answer these questions:

Reflecting on the case study, list the main demographic features of your country/region.

How different are they from those in the Zambian case study?

Select three demographic features in your country and discuss what implications they have for development in your country.

Record your notes in your learning journal.

Earlier in this unit we mentioned the importance of education in promoting the use of family planning methods. In the next section we show the economic benefits of education about contraception.

The benefits of education about contraception

Educating young people about contraception has a number of social and economic benefits. As you can see from the following table, it is not only women who can benefit by limiting and controlling births through family planning, but children, men, youths, families and communities as well.

Social and economic benefits of education about contraception

| Category | Benefits |
|-------------------|--|
| Children | Better health, more food and other resources available, greater opportunity for emotional support from parents, better opportunities for education. |
| Women | Better health protection, freedom of decision, less physical/emotional strain, improved quality of life. |
| Men | Can provide protection from certain diseases, less emotional/economic strain, greater care for each child, improved quality of life. |
| Adolescents/youth | Healthier growth and development, protection from too early and unwanted pregnancy and child birth, can provide protection from STDs/HIV, longer education/job possibilities, more energy for household activities, prevention of unsafe abortion. |
| Couples/families | Freedom to decide when to have children, less emotional/financial strain, increased education opportunities for children, increased economic |

| Category | Benefits |
|-----------|--|
| | opportunities, more energy for personal development and community activities. |
| Community | Reduced strain on environmental resources (land, food, water), reduced strain on community resources (healthcare, education), greater participation by individuals in community affairs. |

Source: World Health Organisation (1995)



Self-help question 4.1

(about 20 minutes)

Give three reasons why education about contraception is important.

Discuss this with your tutorial group, co-workers, friends or family, and write a response in your learning journal.

Compare your answers with those provided at the end of the unit.

Next, we look at various methods of contraception that may be available to young people.

Contraceptive methods

To make the right choices about contraception, young people need to know what methods are available, their effectiveness, cost and how to gain access to them. Below are some of the family contraception methods available in most countries:

- oral contraceptives (commonly known as ‘the pill’)
- condoms and diaphragms (the female condom is still at pre-test stage and is generally not available in developing countries)
- intrauterine devices (IUDs)
- implants
- injectables
- spermicides
- voluntary sterilisation (tubal ligation or vasectomy)
- lactational amenorrhea method
- scientific natural family planning.

It is important for young people to be aware of and use these contraception methods in order to avoid, among other things, teenage pregnancy. When you have read through the next case study you will

recognise the serious, negative effect of teenage pregnancy on young people.



Case study 4.2: Adolescent pregnancy

Teenage pregnancy poses a serious problem in the English-speaking Caribbean. But for years, against the backdrop and perspectives of an earlier, less sophisticated era, it was not recognised as such. Even as late as the 1960s, adult roles and responsibilities came early to most Caribbean youths. With these, very naturally, came early parenthood. Society expected and incorporated teenage pregnancy into its regular cycle of living. It caused no undue concern.

The Caribbean has changed though. Today's Caribbean, and indeed the world, demands more of its citizens than it did in those earlier times. Most of these territories, having discarded their former colonial status in favour of independence, are now engaged in a difficult struggle towards industrial and economic self-reliance: a situation that calls for a better-educated and more productive populace.

However, the stark fact is that, because of teenage pregnancy, a significant portion of the Caribbean's people cannot realise their potential and do not contribute fully to the growth of the region. Each year, more than one in every ten teenage girl gives birth to babies.

Because of childbearing and subsequent child-rearing responsibilities, these young mothers, more than one tenth of all female adolescents, often have their health, educational and economic potential compromised.

And it does not end there. In ripple-like effect, their children, their parents and, eventually, the social and economic welfare of their countries are all negatively affected by their premature advances into parenthood. Their parents are often called upon to provide nurturing and financial support for their babies.

Their babies, in turn, face a greater risk of poor health, a life of poverty, child abuse and lower education than children born to more mature mothers. Their countries are affected because pregnancy often causes these young women to abort their education and self-development. It traps them into low-level skills and jobs and so limits their contribution to society, while increasing the probability of their making demands on the public purse.

In addition, these young women, by becoming mothers at seventeen or earlier, increase their childbearing years and, proportionately, their contribution to an already burgeoning young population who need housing, school places and other health and social services.

Extract from Barker, and Saint-Victor (1992).

As you have read in the case study, some young women in the Caribbean leave school when they get pregnant and their future becomes bleak.

Reflect on what you have read, drawing from your own work through Activity 4.4



Activity 4.4

(about 10 minutes, not counting discussion)

Some schools in Commonwealth countries allow teenage mothers who become pregnant while at school to re-enter school after delivery, while nursing their children. Other schools expel pregnant school girls as soon as the school system becomes aware of the pregnancy, while some expel both the pregnant school girl and the boy who made her pregnant if he was at the same school.

Reflect on these school practices, and discuss with others the advantages and disadvantages of each practice.

If you were in a policy-making position, what policies and programmes would you put in place for girls who fall pregnant while at school? In your learning journal, explain your reasons.



Turn to the Readings section and read through Reading 7: 'Methods of contraception: how to use them (from the Family Planning Services Project, Zambia). and Reading 8: 'Contraceptive methods: their effectiveness', by the module authors.



Activity 4.5

(about 10 minutes)

Reflect on Readings 7 and 8 and answer these questions:

- 1 What are the two categories of contraceptive methods?
- 2 Which contraceptive methods are commonly used by young people in your country?
- 3 Which contraceptive methods would you recommend to young people and why?

We cannot dictate to young people which methods they should use. They have the right to choose. In the next section, we look at the reproductive rights of young people.

Reproductive rights

Having reproductive rights does not only mean that young people are entitled to access to accurate information and relevant health services, contraception that is safe, legal, affordable and available and protection from disease. It also means freedom from coercion into government social engineering or population control programmes (e.g. of the kind that President Indira Gandhi attempted to use in order to combat India's dangerously high birth rates).

It can be a fine line between family planning and population control. In some countries, where for example international loan criteria may have included targets to reduce population growth, governments have responded by introducing heavy-handed population control programmes instead of programmes that empower people to make choices about having children.

The most effective and empowering strategy to reduce population growth, is to improve living standards and access to education and employment, so that poor people, especially young women, are in a position to choose to have fewer children. The expense of educating and bringing up children in a society that is modernising is a significant brake on population growth.

Next we will look at a case study of a country that has recorded some amount of success in promoting family planning.



Case study 4.3

A success story of family planning in Peru

Peru has been heralded as a family planning success story. Since 1961, the country has reduced its fertility rate from an average of six children per woman to three and a half. But the line between planning families and controlling population is a fine one.

Leopoldina Vega has not felt well since her operation. ... She speaks of health workers who bullied her into having her tubes tied ... consent forms she signed, but being illiterate did not understand. And she shudders when she tells how she and three others were lined up on tables to be operated on the same day, one after another. Residents say health workers tried to convince women with four or five children to consent to tubal ligations during a vaccination campaign last May.

Investigations have uncovered numerous cases of coercion and abuse in poor communities across the country. Peru's Office of the Public Defender is investigating 35 cases of illegalities in tubal ligation operations, including nine deaths from alleged complications and unsanitary operating conditions. Doctors performed about 110,000 such sterilisations last year (more than three times the 1996 figure) and 10,000 vasectomies as part of a Government birth-control campaign.

What struck me most about Leopoldina's community was not the poverty, but the possibilities. ... Although houses are without running water, the settlement is not a 'slum' and the people are not starving or malnourished. Their children play in streets which are free from garbage or sewage. Houses have electricity and many are equipped with televisions.

Reforms like piped water, paved roads and a health clinic to provide real choices for family planning would not be difficult. But infrastructure would only encourage the inhabitants to stay. And the Government's response is clearly not about building futures, but about simple population control.

In February 1998, a delegation from Peru travelled to testify before a Congressional Subcommittee on International and Human Rights Operations. Dr Hector Chavez described the pressures on doctors to perform operations. Two women also testified – one claiming she was sterilised without her consent and the other that she was bribed with monthly food shipments.

Dr Chavez told the Subcommittee that women were not given adequate information about the irreversibility of these operations or the risks involved, prior to them being carried out. He also said that many doctors disagreed with the sterilisation campaign, suggesting they were pressured into performing the operations for fear of losing their jobs. ... The Peruvian Government denies there are quotas and maintains that abuses are the fault of individuals and not the health system. A few weeks after Dr Chavez's delegation returned to Peru, he was dismissed from his post for '*not fulfilling his duties*'.

... There is concern that American aid was used to fund the sterilisations – though aid officials claim that this is not the case. Nonetheless, before the abuses were made public, Peru's family planning program (one of the most ambitious in Latin America) received praise from both the UN Population Fund and the World Bank.

Although government agencies perform nearly 80 per cent of Peru's tubal ligations, NGOs often work loosely with government departments. ... Whether they receive direct government funding or not, NGOs in Peru can't function without Lima's consent. Treading too harshly on government toes is never wise.

But the dilemma for women's groups goes beyond the compromising position of funding. Family planning activists fear losing all they've worked for if donors become wary of funding programs or if a conservative backlash frightens women away from clinics and turns birth control back into a taboo subject. ... After working for years to raise awareness about the importance of reproductive health, the issue was taken away from the women themselves once it was finally deemed *important* (by the government).

Mary Vargas, a lawyer working with the Peruvian women's group Demus, cautions that fixating on numbers and population neglects

the social aspect of women's reproductive health, which is heavily influenced by factors such as education, access to economic resources and legal protection. Vargas argues that demographics and population control should not take precedence over women's right to control their own bodies ... having access to reproductive health methods and information is a fundamental right for women everywhere.

(From Boyd, 1998.)



Activity 4.6

(about 20 minutes)

In some countries the term 'birth control' is associated with government population control campaigns, such as the one described in the case study you have just read.

Has damage been done to genuine fertility control or family planning services in your country, by such a programme? Does this make it harder for young people to gain access to contraceptives?

Discuss this issue with others (your tutorial group, health care workers, co-workers, family or friends) and write a response in your learning journal.

As a youth development worker, you should know that despite various strategies to promote use of contraceptive methods, many young people end up with unwanted pregnancies, which most wish to terminate. In the next section we discuss various issues that relate to abortion.

Abortion

Abortion is the ‘termination of pregnancy or expulsion of a foetus from the womb before it is sufficiently developed to survive.’ (Webster’s New World Dictionary, Second College Edition).

A foetus has usually been considered to be a viable pregnancy from 28 weeks of gestation. However, there are some variations between countries because viability of a foetus is being revised as new knowledge emerges from research findings. Although the original cut-off point for foetus viability was 28 weeks of gestation, it is continually revised downwards. Some countries consider that a foetus is viable at 24 and 20 weeks of gestation. These variations are a result of social, economic, religious, moral and legal pressures, and advances in medical knowledge and technology.

The major reason for inducing abortion is unwanted pregnancy. Some of the reasons why pregnancies may not be wanted are:

- pregnancy occurs outside marriage
- a female may be too young or too ill
- a spouse/sexual partner does not accept responsibility for the pregnancy
- pregnancy occurs too soon after the last child’s birth
- pregnancy occurs from socially unacceptable sexual relationships, such as rape, incest or an extra-marital affair
- the pregnancy occurs when the couple or a woman already has the desired number of children
- a couple or a woman has no resources (financial and material) to support a child and pregnancy occurs after contraceptive has failed.

Abortion may be induced for one or more reasons. For example, a schoolgirl may want her pregnancy terminated because she wants to continue with her education and has no resources to support a child. Sometimes abortion is used to regulate fertility in the absence of effective contraceptives or when a mode of contraception has failed.

Types of abortion

Abortion is classified according to whether it is safe or unsafe. Safe abortion is that which is done in medically approved conditions, performed by qualified personnel using standard sterile procedures. On the other hand, unsafe abortion refers to induced abortion undertaken by unqualified personnel or not conducted under medically approved conditions.

Abortion is understood to be widespread, and unsafe abortion is therefore an increasing problem, with health and socio-economic

consequences affecting young women in particular. Unsafe abortion is one of the major causes of maternal mortality. In Nigeria for example, abortion is the leading cause of maternal mortality. The horrors of this problem exist wherever there is poverty and/or where culture militates against openness of accurate information exchange and wide usage of contraception.

We will now look at different types of abortion.

- 1 Spontaneous abortion: Spontaneous abortion or miscarriage occurs without a deliberate effort to terminate the pregnancy. It is a non-intentional process, occurring due to various factors beyond the control of the woman, such as illness (especially involving high fever), accidents and emotional stress.
- 2 Induced abortion: Abortion is classified as induced when there is a deliberate, non-surgical effort to terminate the pregnancy by the woman and/or by another person. Induced abortion should only be performed according to the provisions of the law and recommended medical procedures. However, induced abortion is performed outside the law and under conditions that are not medically safe. Most abortions in the communities of developing countries are believed to be induced and performed by unqualified people. In communities where effective contraceptives are not easily available or not affordable, it is believed that most women will resort to induced abortion at some time.
- 3 Incomplete abortion: Abortion is incomplete if some of the products of pregnancy are retained in the uterus, for example the placenta. Incomplete abortion can result from spontaneous or induced abortion.
- 4 Missed abortion: This refers to retention of a dead foetus in the uterus.
- 5 Complete abortion: This means that all the products of a pregnancy have been expelled from the uterus.
- 6 Threatened abortion: This refers to bleeding during pregnancy. The bleeding will often be accompanied by abdominal pains, though sometimes there is no pain at all. In some women, bleeding stops and the foetus continues to grow normally. However, in some women pain or bleeding may continue and result in complete or incomplete abortion.
- 7 Infected or septic abortion: Infection can result from spontaneous or induced abortion. A retained placenta often causes infection when the abortion is not complete. Bacteria are introduced by unsafe and unhygienic attempts to end a pregnancy, and/or the presence of infection in the genital parts before the abortion.

Abortions are usually done by:

- traditional or local people with experience of inducing abortion
- medical professionals, usually obstetric surgeons
- paramedics (nurses, clinical officers, assistant physicians).

The initial decision whether the pregnancy should be terminated or not is usually a woman's, with or without consultation with other people (spouse, partner, friends or family members). This indicates that women may be independently making important decisions about their bodies as well as about related issues that affect them. This is a crucial aspect of sexual politics, though it may also indicate that abortion is often a taboo or secret subject not to be freely communicated with other people.

Unsafe abortion

The following case study is taken from a report by Uruguayan journalist, Mercedes Sayaguez, first published in 1985, about a hospital for women who have had clandestine abortions.

Case study 4.4

A story of clandestine abortions in Uruguay

Of the 54 beds in the women's ward, this month 27 are taken by these women, the victims of clandestine abortion. Every year the hospital treats over 1,000 women for infections and other complications from these abortions. The Pereira Rossell Hospital is a public hospital serving mainly the poor.

A recent UNICEF study established that 40 per cent of the population of Montevideo lives in poverty. They cannot afford unwanted pregnancies, they cannot afford good medical care. Yet these women are the *lucky* ones.

The next morning I visit the 16th floor of the Hospital de Clinicas, the largest public hospital in the city, with intensive care units and dialysis equipment. This is where women are brought who are in danger of dying from clandestine abortions. From all over the country they come, some to die, some to be saved. They arrive with severe sepsis and peritonitis.

(From Sayaguez, 1985)

Clandestine abortion is characterised by a variety of methods, which as the Uruguayan story illustrates, can be dangerous.

Methods

Methods used to induce abortion vary over time and sometimes between and within countries. These methods are generally not safe and usually result in unsafe abortion:

- ingestion of herbal preparations
- uterine massage
- ingestion of domestic excreta or droppings
- foetal strangulation
- insertion of foreign bodies (i.e. knitting needles, bicycle spokes, pens, iron rods, intrauterine contraceptive devices, coat hangers and sticks, roots of trees believed to have medicinal effect)
- ingestion of chemical conjunctions and/or chemicals (i.e. washing powders, narcotic drugs, chloroquin and other bitter drugs)
- instillation of chemicals into the uterine cavity.

A silent problem

Unfortunately, unsafe abortion is a silent problem, because it mostly affects under-privileged women and youths who do not have much power to influence national policies or to initiate programmes to address the problem of abortion.

Another reason why the problem of unsafe abortion is silent is because young people affected by abortion are invisible compared to other, more dramatic groups, such as victims of war or street children.

Recognising the magnitude of unsafe abortion is also made difficult by socio-cultural factors, which restrict open discussions about sexuality and abortion at all levels, even among friends, with spouses, family members and with formal institutions. As a result, the issue of unsafe abortion remains closed.

Another difficulty leading to the under-estimation of unsafe abortion is that very few women or girls will admit that they have interfered with their pregnancies, even when interference may be obvious to the medical personnel or counsellors. Since most cases of unsafe abortion occur outside formal medical institutions, the actual number of abortion cases will always remain unknown. However, there are indications that unsafe abortion is a very big problem in the Commonwealth.

Indicators

In some cases, it is hard to tell if a woman has had an abortion or not, especially if there are no complications, but these are indicators of possible unsafe abortion:

- foreign bodies in the uterus, vagina or cervix
- presence of local or generalised infection
- purulent vaginal discharge
- injury to the genitalia
- history of unwanted pregnancies which have been terminated
- being in a high risk group (not married, and/or school/college girl, with no history of using any effective contraceptive method prior to the terminated pregnancy).

Factors that contribute to unsafe abortion

There are three main factors that contribute to women risking unsafe abortions: restrictive laws, gaps in knowledge and social or cultural taboos.

Restrictive laws

Most countries have restrictive laws or social norms that limit access to safe termination of pregnancies. As a result, many individuals who want to terminate their pregnancies, for various reasons, are forced to rely on clandestine and dangerous means of abortion, risking their health and lives.

Gaps in knowledge

Gaps in knowledge contribute to unsafe abortion. Knowledge is a key factor in promoting positive reproductive behaviours. Knowledge facilitates utilisation of available information and community programmes. Knowledge empowers individuals, groups of people and communities to fight for their rights. Accurate knowledge also enables policy makers and planners to devise responsible policies and programmes to identify recognised community and/or national problems. However, efforts to prevent and manage unsafe abortions are limited by various knowledge gaps at every level.

Knowledge gaps and lack of services at youth level

The problem of unsafe abortion continues to increase and affect youths because youths as a group:

- lack knowledge about their bodies and exactly how pregnancy occurs
- lack youth specific services that would give them access to information and contraceptives.

As a result, it is difficult for them to seek effective ways of preventing unwanted pregnancy. Youths do not have accurate information about the range of effective contraceptive methods, and so generally do not use them.

There are also a lot of rumours or misconceptions about pregnancy and contraceptive methods. For example, some youths believe that if a girl washes her vagina immediately after sexual intercourse, pregnancy may not occur. There are others who believe that use of contraceptives by young people may cause infertility later in adulthood. Misconceptions like these lead to uninformed sexual decisions and actions.

It might also simply be that access to contraception is not available to young people.

Finally, youths lack correct and adequate information about complications associated with unsafe abortions. As a result they fail to make informed decisions about the risks.

Knowledge gaps at family level

In many cultures, it is a taboo to discuss such issues. Even where this is not so, information about sexuality and reproductive health is very often not disseminated at family level, and anyway both parents and children usually lack the knowledge and skills to discuss matters related to sexuality. Lack of communication about sexuality within the family means that youths have to rely on the media, friends and informal institutions as sources of information about sexuality and reproductive health. Often information from these sources is not correct and youths have no effective means of verifying it.

Knowledge gaps at national (government) level

Policy makers and planners lack knowledge about the magnitude of the problem of unsafe abortion and its socio-economic and medical consequences on the individual, family and society in general. As a result, policy makers do not devote much attention and resources to formulate appropriate policies and programmes for preventing unwanted pregnancy and unsafe abortion.

Apart from the above mentioned factors, that contribute to unsafe abortion, there is a social and cultural dimension to the problem. You will read more about this in the next section.

Social and cultural factors

Apart from restrictive laws and knowledge gaps, there are other factors that contribute to the problem of unsafe abortion. The major factor is that many societies and cultures deny the problem of unwanted pregnancy and unsafe abortion. Such knowledge is considered profane (i.e. 'dirty' and 'polluting') in the domain of childbirth, which is considered sacred.

Some religions are anti-contraception and sometimes anti-family planning, especially for the young, on ethical grounds. They believe in utilising abstinence (perhaps using the 'rhythm method') as the major means of preventing pregnancy. Use of scientifically supported family planning methods, such as oral contraceptives and condoms, are

considered to be productive of sins such as extra-marital sex. Such beliefs result in the religious bodies concerned not only failing to provide information and appropriate scientific services to prevent unwanted pregnancy and unsafe abortion, but also in them labelling contraception as sinful. When supported by cultural factors that protect young women, this may work well of course, but often these are not in place.

Many societies, like some of the churches, often do not publicly admit the reality that sexuality is present in childhood and develops further very early in adolescence. Perhaps this is because of the implied social disorder in this idea. Parents deny that their adolescents and children engage in sex. Like the church, they believe that youths should abstain from sex until marriage, even when they themselves enjoyed sexual interaction as children and teenagers.

Often, rural communities are much more realistic. They allow a measure of exploration and freedom among their children until puberty, then find ways of controlling sexual behaviour, either by separating young men from young women (as the Masai do, for example) or by early marriages often with near relatives, which creates significant sexual control (as many Kashmiri families do, for example).

The weakening of the extended family, associated with the industrialisation and urbanisation processes in most countries, has resulted in making the family, especially the extended family that used to provide family life and family planning education, ineffective in these areas. This is a particular problem among many former rural Asian and African families who have migrated to metropolitan countries and are now finding significant problems in these areas because their children have come under the influence of urban values and norms. Youths have to rely on formal institutions, especially the education systems and some NGOs, to provide sexual and reproductive health education. Unfortunately, some of these institutions do not adequately provide comprehensive and effective education to youths.

The increase in the age of first marriage for females, because of schooling and socio-economic considerations, and the decline in the average age at menarche in Africa due to improved diet, contributes to unwanted teen pregnancy.

As you have seen from what you have read so far, abortion is a very serious problem that needs to be addressed with the full participation of youth development workers. In the next section we focus on the prevention and management of unsafe abortion.

Prevention and management of unsafe abortion

Prevention and management strategies for unsafe abortion need to address the root causes of this problem. You will remember from an earlier section of this unit that the main reasons for the occurrence of unsafe abortion among young people are that:

- most of the pregnancies among young people are unwanted
- young people do not have accurate and adequate relevant information about sexuality and contraceptive methods
- they have limited access to effective and safe family planning services.

Therefore, preventive and management strategies for unsafe abortion must include strategies to narrow the knowledge gaps identified at the individual, family and national levels.

Apart from narrowing the knowledge gaps, strategies to increase youth access to sexual and reproductive health services are needed. Reducing the overall number of unwanted pregnancies through access to contraception reduces the frequency of unsafe abortion.

For family planning programmes to be effective they must provide:

- a broad spectrum of reproductive health services
- a wide range of contraceptives to meet changing preferences (Jacobson, 1991)
- services to all individuals including youths, adolescent schoolgirls and unmarried women
- education about preventing unwanted pregnancies at all levels of health care
- counselling for women being treated for induced abortions to prevent repeated unwanted pregnancies and unsafe procured abortions.

Largely because of the fact that many schoolgirls are victims of unwanted pregnancies and unsafe abortion, authorities in some countries have argued for the inclusion of reproductive health education in the school curriculum. In the next section we discuss the importance of this argument as well as the challenge of such a strategy.

Sexual and reproductive health programmes for young people

There is a need to integrate the study of sexual and reproductive health, and family planning education, with school curricula. There is also a need for effective, youth-specific, community-based education programmes. Family planning education must begin at an early stage in life, before negative attitudes and stereotypes about sexuality and reproduction are formed.

However, there may well be considerable resistance to this on established religious and cultural grounds (for example from some Muslim communities). This resistance has to be respected, but the way forward would seem to be through the education services negotiating a shared programme with the communities concerned. Whether reproductive health is provided within or outside the school system does not seem to matter.

Governments need to provide sexual and reproductive health programmes that are sensitive to the situations of young people. Youths often say that they find existing services unfriendly and unacceptable: sometimes, for example, youths are asked to bring written parental consent, yet they may well not want their parents to know that they are sexually active.

Use of existing reproductive health services by young people may also be limited because:

- the services may not be within geographical reach
- the services may exclude young, single people
- the fees may be too high for youths
- the approach used to deliver family planning may not be acceptable or relevant to the way young people live their lives.

Inappropriate programmes and poor utilisation of services should not perhaps surprise us, since youths are not usually involved in the planning, design and implementation of sexual and reproductive health programmes.

Education about this issue must also target parents and the public in general so that they realise the need to support rather than criticise young people. Policy makers and planners also need the most accurate information in order to formulate appropriate policies and programmes for preventing unsafe abortion.

Provision of safe abortion services should also be integral with family planning services. People usually object to proposals to increase youth access to safe abortion, arguing that increased access to safe abortion will encourage youths towards more sexual adventure and a culture of abortion on demand.

However, it must be understood that, even in developed countries with most elaborate and efficient family planning services, many unwanted pregnancies still occur, and the supporters of the young people involved have had to fight politically in order to get access to medically supervised abortion.



Self-help question 4.3

(about 10 minutes)

Mutinta completed her secondary education three years ago. Since then she has not been able to secure a job. Last month she discovered that she was pregnant and attempted to abort the foetus by swallowing an overdose of chloroquin tablets. She did not succeed in terminating her pregnancy. Instead, she bled so much that she almost died due to excessive blood loss.

Reflect on Mutinta's case and discuss the following three questions:

- 1 What factors influenced Mutinta into becoming pregnant?
- 2 Why did Mutinta attempt to terminate her pregnancy using an unsafe method?
- 3 What kind of support/help does Mutinta need to cope with her immediate situation and to avoid a similar problem in future?

Compare your answers with those provided at the end of the unit.



Activity 4.7

(about 15 minutes)

Teen pregnancy and unsafe abortion are common in most Commonwealth countries. Consider the following questions in relation to your community or country.

- 1 What factors contribute to these problems?
- 2 What socio-economic consequences do early pregnancy and unsafe abortion have for young women, and for general development work in your country?
- 3 How do you think unwanted pregnancies and unsafe abortion could be prevented, or at least reduced in your community?

Write your answers in your learning journal.

In many communities, sexual and reproductive health is influenced by some traditional beliefs and practices. As a youth development worker you need to learn more about traditional practices and reproductive health for you to help plan appropriate interventions. We look at these in the next section.

Traditional practices

Traditions can be good and bad. Tradition changes over time as the social ethos changes. Nevertheless, within the Commonwealth, particularly in Africa, there still exist some basic traditional practices such as FGM (female genital mutilation, also referred to as 'female genital circumcision' or FGC), wife inheritance or early marriages that in developed countries are considered harmful to the sexual and reproductive health of young women.

Many African ethnic groups have stopped practising some of the traditions they once thought were good and beneficial to their communities. For example, some Africans supported body decorations with different tribal markings and tattoos to indicate their clan conformity and as a sign of beauty. Today this tradition is diminishing as people become more aware and educated about other means to identify one another and as our concept of what constitutes physical beauty changes.

What was a good tradition yesterday is not necessarily a good tradition today. For example, it was once acceptable in some African and other societies for girls to stay at home and for boys to go to school and work. Today, millions of young African girls go to school and millions of African women are engaged in many forms of

productive work related to politics, business, education, health, farming and science, to name a few.

People all around the world modify and/or abandon their traditions as they discover the harmful effects of some traditional practices (such as foot-binding in China), and as the need for them diminishes and disappears.

A good tradition is a tradition that respects, honours, and safeguards human worth and lives. Certain types of female genital mutilation have had the purpose of marking the sudden transition from girlhood to womanhood in a dramatic and painful process, meant to ensure that the girls understand symbolically the boundaries of their new roles. In subsistence farming and hunter/gatherer communities, understanding that rationale is crucial if the tradition is to be changed without social disruption. It is important to remember that from the point of menarche the young women have probably been kept separate from men and spent time in the company of older women who have taught them crucial things about their sexual behaviour. Where practised, the ceremony where genital mutilation occurs would be the climax of that transition process. Because the world in which women live today is changing so quickly, it means that this tradition may no longer have any practical basis in the social and cultural formation.

Employing the criteria with which modern developing societies now construct their cultural symbols and practices, female genital mutilation by the practice of removing and/or stitching sensitive parts of the female clitoris, mutilates the selfhood of women and young girls, also putting their health and well-being at risk. Moreover, the other main social control strategy, early marriage, today means that the girl is denied an opportunity to complete her education, which means a very serious potential loss of skilled labour to the family and society. It also means that she is likely to start child-bearing at a very young age and is likely to have several more children than she desires or can support.

Social and health effects of harmful traditional practices

Female genital mutilation (FGM) refers to the traditional rituals of cutting and removing parts of the female sexual organs for cultural, non-medical reasons. It may be performed during infancy, childhood or adolescence and is prevalent in about 28 countries in Africa. There are three types of FGM:

Type 1: clitoridectomy – the prepuce (clitoral head) is removed, sometimes along with part or all of the clitoris.

Type 2: excision – both the clitoris and part or all of the labia minora (inner vaginal lips) are removed.

Type 3: infibulation – the clitoris is removed, some or all of the labia minora are amputated and incisions are made on the labia majora (outer lips) to create a raw surface. These surfaces are either stitched

together and/or kept in contact until they grow together as a 'hood of skin' covering the urethra and most of the vaginal opening. A small opening (sometimes the size of a match head or the tip of the small finger) is left to allow for the flow of urine and menstrual blood.

FGM is usually performed in bushes, under trees or in people's homes, by traditional circumcisers or traditional birth attendants.

Immediate complications

The immediate complications of FGM include:

- haemorrhage, which can result in death.
- shock due to bleeding and severe pain and anguish
- infection (from tetanus for example), due to unhygienic conditions and the use of unsterilised or crude tools (HIV can also be transmitted through the use of dirty circumcision knives).
- urine retention due to fear of passing urine on the raw wound
- injury to adjacent tissue.

Long-term complications

The long-term complications of FGM include:

- bleeding after defibulation and reinfibulation in order to facilitate childbirth
- difficult urination due to the obstruction of the urinary opening
- recurrent urinary tract infections due to the damage of the lower urinary tract or because of subsequent complications
- incontinence due to a damaged urethra
- chronic pelvic infections
- infertility due to pelvic inflammatory disease or other diseases of the reproductive organs
- vulval abscesses due to infections
- keloid formation due to wounds healing with hard scar tissue
- vesico-vaginal or recto-vaginal fistulae due to formation of unusual opening between the vagina and the anus or the bladder
- sexual dysfunction due to the absence of the clitoris and labia minora which are responsible for women's sexual pleasure
- menstrual difficulties
- problems in childbirth as there is no room for the child to leave the mother's body
- HIV transmission is arguably an increased risk.

Good traditions continue because they are beneficial, and harmful ones are discarded because they cause problems. However, where FGM has been found to be harmful in Africa, it has not always been discarded. The reasons for this are:

- FGM is still considered a significant rite of passage to adulthood.
- ‘Circumcised’ girls and women receive important recognition among peers and within their community.
- ‘Uncircumcised’ girls can be abused by their ‘circumcised’ peers or even by younger ‘circumcised’ girls
- It is believed that FGM prevents promiscuity.
- FGM reduces the sexual desire of girls.
- It is considered taboo for an uncircumcised girl to have sex or become pregnant.
- FGM increases marriage opportunities for the girl and attracts a big dowry.
- Bearing the pain of FGM is supposed to ‘toughen’ the girl for the subsequent pains of child birth and wife beating.
- It is said to give greater sexual pleasure to the husband.
- Many men refuse to marry a girl who is ‘uncircumcised’.



Activity 4.8

(about 5 minutes)

List any cultural traditions in your community or country that promote or impact negatively on the sexual and reproductive health of the youth.

What efforts are there to eradicate harmful traditional practices?

It is very likely that you have identified some harmful traditional practices that are being challenged in your community or country. You will see from the next section that this problem is also being addressed at international level.

Eradicating harmful traditional practices

The ‘programme of action’ of the 1994 International Conference on Population and Development (held in Cairo), and adopted by 184 UN member states, takes a strong stand against female genital mutilation (FGM). It urges governments to act ‘wherever it (FGM) exists and to give vigorous support to efforts among non-governmental and community organisations and religious institutions to eliminate such practices.’

The Declaration Platform for Action of the 1995 Fourth World Conference on Women (held in Beijing) was adopted by 187 UN member states. This Platform underscores the importance of education, particularly of parents, to aid in understanding the health consequences of FGM.

Unit summary

In this unit you covered the following main points:

- the meaning of sexuality and reproductive health
- contraception, its nature and the importance and benefits of education about contraception
- different types of contraceptive methods
- the reproductive rights of young people
- abortion, its cause and types, including the problem of unsafe abortion and factors that contribute to it, including social and cultural factors
- the need for sexual and reproductive health programmes for young people
- traditional practices and sexual and reproductive health.

To check how you have got on, look back at the learning outcomes for this unit and see if you can now do them. When you have done this, look through your learning journal to remind yourself of what you have learned and the ideas you have generated.

You are now ready to go on to Unit 5, which deals with another very important subject – sexually transmitted diseases (STDs) and HIV/AIDS.

Answers to self-help questions

Self-help question 4.1

Access to and use of contraceptives benefits all in the community. In particular, it protects the health of poor, young women, by preventing:

- unwanted pregnancies
- the need for clandestine abortions
- childbearing in women who are too young or ill
- a further drop into poverty.

The use of contraception allows people to choose when to have children and how many, with consideration of how well they can provide for them.

Contraception is also important in preventing the spread of sexually transmitted diseases (STDs). The male condom is particularly effective in preventing the transmission of syphilis, gonorrhoea and HIV.

Although family planning can be seen as a visible way for countries to deal with a population crisis that may bring economic and social chaos, it sometimes seems, as in the case of India, that family planning has *not* been a very significant tool for dealing with a gigantic problem. The reasons are that population trends are very complex phenomena, that defy one solution answers.

However, individuals and families in developed countries have used contraception successfully as a method of maintaining high living standards, particularly over the last forty years.

China, faced with a massive population crisis, is persevering with a legally supported requirement for families to have only one child or suffer economic penalties. The price of *not* curtailing population growth for China is the possible failure of the economy, and social upheaval because of the shortage of productive land where China's huge peasantry can make a living. However, democratic countries claim that some of the strategies for population control used in China may overstep the rights of the individual, as interpreted by their own regimes. It is a complex example and needs to be thought through carefully. Population crisis is a worldwide problem and ethical solutions, one of which is to raise the living and educational standards of the poor, lie with the global community and with the movers and shakers of the global economy.

Self-help question 4.2

The answer to this will depend on what your audit of youth health provision revealed. What exists in health care will largely determine what you can do and how you might best work as part of the team.

You will have to learn about the attitudes and practices of all the available agencies for health provision. There will always be a mixture, ranging from those agencies needing mainstream support and therefore probably holding mainstream views, to those which have independent means and/or independent minds.

You will have to represent your case to them in ways that they find acceptable, and to locate sympathetic and active agents inside those organisations.

The main task may well be with the families and community leaders of the youths with whom you are working, as most sexual and reproductive practices are based on traditional patterns.

You will need to ascertain the degree of cultural blockage to the use of contraceptives among young people, no matter what they may claim publicly to you. In many countries, for example Catholic countries, the language you use may be important, for example, 'contraception' is formally forbidden (although the term includes natural methods), though 'family planning' is not, if the rhythm or 'calendar' method is used.

Equally, in some cultures, family planning may not be forbidden but may well be treated as a social taboo. In these cases, you will have to ascertain what you can do to raise awareness on all levels – community, family and with young people.

Self-help question 4.3

- 1 Many factors could have led to Mutinta becoming pregnant. For example she may have lacked:
 - information or understanding about sex and pregnancy
 - the assertiveness skills to be able to say no to unprotected sex
 - access to services where she or her partner could get contraceptives.

She is most at risk because she is unemployed and presumably poor.

- 2 Being poor, Mutinta is unlikely to be able to afford conventional family planning methods and will not have the money to pay a hospital for a safe abortion, which leaves clandestine abortion or an unwanted child as the only options. She may live in a country where abortion is illegal, or a serious social taboo, which would also make it impossible for her to acquire a safe abortion.

- 3 This last question requires that you make the most of the audit of youth health provision in your area. Mutinta needs urgent medical help from the best available medical agencies who will charge nothing. To safeguard her in future she will begin by needing skilled medical and personal counselling.

That, however, is only a first stage—because she urgently needs a job of some kind to provide money for contraceptives, or at least a source of free family planning advice and help. Like so many problems, this breaks down to a question of social position, employment and money.

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Unit 5: STDs and HIV/AIDS

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Unit introduction

Welcome to Unit 5 *STDs and HIV/AIDS*.

The unit focuses on sexually transmitted diseases (STDs), particularly HIV/AIDS, and aims to counter some of the widespread misinformation about these conditions. It also seeks to create a context for the promotion of understanding and compassion for people with AIDS.

Clearly, young people should be helped to delay becoming sexually active until they are really ready to do so. There are potentially serious dangers (described in Units 4 and 5) for those who make the decision to become sexually active early. This unit advocates the consistent and correct use of condoms as the simplest and most effective way for sexually active young people to avoid STDs of all kinds.

The unit should therefore be studied in conjunction with Unit 4. It supports the equipping of young people with appropriate communication skills to enable them to resist peer and partner pressure and to give them options for sexual expression other than sexual intercourse. It also looks at the issue of the self-esteem of young people and its relationship to STDs, including HIV/AIDS.

Unit learning outcomes

When you have worked through this unit, you will be able to:

- explain the essential basic facts about STD and HIV infections
- describe and critically discuss methods of STD and HIV prevention
- explain the impact of HIV/AIDS on young people.
- identify signs of AIDS
- describe ways of living positively.

STDs

You have no doubt heard and read about sexually transmitted diseases (STDs). In this section you will read more about the nature and seriousness of sexually transmitted diseases.

STDs (also referred to as sexually transmitted infections or STIs) are a group of more than 25 infectious diseases that are spread through sexual contact. They may be caused by bacterial or viral infections and are extraordinarily common. In fact, STDs constitute a major health problem. In some countries, 10 per cent of all hospital attendances are STD cases.

STDs can affect any sexually active person. Among the groups of people that are at higher risk than others are economically vulnerable people, such as schoolgirls, street children and women without income. Since they are among the most sexually active social groups, and because they often engage in risk-taking behaviours, young men and women are in significant danger of catching STDs. The spread of STDs is facilitated by a number of factors, such as having multiple sexual partners and having unprotected sex.

Several STDs other than HIV/AIDS are quite serious. Diseases like syphilis, gonorrhoea, and chlamydia can have long-term consequences, including pelvic inflammatory disease (PID), which can lead to sterility as well as chronic pelvic pain. Human papilloma virus (HPV), the virus that causes genital warts, is strongly linked to the development of cervical cancer. STD infection during pregnancy can cause pregnancy complications and, in some cases, lead to illness in the newborn.

Bacterial STDs such as gonorrhoea, chlamydia, and syphilis can readily be cured with antibiotics. Although viral STDs, such as genital herpes, are lifelong infections, treatments to minimise some of their symptoms have been developed. However, no cure has yet been found for HIV/AIDS.

In the next section we identify the most common STDs.

What are the most common STDs?

STDs that frequently affect youths may differ from country to country. For example, in Zambia STDs are the third commonest cause of hospital attendances – about 10 per cent of all hospital attendances. Some of the most common STDs include:

- gonorrhoea ('the clap')
- syphilis
- chancroid
- trichomoniasis/candidiasis
- chlamydia

- genital herpes
- HIV/AIDS.



Activity 5.1

(about 10 minutes)

Reflecting on the above and from what you read in Unit 4, answer the following questions in your learning journal:

- Which of the above are the most common STDs in your local community?
- Why do you think STDs often affect youths?
- How can youths prevent themselves from getting STDs?
- Are there any services in your community that assist young people with STDs?

However, it is not only young people that get affected by STDs.

Who can get STDs?

STDs are not limited to any group of people, race or country. They can affect:

- any sexually active person of either sex
- babies through their mothers, during pregnancy and at birth
- young children who are sexually abused.

Although anyone can get STDs, some groups are at higher risk than others. For example:

- people with multiple sexual partners
- commercial sex workers
- highly mobile groups like long-distance drivers, musicians, soldiers, fishmongers, pilots and air crews, businessmen/women who travel, and field workers
- hotel/bar workers
- economically vulnerable people such as schoolgirls, street children and women without income
- people with a high disposable income who choose to adopt lifestyles which may expose them to excessive alcohol or drug intake and associated sexual promiscuity.

Each of the high-risk groups includes at least some young people, and people in highly mobile professions, such as soldiers and musicians, are mainly young. Many young people are not well informed about the risks they are taking through sexual activity, and since they may tend towards risk-taking behaviours anyway, they are extremely

vulnerable to STDs. Even those who are aware may not have access to services or products that allow them to have safe sex.

In order for you to help in preventing the spread of STDs among young people in your community, you first need to understand how STDs spread.

How are STDs spread?

STDs are passed from one person to another by unprotected penetrative sexual intercourse: vaginal, anal or oral sex with an infected person, without using condoms.

STDs may also be transmitted from an infected pregnant woman to an unborn baby during pregnancy and at birth. Syphilis and HIV can penetrate the placental barrier and infect the unborn child. Syphilis, gonorrhoea and HIV can also be transmitted to the baby during the process of birth.

Several factors independently or jointly facilitate the spread of STDs. They include having:

- more than one sexual partner
- unprotected sex
- poor personal hygiene.

STDs may also be contracted through certain traditional practices, such as:

- sexual ritual cleansing (e.g. the practice of a widower or widow having sex with relatives of his/her late spouse)
- dry sex (the practice of drying the vagina with herbs in order to increase the sexual pleasure for the male partner in some cultures)
- use of unsterile instruments like razor blades for procedures that involve blood letting (e.g. circumcision and tattooing).

Another problem is the stigma associated with STDs, which results in people feeling ashamed or afraid of seeking early medical treatment, or failing to communicate the presence of STD symptoms to spouses or casual sex partners.

How can someone know that they have an STD?

Any of the following can indicate to someone who has had sexual intercourse that they may have an STD and should therefore consult a doctor or clinic:

- redness or soreness of the genitals
- pain at urination; or cloudy or strong-smelling urine
- unusual discharge from the penis or vagina

- a sore or blisters on or around the genitals, near the anus or inside the mouth
- excessive itching or a rash
- abdominal cramp/pain
- a slight fever and an overall sick feeling
- a sexual partner with symptoms
- weight loss, fatigue, night sweats, purple lesions on the skins, diarrhoea, pneumonia and other diseases (AIDS symptoms).

You should take particular note of the fact that both men and women can have an STD without physical symptoms, with females more likely to be symptom-free at first. However, the complications from STDs are more severe in women than in men.



Activity 5.2

(about 5 minutes)

Reflect on what you have read in the preceding sections and answer the following questions in your learning journal:

- Which groups of people are more vulnerable to STDs and why?
- How are STDs spread?
- List four common symptoms of STDs

Although the effect of STDs can be devastating, they can be prevented, as described in the next section.

STD prevention

The only completely effective preventive measure is to abstain from oral, anal and vaginal sexual intercourse. Contact with another person's body fluids can result in STD infection.

There are several ways to reduce the risk of STD infection when having intercourse:

- **For the greatest protection:** Use condoms and spermicides such as nonoxynol-9 for every act of sexual intercourse. Use a moisture barrier, such as a dental dam, cut-open latex condom or plastic, when having oral intercourse with a female partner.
- **For minimal protection:** Inspect your partner's genitals; wash your genitals after sexual intercourse; use contraceptives such as foams, jellies, and creams that contain nonoxynol-9; limit your sexual partners to one person; avoid partners who have sex with other partners; talk to your partner about their sexual habits, drug use and health; have yourself and your partner tested for sexually transmitted infections, if you have worries or suspicion.

What are appropriate responses to an STD?

If an STD is suspected, it is important to do all of the following:

- Seek medical treatment immediately and complete your treatment. Do not share your medicine with a partner or anyone else.
- Inform your sexual partner(s).
- Strongly encourage your partner(s) to get treatment.
- Abstain from sexual contact while infectious.
- Abstain from sex or protect yourself with condoms every time you have sex.

Treating STDs

STDs are treatable, especially if medical treatment is sought early. Most health clinics and hospitals are able to treat STDs. If a patient is prescribed medication, they should complete whatever course of treatment is advised by the medical personnel, otherwise the treatment may not be effective.

Self-medication is not advisable. It is usually ineffective and may even be dangerous. It is possible to have more than one STD and in such a case, a person who is self-medicating may not identify their second STD. In addition, the person may over-prescribe the medication and cause some resistance to the treatment, in particular to antibiotics.

Partner notification is an integral part of STD prevention and management. If a partner is not treated, there is a danger of re-infection via the partner. There is also a danger of the partner not knowing about their condition and developing complications because of lack of diagnosis and treatment. Such a partner may even transmit the infection to an unborn baby.

All STDs can be prevented from developing, but this can only be achieved by avoiding multiple sexual partners, avoiding unprotected sex, observing personal hygiene, seeking help early if required and notifying partners.



Activity 5.3

(about 5 minutes)

What advice would you give to young people on how to avoid contracting spreading STDs?

Make notes in your learning journal.



To end this section on STDs, look at Reading 9: ‘Common Sexually Transmitted Diseases’ by the module authors. It lists STD symptoms, the damage they cause, diagnosis and treatment. Look through the list, and use it for future reference.

As mentioned in Unit 1, young people tend to experiment and take risks, such as having casual sex. This exposes them to STD infections, the most harmful of which is HIV/AIDS.

HIV/AIDS

In order to show the devastating effect of the HIV/AIDS worldwide, we will begin this section with a quotation from UNAIDS report of 2005. The figures given in this report are still rising today:

Since AIDS was first identified during the 1980s, it has become one of the most significant health challenges facing the international community. Since the beginning of the pandemic, HIV/AIDS has killed at least 20 million of the more than 60 million people it has infected thus far. Over 3 million people died of the disease in 2002. Around five million people are infected with HIV each year.

About 42 million people are living with the virus, including 19.2 million women and 3.2 million children. The brunt of the pandemic is being borne by the developing world, where 95 percent of people with HIV/AIDS live. Sub-Saharan Africa is by far the worst affected region, and in three countries, Swaziland, Botswana and Zimbabwe, one out of every three adults is infected. AIDS has affected families, communities and nations. There are already 14 million AIDS orphans worldwide.

(UNAIDS, 2005)

You may have noticed that some people in your community do not make any distinction between the terms ‘HIV’ and ‘AIDS’. However, as you may know, they are not the same thing.

The difference between HIV and AIDS

The acronym HIV is so commonly used that sometimes people may not pay attention to its full meaning. HIV stands for Human Immunodeficiency Virus. HIV is the virus that often eventually leads to AIDS. The virus works by slowly destroying (over an average of ten years) the body’s defences (the immune system), by killing those cells in the body that attack invading cells and protect us from different illnesses.

The HIV virus was first documented in the early 1980s among the homosexual community in the United States of America and Britain. It was also identified in sub-Saharan Africa in the mid-1980s amongst the heterosexual population. In fact, today almost all the newly

infected adults acquire HIV from intercourse between men and women; we find this general swing towards heterosexual transmission of the virus in both the industrialised and developing worlds.

The majority of people who become infected with HIV do not notice that they have been infected. Soon after being infected, some people may suffer flu-like symptoms for a week or so. Despite the lack of obvious symptoms, nevertheless, the virus remains in the body and can be transmitted to other people through sexual activity.

AIDS is an acronym which stands for Acquired Immune Deficiency Syndrome. It starts with infection with HIV, through sexual intercourse or contact with infected blood including intravenous drug abuse, but also by mother to child transmission. The deterioration of the immune system eventually causes AIDS. A person infected with AIDS is vulnerable to serious health problems from a group of illnesses (opportunistic illnesses) that a healthy person without the virus would be unlikely to be badly harmed by.

A person infected with HIV can remain healthy for many years with no physical signs or symptoms of infection. A person with the virus but no symptoms is 'HIV positive' or has 'asymptomatic HIV disease' (having no symptoms). If symptoms develop, that person is said to have 'symptomatic HIV infection', 'symptomatic HIV disease', 'advanced HIV disease' or 'AIDS'. It is helpful to think of HIV infection as a continuum, starting from the moment of infection, through the first signs of sickness, to the appearance of one of the indicators or diseases that is on the AIDS list. This is an important concept, because it means that:

- someone can be infected for a long time and have no symptoms and feel healthy
- someone can be infected and feel poorly, but only have some of the indicators or diseases that meet the definition of AIDS.

How HIV makes someone sick

Each of the many different kinds of cells that make up the immune system performs a different job, although they all work together to keep a person healthy. The 'helper cells', or 'T-cells,' orchestrate many parts of the immune response. The HIV virus has become able to enter the T-cells and begin to multiply. The T-cells then become miniature factories that reproduce HIV. Eventually, the virus kills the T-cell.

As more and more T-cells die, the immune system is less able to do its job of protecting the body from opportunistic infections. The word 'opportunistic' indicates that these infections, which would normally not be able to develop very powerfully in the presence of a strong immune system, now do so by taking advantage of a weakened immune system. Other infections are caused by germs that most healthy humans carry and can deal with but to which people infected with HIV are vulnerable. One or more of these opportunistic

infections, and not HIV itself, is what eventually kills a person with AIDS.

Common questions about HIV/AIDS

The following sections cover frequently asked questions about HIV/AIDS.

Is there a cure for AIDS?

There is no cure for AIDS. No vaccine has been developed to inoculate people against the virus and no medicine has yet been formulated to kill the virus in people who are already infected. Doctors and scientists can temporarily treat most of the opportunistic diseases such as pneumonia, and have also developed a variety of medications that delay the onset of symptoms, prolonging the lives of people infected with HIV. Those drugs have improved the quality of life for people with HIV, but they are not cures. They are also very expensive. Many of them are not yet even available in public sector health facilities in Africa.

Will everyone who is infected with HIV develop AIDS and die?

It is unclear whether everyone who is infected with HIV will develop AIDS. There have been occasional stories of individuals who have apparently been diagnosed with HIV who have eventually been declared clear of the disease. But there is considerable doubt about whether the initial diagnoses were accurate, and researchers estimate that a very high percentage indeed of HIV-infected people will develop AIDS, and that eventually, people with AIDS die of one or more of the opportunistic infections that invade their bodies.

When are people with the virus infectious to others?

People with HIV are infectious to others as soon as they are carrying the virus, even before antibodies are produced. People with HIV may not know they are infected and may look, act and feel healthy for a long time, possibly longer than ten years. It is *impossible* to tell from looking at a person whether or not they are infected. Knowing a person well does not tell you anything about their HIV positive or negative status.

How is HIV transmitted?

HIV is transmitted from person to person through blood or membrane contact involving blood, semen, vaginal fluids and breast milk. The virus can be passed on by:

- exchanging blood, semen or vaginal secretions during sex with someone who has HIV

- sharing circumcision knives and needles-which are used for injecting drugs (including steroids), tattooing or ear-piecing – with someone who has HIV
- being born to a mother who has the virus (HIV can be passed to a foetus through the umbilical cord while it is still inside the mother, through contact with vaginal fluids and blood during birth or through breast milk). At least 30 per cent of babies born to an HIV-positive mother develop AIDS.

HIV cannot survive in air, water or on things people touch. You cannot get it from:

- touching, hugging, talking to or sharing a home with a person who is HIV infected or has AIDS
- sharing plates, glasses or towels used by someone with HIV infections or AIDS
- using swimming pools, hot tubs, drinking fountains, toilet seats, doorknobs, gym equipment or telephones used by people with HIV infection or AIDS
- having someone with HIV or AIDS spit, sweat or cry on you
- being bitten by mosquitoes
- donating blood
- being sneezed at or coughed on by a person with HIV infection or AIDS.

What is 'safer sex?'

'Safer sex' describes a range of ways that sexually active people can protect themselves from infection with all sexually transmitted diseases, including HIV infection. Practising safer sex also provides birth control protection.

There are lots of ways for loving and sexual feelings to be shared that are *not risky*. Some of them include:

- hugging
- holding hands
- massaging
- rubbing against each other with clothes on
- sharing fantasies
- masturbating your partner or masturbating together, as long as males do not ejaculate near any opening or broken skin on partners.

There are other activities that are probably safe, such as using a latex condom for every act of sexual intercourse and deep kissing. However, having any kind of sexual intercourse without using a

condom is very risky. It leads to exposure to the bodily fluids in which HIV lives.

What about kissing?

There are no reported cases of people becoming infected with HIV just from deep kissing. It might be risky, however, to kiss someone if there is a chance of blood contact – if the person with HIV has an open cut or sore in the mouth or on the gums. It would be even more risky if both people had bleeding cuts or sores. People should use common sense and should wait until any sores or cuts have healed before kissing.

Why is sharing needles risky?

Sharing needles for injecting drugs, shooting steroids, tattooing or ear piercing is risky because blood from the first user often remains on the needle or in the syringe. It can then be directly injected into the bloodstream of the next user. So far, injecting drugs isn't as big a problem in Africa as it is in Europe and North America.

Of course, it is safest not to share needles and syringes, but, if shared, they should be cleaned between uses with bleach water. Bleach (such as 'Jik') kills HIV. The correct procedure for cleaning needles and syringes used for drug injections is: fill the syringes with bleach, then flush the bleach through the needle into a sink, toilet or container and repeat. Then fill the syringe or needle with water and flush the water through the needle into a sink, toilet or container and repeat this also.

Other risk factors

Other risk factors that expose people to HIV infection are STDs and traditional methods of circumcision.

STDs such as syphilis, genital herpes and chancroid greatly increase the rates at which HIV is transmitted. This is because, in part, the genital ulcers (or open sores) that the STDs cause provide the entrance for the virus to pass from an infected partner to another. If a person has an STD even with tiny invisible sores and has sexual contact with a person infected with HIV, it becomes very easy for the HIV virus to enter their body.

As the disease develops, HIV infection also makes people vulnerable to other infections like TB, malaria and infections causing diarrhoea. It also makes them vulnerable to other STDs, because the immune system is weakened. STDs must be treated immediately to reduce the chance of transmitting or contracting HIV infection.

Circumcision is the removal of the foreskin that is at the tip of the penis. This is normally done soon after childbirth or by some tribal groups when young boys experience physical changes in their bodies indicative of puberty.

The procedures carried out at a hospital are normally under very sterile and clean conditions. However, the more traditional rituals of circumcision involving many boys can be highly risky, as the same instrument may be used on a number of boys at a time. For such ceremonies, disposable instruments should be encouraged. Medical centres or clinics can provide advice on this kind of circumcision.

Proper clean circumcision procedures are an advantage for men. Uncircumcised men are at higher risk of contracting HIV than those who are circumcised. In a Reuters report (8 February 2006), it was reported that a US team in Uganda had found, in a reinvestigation of the data, that circumcision reduced the risk of HIV infection in men by 50 per cent and by 70 per cent in the highest risk men. Head of the US team, Dr Thomas Quinn, said that this could be because the inner lining of the foreskin carries cells vulnerable to the AIDS virus, and the lining is thin so that the virus finds it easier to penetrate. The same report says that the Ugandan study showed that circumcising men reduced infections in their female partners by 30 per cent.



Activity 5.4

(about 10 minutes)

Reflect on what you have read so far and answer the following questions in your learning journal:

- 1 What is the HIV infection rate in your country?
- 2 How many people die of AIDS per year in your country?
- 3 When is a person at risk of contracting HIV?
- 4 How can someone avoid contracting HIV?

If you don't know the answers to these questions, plan how you will find out.

As a youth development worker you have no doubt met people suffering from AIDS. It is important for you to recognise the symptoms of the disease in order that you may assist those who are suffering from it.

The clinical signs of AIDS

The two main clinical signs of AIDS are opportunistic infections and certain cancers. These can be treated by drugs, but as the immune system continues to weaken, the infected person responds less and less positively to treatment. Eventually, they will not respond at all to treatment, and death is the result of whatever infection happens to have occurred at that time.

Symptoms

The following may be symptoms of AIDS:

- excessive weight loss (greater than 10 per cent of body weight)
- cough for more than one month
- itchy skin rashes
- fever for longer than one month
- cold sores all over body
- diarrhoea for longer than a month
- shingles (on and off or all the time)
- thrush in the mouth and throat
- persistent severe fatigue
- swollen glands at two or more sites (excluding the groin) for more than three months.

Progression from HIV to AIDS

Once someone has become infected with HIV, it can take years to develop AIDS. Each individual will experience different opportunistic illnesses and responses to it. Since the problem is with a weakened immune system, there is no single pattern of the disease. The differences in responses to HIV infection and illnesses are therefore affected by the following factors:

- the mental and physical health of the individual
- the individual's lifestyle
- access to good medical care
- good eating habits, including a nutritious diet
- the degree of support from loved ones
- the natural resistance to disease by an individual (if a person has strong immunity it may take time for the HIV to completely destroy the immunity)
- the age of the host (for example in a young baby the immune system is not yet fully developed so the chance of a baby developing AIDS faster is high)
- the strain of HIV (individuals infected with aggressive strains will progress to AIDS faster)
- the social, economic and environmental conditions (people of low economic status, especially in disease endemic areas, may develop AIDS faster).

Treatment for AIDS

As we have already said, there is no known cure for AIDS. The management of AIDS therefore consists of providing early treatment of the different opportunistic infections. However, the underlying damage to the immune system persists and the person is likely to develop further opportunistic infections, though early treatment and positive living behaviours are known to help. Many HIV doctors now believe that provided a person with HIV receives effective anti-HIV treatment before the immune system has been severely damaged by the virus; and that a person takes their drugs properly and are able to tolerate them, then they could live a more or less normal life span.

Drugs used to combat HIV

There are several drugs that are used in HIV therapy; the best known is AZT. Anti-HIV drugs are most effective when taken in a combination of three or more at the same time. A number of vaccines are being developed world wide, and they may hold the best long-term hope. However, these are still in the testing stage and not yet available for use.

Most of the drugs that are currently available are very expensive and may have severe side effects. Young people, because of their poor economic position, are generally unlikely to be able to afford to purchase these drugs. Therefore, prevention is the only way to stop the spread of HIV.

The use of traditional medicine

The words *'we want them to stop the monopoly (of the drugs companies) and consider other forms of medicines'* that have been uttered by the prominent AIDS activist body 'Treatment Action Campaign' (TAC) draws attention to the need for us to recognise the widespread use of traditional medicines and the role of traditional healers in the fight against an epidemic that afflicts millions of youths. Additionally, traditional leaders play a vital role in providing primary health care for many families. This is particularly relevant to parts of Africa, Asia and Latin America, where cost, affordability and accessibility create huge problems for poor households.

WHO defines traditional medicines as:

'...health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illness or maintain well-being'.

AIDS prevention

At present, the only treatment available to all people, poor or rich, is prevention. In the absence of any scientific treatment, we must look

to prevention as the main strategy for overcoming this terrible disease for the immediate future. The most important way to prevent the spread of HIV is for people to ensure that their sexual behaviour does not put them and their partners at risk.



Activity 5.5

(about 10 minutes)

Having read through the unit so far, work through the following:

- List five common symptoms of HIV/AIDS.
- List four factors that determine responses to HIV infection and illness.
- Do AIDS sufferers in your community seek treatment from traditional healers or from clinics/hospital?
- What is the best way of preventing HIV?

The following reading presents one model being used in Melbourne, Australia for preventing the spread of AIDS by injecting drug users.



Turn to the readings section and Reading 10: 'AIDS Prevention and Health Awareness Program (APHAP)' by Mark Young.

Pay special attention to the strategies used by the APHAP and alliances between different agencies and individuals.



Self-help question 5.1

(about 5 minutes)

Having read Reading 10, suggest ways to prevent the spread of HIV, while acknowledging that people with HIV or AIDS sufferers, who are likely to be young, have a right to a satisfying sex life.

Compare your answers with those provided at the end of the unit.



Activity 5.6

(about 5 minutes)

Write responses to the following questions and issues in your learning journal:

- What HIV/AIDS prevention programmes exist in your country, region or community?
- What are the traditional medicines that are used in your village or another geographical area of your country to help fight the HIV/AIDS epidemic?
- What types of programmes do you think should be available to young people (if they are not already available).

If you don't know the answers to these questions, plan how you will find out.

This section on HIV/AIDS opened with a description of the global impact of HIV/AIDS. In the next section we will focus on the impact of HIV/AIDS specifically on young people, world wide.

HIV/AIDS and young people

The Y-RISE: The Service-Learning and HIV/AIDS Initiative provides the following compelling scenario.

‘AIDS is not an equal-opportunity disease. The statistical likelihood of contracting HIV varies with age, ethnicity, geographic region, gender, and socio-economic status. Youths, in particular, are profoundly impacted. For example, in 2001, 2.1 million new youth infections were reported worldwide, accounting for more than 40 percent of all new infections.’

We consider the impact from a global perspective and then in sub-Saharan Africa in particular.

Global perspective

The following facts are taken from the UNAIDS/WHO 2005 report, and associated reports:

- An estimated 40.3 million persons are living with HIV/AIDS. This means that 400 million people are affected in some way.
- The UN Declaration of Commitment on HIV/AIDS (2001), to which 189 countries were signatories, sought to reduce the rate of HIV infection among young people aged 15–24 by 25 per cent in 2005. In fact, in 2005 infections among young people have

actually increased and account for half of all new infections. 6000 young people aged 15–24 are being infected every day; they account for 11.8 million cases. Of those, 62 percent are female.

- An estimated 4.9 million people were infected in 2005, the highest jump since the first reported case in 1981. With an estimated 3.1 million deaths in 2005 (including 570,000 children), one can only fear for the estimate of the size of the death rate ten years or more from now.
- 55 per cent of those living with HIV/AIDS are estimated to be females between the ages of 15 and 49. As many as 60 percent of HIV positive women were infected before the age of 20.8.
- In 2005, children under age 15 accounted for 700,000 of all new infections, and youths aged 15–24 accounted for 45 per cent.
- 14 million children have been orphaned by AIDS worldwide.
- An estimated one million children are abducted or coerced into the sex trade each year, by age 13, making them extremely vulnerable to HIV infection. In India for example, about 200 girls and women enter prostitution daily, 80 per cent unwillingly.

As you will see from the next section, the HIV/AIDS problem poses a very serious challenge in sub-Saharan Africa, which needs to be addressed seriously.

In sub-Saharan Africa

The prevalence and effect of HIV/AIDS vary from one African country to another. However the general picture is that:

- HIV and AIDS have hit Sub-Saharan Africa harder than any other region, with AIDS the leading cause of disease. The average life expectancy is now 47 years when it would have been 62 years without AIDS.
- Though it only has 11 percent of the global population, the region accounts for 73 per cent (29.4million) of all people living with HIV/AIDS.
- In Africa there are twelve countries in which more than 10 per cent of the adult population is infected with HIV. Countries in Sub-Saharan Africa have the highest adult HIV prevalence, including Swaziland (33.4 percent), Botswana (38.8 percent), Zimbabwe (33.7 percent), Namibia (22.5 percent) and South Africa (20.1 percent).
- The region has an estimated 29.4 million persons living with HIV/AIDS. Youths aged 15–24 account for at least 32 percent of those cases.
- South Africa has 5 million people living with HIV/AIDS, the largest infected population in the world.

- In countries such as Cameroon, Central African Republic, Equatorial Guinea, Lesotho, and Sierra Leone, more than 80 percent of young women aged 15–24 lack adequate knowledge about HIV prevention.
- It's estimated that more than 60 percent of 15-year-old boys in Botswana, South Africa and Zimbabwe, will become infected with HIV during their lifetime.
- In Africa, the HIV infection rate for women is at least 1.2 times that of men.
- More than two thirds of Sub-Saharan Africa's newly infected 15- to 19-year-olds are female.
- Young girls have infection rates between five and six times higher than boys of the same age group.

(Source: YES HIV/AIDS Fact Sheet, June 2004)

Now let's examine briefly the general impact of HIV/AIDS on young people, using broad categories for the purpose of simplification, namely demographic, socio-economic, education, and psychological.

Demographic

A major consequence of the HIV/AIDS pandemic is the increase in the number of orphans whose prospects for school and other support are thus compromised. The UNAIDS/WHO report of 2005 claims that fourteen million children have been orphaned as a result of AIDS. The disease most threatens the economically most productive groups, who are also the most sexually active groups and the ones most likely to have children who become orphans. Lack of parental care and support causes these orphaned youths to engage in risky behaviours with serious consequences for health. They fall into an unforeseen cycle of poverty and health risks.

Socio-economic

It is evident that HIV/AIDS will cause many more serious socio-economic health losses to communities and countries. Because those affected are usually in the most productive age groups, many having received education and training, the ones who succumb to the disease are a serious loss of expensive human capital in economies already struggling with the problems of lack of capital formation. Their skills, knowledge and energy will simply be lost. With such losses, it will be extremely difficult for some towns and villages, and certainly families, possibly even whole countries, to manage their economic and social activities. It looks highly probable that young people will suffer badly in this situation: they are easily the most vulnerable group.

The economic impact of HIV/AIDS on youth is grave. Young people who lose their parent/s (the only or main bread winners of the family) to the disease, are forced to leave school early and to seek low-paid or dangerous employment in order to meet medical expenses as

well as provide the basic needs of their families. Ultimately, poverty levels of such families will increase seriously. Young people (especially young girls and women) will seek alternative incomes through the sex industry, which will undoubtedly increase their own vulnerability to HIV/AIDS. Additionally, youths who are infected with HIV/AIDS are further faced with the problem of unemployment: this is a particular problem in developing countries where agriculture is a major economic pillar and farm labour is vital to production.

Concern (Feb 2006) says that its own research proves that poverty is one of the main drivers of the HIV epidemic, and that the disease is also increasing poverty, reversing human development, worsening gender inequalities and eroding the capacity of governments to provide essential services.

Education

According to Concern (2006), the disease has been a major factor in the collapse of education, health and social support services in the worst affected countries. Many teachers and administrative officials have become victims, and young men and women affected by HIV/AIDS are often forced to leave school and in so doing lose the opportunity to receive an education that will empower them for life. Reasons for school drop-out include having to care for the elderly who are infected with HIV/AIDS, lack of finances in the households and the pressure to seek employment to maintain the home and family members.

Psychological

Young people who are infected with HIV/AIDS or who have family members infected with the disease often suffer from emotional concerns about peer acceptance, low self-esteem, and their future. In more ways than one they feel ostracised (excluded) by society, especially in places where there is lack of public education on HIV/AIDS.



Self-help question 5.2

(about 30 minutes)

Discuss the following statement with others (your tutorial group, co-workers, health care workers, family and friends) and make notes in your learning journal.

‘All people with AIDS should be isolated so that HIV/AIDS is less likely to spread.’

Compare your answers with those provided at the end of the unit.

We have looked at the impact of HIV/AIDS on young people in general. Let's now examine the HIV/AIDS problem in terms of gender.

HIV/AIDS and gender

HIV/AIDS is not a socially neutral health problem. World-wide, women made up slightly less than half of the 37.2 million adults living with HIV/AIDS in December 2004 (UNAIDS/WHO AIDS epidemic update 2004), but their numbers are rapidly increasing, and in sub-Saharan Africa 60 per cent of the adults living with the condition are women. The risk is greatest for young women aged 15–24 who are three to four times more likely to be infected than men.

One of the root causes of its uneven distribution lies in the unequal balance of power between the sexes, a balance of power that badly disadvantages women, particularly in some cultures.

For example, it is widely recognised in Africa that the behaviour of men is directing the advance of the HIV/AIDS epidemic. Due to lack of social and economic power, many women and girls are unable to negotiate relationships with men based on abstinence, faithfulness and use of condoms (see Module 5). Men are expected to be more promiscuous than women. They are able to use violence against women to exploit sexual relations because the practice is still widely accepted. An article on Ghanaweb (3 January, 2006) notes the *'cultural practice, which gave men the exclusive right to decide when, how and why to have sex with women in or out of marriage.'* This is reinforced by women's economic dependence on men. The Ghanaweb article claims that it is estimated that in Ghana for two out of ten women, their first experience of sexual intercourse has been by force.

Women are also physically more susceptible to HIV infection than men. The WHO factsheet 'Human rights, women and HIV/AIDS' argues that coerced sex, from rape to cultural/economic obligations to have sex even when women don't want it, increases the risks of microlesions that are therefore potential access points for HIV-carrying body fluids. Women do not have the power, in poor countries particularly, to compel men to use condoms, and the men are usually culturally expected to be 'macho' enough not to need to look after their own sexual health and hygiene.

In some villages of Uganda, focus group discussions revealed that not a single woman had seen a condom. Further:

'a behavioural survey in Tamil Nadu in India revealed that 82 per cent of the male STD patients had had sexual intercourse with multiple partners within the preceding months and only 12 per cent had used a condom. Data from the same country revealed that 90 per cent of the male clients of male sex workers

were married. In South Africa 71 per cent of the girls had experienced sex against their will’.

(Nath, 2001)

These inequalities have contributed significantly to increasing vulnerabilities among women to HIV/AIDS. Discrimination, combined with the belief that men are superior, denies women opportunities, resources, dignity, respect and decision-making powers at all levels of society, in homes, organisations, communities and nations.

Of course, the picture changes all the time and there is evidence that increased funding and increased international commitment are breaking down barriers in a number of countries. So there is cause for you to feel that you can become part of a programme that will eventually enable us to deal with the problem.

The following case study demonstrates the gender perspective of HIV/AIDS.



Case Study 5.1

A story of an HIV-infected woman

Twenty-nine year old Nnini is a newly recruited cleaner at a government institution. After she lost both her mother and father, she decided to migrate to the city in search of work. She was soon hired, but on very poor pay. She met a fairly rich man, Henry, who was willing to take care of her basic needs. Nnini could not resist the temptation of living in a big, well-furnished house with a boyfriend. He was her first partner. She then moved out of her little room in her uncle’s house to stay with Henry.

One day she began to notice sores on her body. Little did she know she was infected with HIV. She thought her body sores might be normal. After a few days, she realised that more sores were appearing. She started worrying and thought endlessly about going for a test. However, she was not confident enough to face voluntary testing. She got weaker and weaker until she was finally persuaded by a friend to go for the test. After three months, she plucked up the courage to go. She was diagnosed HIV positive. Her days were darkened when she learnt about the results. She was not able to afford the drugs on her own. She felt her future possibilities were bleak, and her life had changed drastically. She no longer enjoyed the company of her friends. She spent days and nights thinking about orphanhood and especially of her mother. She decided to break the news to Henry, who was furious and accused her of promiscuity. He evicted her out of his luxurious house. There was nowhere for her to go except to her uncle, the only close relative she had. She decided to break the news to him as well, hoping that he would sympathise with her situation, but he too was furious. He accused her of irresponsibility, carelessness and promiscuous behaviour. He told her to rent a house

somewhere far from where he lived. He ordered her to stop using his surname, as she had been a disgrace to the family. She was devastated. The man she thought so highly of had cut her off and even changed his address. She felt miserable and rejected.

After some time, Henry got married to one of Nnini's best friends. They have two children, both of them diagnosed HIV positive. The last Nnini heard was that both Henry and his wife had left employment because of ill health and were on anti-retroviral drugs.

(Taken from 'Gender Sensitive Approaches to HIV/AIDS Training Kit for Peer Educators.' Commonwealth Secretariat, 2004)



Activity 5.6

(about 5 minutes)

Having read through the case study, answer the following questions in your learning journal:

- Have you come across such a case in your community?
- How can women avoid such situations?
- What lessons can be drawn from this case study?

You may have included the following lessons in your answer to the last question.

- Women are more susceptible to HIV than men.
- It is important to recognise the symptoms of AIDS.
- It is necessary and important to test for HIV/AIDS.
- Stigma is a very serious challenge in the management of HIV/AIDS.

It has been mentioned in an earlier section that HIV/AIDS can have a serious psychological effect on sufferers. The case of Nnini illustrates this point. However, you should know from your experience that it is possible and encouraged to live positively. In the next section we explain how this can be achieved.

Living positively with HIV/AIDS

When people learn that they are HIV-positive, common reactions include shock, anger, anxiety, helplessness, guilt, depression and sometimes suicidal feelings. As time passes these feelings may fade or reduce in intensity. However, in some people these negative feelings persist.

Living positively with HIV/AIDS means developing a positive attitude towards managing the disease. Counselling services are very important in promoting positive living.

HIV/AIDS counselling

Counselling is an interactive process – a dialogue between a client and a counsellor – aimed at enabling the client to cope with psychological, physical or spiritual stress and to take personal decisions related to HIV/AIDS.

Counselling has both preventive and supportive goals. It aims to assist clients live more satisfying lives by providing psycho-social support to those affected by HIV/AIDS and to prevent HIV/AIDS infection and its transmission to others. However, in order to benefit from counselling, women will have to overcome the socio-cultural barriers (for example being constrained from talking about sex and sexuality) that have often prevented them from opening up communication with clinicians and counsellors. Now let's examine the different aspects of HIV/AIDS counselling.

Basic elements of counselling

If you have been involved in counselling before, you may know that the following are the key components:

- **Assessment:** this helps to determine how help can best be provided through youths' articulation of their concerns: the reason they have come, the context in which the difficulty has arisen, how they feel about being there, and what they hope to achieve. The counsellor should seek throughout to enable the young people to articulate their feelings, as this is often the most crucial difficulty they have, and the most neglected aspect of motivating them.
- **Asking predominantly open-ended questions** designed to explore their feelings and their constructions of their state of health will help the young people reflect upon their situations. That willingness and ability to reflect upon the situations they are in will help them come to terms with the state of being infected. An understanding of the root social and psychological causes of their becoming infected and the mental states accompanying the condition will help stimulate them to positive action, as will knowledge of the growing success of such programmes as the '3 by 5' programme for anti-retroviral treatment (WHO, December 2004) which can be introduced to them through counselling. (The '3 by 5' programme intended to treat 3 million people in low- and middle-income countries for HIV/AIDS by the end of 2005.)
- **Accurate information** is needed to enable them to explore options related to their identified needs. This will counter any aspect of the widespread misinformation they are likely to have been subject to.

- Support is vital for them in helping them make decisions, and includes consideration of the implications of any decisions on the young people themselves, and family and friends.
- Referral to agencies where the young person can get additional assistance is likely to be necessary: for example, a medical examination, psychological testing, or a social service where such services are available. Obtaining the agreement of the young person is important and special care is needed so that the youth does not feel personally rejected.

(Adapted from WHO, 1999, 'Programming for Adolescent Health and Development', WHO Technical Report Series.)

Counselling is more effective when it is done with specific objectives and by people with appropriate qualities. You will read more about these issues in the next two sections.

Specific objectives of counselling

The specific objectives of counselling include assisting clients to:

- address and resolve specific problems
- make their own informed decisions
- cope with a personal or family crisis or life-threatening events
- understand their position
- work through feelings and inner conflicts
- improve relationships with others
- consider the range of possible alternatives.

Qualities of a counsellor

The required qualities of a counsellor include:

- knowledge and skills of the counselling process
- knowledge about the issues that they will be dealing with
- ability to transcend one's moral and religious convictions in an effort to understand and empathise with HIV/AIDS victims, rather than become judgemental
- knowledge about personality development
- self-awareness and understanding.

The relationship between a counsellor and client is very important. The key attributes of a good counsellor include: empathy (the ability to understand and imaginatively enter into another person's feelings, as opposed to sympathy in the sense of compassion or sharing another's feelings), respect, acceptance, caring, genuineness and good judgement.

Counselling should take place in an atmosphere of empathy (not sympathy) trust and understanding. It should seek to assist clients to define the nature of the problems they are facing and make realistic decisions on how to cope with or reduce the impact of those problems.



Turn to the Readings section and read Reading 11: 'Advice to AIDS sufferers', by the module authors. You might find this information useful if you are working with someone who has AIDS.



Activity 5.7

(about 5 minutes)

Having read through Reading 11, answer the following:

- As a youth development worker, how can you assist people with HIV/AIDS to live positively?
- How difficult do you think it would be for young people in your region to live positively with HIV/AIDS? Why?

Write your responses in your learning journal.

In addition to counselling services, there should be an enabling environment in relation to the health care of people living with HIV/AIDS. It is particularly important for AIDS sufferers to have easy access to medicines.

Access to medicines

Following the commitment of the G8 members (the rich states) and then the heads of government and states at the 2005 UN World Summit, the UNAIDS Secretariat and their partners have been engaging in consultations to define the issues involved and to create a framework for 'universal access to HIV/AIDS prevention, treatment and care by 2010.' However, presently less than 20 per cent of those who need it have access to such treatment.

Free market initiatives alone are not enough and government health services must provide the essential provision and distribution of anti-retroviral medications to young people who are victims of HIV/AIDS. Only this will dramatically decrease their vulnerability.

Currently, such access is still a dream for many youths (particularly girls and young women) living in Asia, Africa and the Caribbean; but as Nath (2001) showed, access to health services increases the hope and self esteem of women living with HIV/AIDS. To this end, many households seek the assistance of traditional healers; hence the need for national legislation and regulation as a means of control and to ensure public safety.

While counselling and medicines are important for people living with HIV/AIDS, there is an additional need for broader strategies at

national level, to mitigate against the effects of the disease. The next section looks at this.

Strategies at the macro-level

Because vulnerability to STDs and particularly to HIV/AIDS is a manifestation of a number of political, social, economic and cultural factors (for example, increased poverty caused by structural adjustment policies, increasing globalisation, lack of political will and commitment, budgetary constraints, power relations between men and women, and cultural traditions) there is a profound need for intervention at the macro level. Chief among these kinds of intervention are the formulation and implementation of a national policy and action plan, involving education, health and other social agencies.

National policy

Formulating and implementing a national policy and action plan to combat the causes and consequences of HIV/AIDS requires a wide range of resources (financial, technical, human). These in turn are determined to a large extent by political will and commitment, as can be observed in Uganda.



Case Study 5.2

The Ugandan response to HIV/AIDS

After the first HIV/AIDS case was identified in 1982, there was a very ineffective response by government, so that by 1992 the national prevalence rate had soared to 18 per cent. In recognition of the socio-economic implications of HIV/AIDS, the Government of Uganda adopted a multi-sectoral approach to the control of AIDS in 1990. The multi-sectoral policy and strategy stipulates:

‘All Ugandans have individual and collective responsibility to be actively involved in AIDS prevention and control activities, in a coordinated manner, at the various administrative and political levels down to the grassroots level’

At the national level, programmes have been developed to enhance and/or revive action in specific spheres. Examples include the ‘Scale-up Plan’ and the ‘Political Mobilisation Strategy’.

One of the principal outcomes of this policy is the establishment of the Uganda AIDS Commission (UAC), which has overall responsibility for collaborative planning, and monitoring and evaluation of the national response to the policy. Key stakeholders are periodically brought together to identify priority areas for the national programme and for particular aspects of the response to the

programme. This is to ensure that all the agencies involved have a shared perspective and that they are focusing on common problems. The intention is also to promote ownership of the national programme by the various stakeholders. Besides the UAC, other lead sectors also develop programme priorities that are largely funded and implemented under the aegis of particular Ministries.

The UAC has then, since 1992, spearheaded the development of a Multi-sectoral Approach to the Control of HIV/AIDS (the MACA), a national policy that has served as the basis for developing periodic national program priorities and implementation mechanisms. The National Operational Plan (NOP) for STI/HIV/AIDS Activities 1994–1998, guided the response to sexually transmitted disease for that period; the National Strategic Framework (NSF) for HIV/AIDS Activities 1998–2000, succeeded the NOP. The NSF 1998–2000 was revised in 1999/2000, to become the NSF 2000/1–2005/6. The Mid-Term Review (MTR) of the current NSF 2000/1–2005/6 was conducted between October and December 2003. The findings of the MTR informed the revision of the NSF to reflect slightly changed priorities for the remaining period of implementation. The revised NSF 2004–2006 has been disseminated to all stakeholders at national and lower levels.

The stakeholders in the fight against HIV/AIDS include local and international civil society organisations, faith-based organisations, organisations of People Living with HIV/AIDS, development partners and the private sector, as well as several hundred community-based organisations. Districts and communities have also taken new initiatives and supported them. In most cases they also support the implementation of initiatives by national level stakeholders.

Uganda's response to the country's devastating HIV/AIDS epidemic in a resource constrained setting has been acclaimed as a global model. It is especially recognised that Uganda's modest achievements in fighting the epidemic cannot be attributed to a single stakeholder or even a cluster of stakeholders but to the collective efforts of all the agencies. Great emphasis is therefore put on the co-ordination of the activities of all the participants spearheaded by the UAC. It is this co-ordination that has ensured that there is a harmonised focus on common goals, that duplication of provision is seriously reduced and that equity in service delivery is ensured.

Interest in Uganda's programme resulted from the 1995 announcement of a decline in the national HIV prevalence rates. The announcement brought a lot of international focus on Uganda's approaches and interventions, especially on the adopted HIV prevention approach, the ABC (A=Abstinence, B=Being faithful to one partner, C=Condom use). By the end of 2002 the national prevalence rate was estimated to have fallen to an average rate of 6.2 per cent of the total Ugandan population.

(Source: Uganda AIDS Commission, National AIDS Documentation and Information Centre)



Activity 5.8

(about 15 minutes)

Read through the Ugandan case study again and answer the following questions:

- 1 Does your country have a policy and strategy/plan of action to address the problems of HIV/AIDS? If it does, how effective do you think it is? If your country has neither policy nor strategy, what do you think could be included if a policy or strategy/action plan were to be developed.
- 2 What important lesson have you learnt from the Ugandan case study?

Write your responses in your learning journal.

In Units 1 and 4 particularly, the role of education in youth development and reproductive health has been highlighted. You will see from the next section that the importance of this subject is recognised at a high level in the Commonwealth, especially with regard to addressing the challenge of HIV/AIDS.

Education

The role of education is implicit in the following statement made by Ministers of Education of Commonwealth Small States.

- We, the Ministers of Education of Commonwealth Small States, have met at Stoke Rochford in the United Kingdom on September 2nd, 2004 to consider the current and potential impact of HIV/AIDS in our countries and the role of education in addressing this serious issue. It is one that threatens to undermine the efforts of many Commonwealth member states to attain the Millennium Development Goals for education.
- We recognise that education and research are critical tools in the struggle to contain the spread of HIV and AIDS. Education must contribute substantially to our National AIDS Strategies and work closely with the health and other sectors in our countries.
- We reaffirm the commitment made by Commonwealth Education Ministers in Edinburgh last year 'to include compulsory age-appropriate HIV/AIDS education in the curriculum of every education system within the Commonwealth, including teacher education'. It is our aim to ensure that in every educational institution our students will be given information and services necessary to develop attitudes and skills that will reduce vulnerability to HIV infection. Parents should be involved in planning the provision of such education.

- We are concerned to protect access to education of children and older learners affected by HIV/AIDS, whether they are themselves directly infected, or are in a situation where their opportunity for participation in education may be adversely affected by the incapacity or death of family members because of HIV/AIDS. We shall endeavour to provide the necessary support mechanisms to schools and families to make possible the retention of affected learners in education.
- We pledge to extend parallel support to teachers and other education employees wherever possible, to make it possible for those directly and indirectly affected by HIV/AIDS to continue to work in schools and colleges as long as they are able beneficially to do so.
- We intend that all our future education sector plans and policies shall take full account of the impact of the HIV/AIDS epidemic and the necessity to mobilize education programmes to combat it. This includes preparing projections of learner enrolment and teacher supply that reflect the latest expectations of retention and loss due to HIV/AIDS.
- Education by itself cannot resolve the issues posed for our societies by HIV/AIDS, but it has a major contribution to make. We recognise that other sectors have an important part to play, and that our societies as a whole may need to face up to a variety of often-ignored sensitive issues including cultural practices, drug abuse, sexual behaviour of young people in particular, the sex service industry and so on.

Unit summary

In this unit, you have covered the following points:

- the critical aspects of sexual and reproductive health
- sexually transmitted diseases (STDs) and ways of preventing them
- HIV/AIDS, the difference between them and the issues of transmission, risk and 'safer sex' and the question of treatment by drugs and use of traditional medicines
- the impact of HIV/AIDS on young people from a global perspective and specifically in sub-Saharan Africa
- HIV/AIDS and gender and ways in which gender inequalities can increase risks for women
- living positively with HIV/AIDS, discussing the importance of HIV/AIDS counselling and access to medicines
- the need for strategies at the macro level in terms of national policy and education.

To check how you have got on, look back at the learning outcomes for this unit and see if you can now do them. When you have done this, look through your learning journal to remind yourself of what you have learned and the ideas you have generated.

You are now ready to advance to Unit 6, the final unit in this module, in which we discuss issues related to mental health and drug abuse.

Answers to self-help questions

Self-help question 5.1

Catholic priests, monks and nuns have generally shown that a life without sexual partners is a feasible option and can be a satisfying existence, but this is unlikely to be acceptable to most people.

Again, while it is possible to achieve a certain measure of satisfaction from masturbation, and there are ways in which it is possible to develop enjoyable ways of having non-penetrative sex, penetrative sex is clearly what most of us need to fulfil our basic needs, particularly when we are in the most potent reproductive stage of our lives – youth.

The only real protection that a person with AIDS can give to their partners is to engage only in penetrative sex if it is with protection. The best protection is the high-quality condom, used on the penis and/or the tongue. This is particularly important for workers in the sex industry.

Self-help question 5.2

Isolating people with AIDS was an early response in Britain and parts of America by some people living near AIDS victims. They were worried by the lack of information and not knowing whether the virus could be spread by touch or through the air.

In fact, because HIV does not survive very easily outside the body, it *cannot* be transmitted by casual contact at work or in school, such as touching other people or breathing the same air. It does not spread through toilet seats or in water, through sharing food or drink, nor do insects such as mosquitoes carry it.

It could be argued that isolating people with AIDS is a violation of human rights. There is an additional danger. If people outside the AIDS-infected group feel that they have somehow managed to eliminate the risk, an atmosphere of complacency could develop. Despite their lack of symptoms, many of them could already be HIV-infected, but living in a false sense of security that the problem has been isolated away from society. By living with the consequences around us, and trying to understand it as a socially constituted phenomenon, we may have a much better chance of preventing its advance.

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Unit 6: Mental health and drug abuse

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Unit introduction

Welcome to Unit 6 *Mental Health and Drug Abuse*.

In Unit 1, we examined the concept of health as a social resource distributed along lines of culture, social structure and wealth. In Unit 4, we examined various aspects of sexual and reproductive health. In this unit, we will build on what was explored in these two units. We shall begin by briefly discussing the problems of mental health that affect young people today, and examine aspects of health resulting from and relating to substance use and misuse.

We will also examine a health-related phenomenon that is also structured along socio-economic and cultural lines but concerns a powerfully subjective aspect of deviant – health-related behaviour.

In order for you to be able to intervene, actively and productively, in people's health-related behaviour, it is crucially important first to understand the social and psychological reasons for deviant behaviours, for example the misuse of an illegal substance. The reasons may well vary between individuals and between groups within a society.

Unit learning outcomes

When you have worked through this unit, you should be able to:

- identify the causes and symptoms of poor mental health
- describe the steps necessary to improve your mental health
- identify the symptoms of deviant behaviour that affects young people's health
- define drug and substance abuse and identify the common drugs and substances abused by young people
- identify types of drugs abused by different categories of young people
- list the general factors that contribute to drug and substance abuse among young people
- identify the problems associated with drug and substance abuse and the relevant prevention and support schemes.

What is mental health?

In the introduction to Unit 1 it was mentioned that mental health is an important aspect of our 'complete health'. Like physical health, mental health is important throughout the life-span, and is partly affected by nutrition, as discussed in Unit 3.

Unfortunately, many youths are diagnosed with mental illness. Mental health affects the way youths think, feel and act, including the ways they view themselves, their lives and others in their lives. You may also recall that psychological needs feature in Maslow's hierarchy of needs, which you looked at in Module 1.

Before we explore various aspects of mental health we need to be clear about what we understand by the term. We will therefore begin by defining mental health.

A state of mental health is 'the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity.' (Source: Fountain House.) Mental health affects the nature and quality of an individual's thoughts, feelings and actions, particularly when faced with life's challenges and stresses. It is not simply confined to the absence of mental health problems. Although different cultures have differing expectations for health, many of the following characteristics are likely to be present in individuals with good mental health:

- a sense of well-being and contentment
- a zest for living – the ability to enjoy life, to laugh and have fun
- resiliency – being able to deal with life's stresses and bounce back from adversity
- self-realisation – participating in life to the fullest extent possible, through meaningful activities and positive relationships
- flexibility – the ability to change, grow, and cope with a range of feelings, as life's circumstances change
- a sense of balance in one's life – between solitude and sociability, work and play, sleep and wakefulness, rest and exercise, etc.
- a sense of well-roundedness – development of mind, body, spirit, creativity
- the ability to care for oneself and for others
- self-confidence and balanced self-esteem.

Steps to improve your mental health

As in the case of nutrition, there are certain things we all need to take, do or avoid in order to improve our mental health. These include the following:

- Get enough rest.
- Eat a balanced diet.
- Avoid excessive caffeine and alcohol.
- Avoid tobacco and other drugs.
- Engage in physical exercise.
- Perform a healthy activity that you enjoy and that is relaxing (e.g. go to a good movie, take a walk on the beach, listen to music, read a good book, talk to a friend).
- Attend to your spiritual needs by meditating, praying, or appreciating nature.
- Make a list of the things that are troubling you; then fold it and put it away for the rest of the day.
- Prioritise your challenges and deal theoretically with the ones that are either most stressful or easiest to check off the list.
- Be sure to spend ample time with people whose company you enjoy, generally those who have an upbeat and positive attitude.

(Source: <http://www.helpguide.org/about.htm> – 1996–2005)

Youths with mental disturbance need to be encouraged to discuss their problems with their parents/family and any informal support group, and to visit community centres with health support services, such as counselling. Especially during the adolescent stage, young people may be faced with serious emotional problems and need people to recognise this and respond in a positive rather than negative way.

Medical research suggests that there is a direct relationship between mental disorder, deviant behaviour and drug abuse, all of which are discussed further in this unit. In particular, young people with mental disorders often use drugs that they know are mood-altering, a consequence of which is that these also distort their judgement.



Activity 6.1

(about 15 minutes)

- 1 Is mental health an important health issue in your country?
- 2 Out of the list of steps you need to take to improve your mental health, which ones do you think are the most important and why?
- 3 Does your country have a system or facilities specifically designed to help with mental health victims? If so, briefly describe them.

Make notes in your learning journal in answer to these questions.

Self-abuse and deviant behaviour

Is self-abuse a form of deviant behaviour? Whether or not acts of self-abuse are considered deviant behaviour depends on the norms of the culture. Deviant behaviour is that which differs from normal behaviour within a society or culture. Acts of self-abuse can of course be quite normal for large social groups, as for example the eating habits of some people in developed countries, where over-eating has led to serious obesity and the consumption of large quantities of animal fats and protein has led to increasing rates of heart disease.

Some forms of self-abuse may be considered normal within certain sub-cultures, for example the widespread use of cocaine among rich young Californians, or the use of betel nut in the Solomon Islands. Although these examples are considered normal behaviour within the sub-group, they still constitute a health risk.

It is not helpful to call the over-eating habit found in developed countries deviant, since it is accepted as normal by the society at large. On the other hand, we should be concerned about it from the point of view of primary health care. There can, however, be deviant individual acts of overeating and drinking, for example when somebody becomes bulimic or alcoholic.

Because these types of abuse are deviant, even though they are little more than variations of social norms, they suggest a need for special support for young people, and can be partly understood as issues within the sociology of deviance, and partly as issues within the social psychology of the self.

Understanding the issues

Taylor *et al* (1975) argued that there were seven issues that need to be addressed when attempting to understand deviant behaviour:

- 1 the immediate origins of the deviant act – why those who commit deviant acts think that they do compared with those who do not
- 2 the wider origins of deviant acts – examining deviant behaviour against the overall social context of inequalities of power, wealth and authority (remember the structural conflict perspective?)
- 3 the social dynamics surrounding deviant acts (remember the conflict interactionist perspective?)
- 4 the immediate origins of social reaction to deviant acts such as the moral climate and the influence of these reactions on those who do deviant acts
- 5 the wider origins of the reaction to deviant acts – do societies ensure that acts that threaten them are categorised as deviant?
- 6 the outcome of social reaction to deviance on the deviant's behaviour – how far does this help to construct more deep-seated deviance?
- 7 integration of these first six issues into:
 - (a) a political economy of deviance
 - (b) a social psychology of becoming deviant
 - (c) an understanding of the social dynamics of societal reactions to deviance.

All this may seem to be a long way from analysing youth health, but if health is socially constituted, then we really do have to make this kind of social analysis. You are likely to have to deal with it at the face-to-face level where the central issues are the psychological processes that are taking place. Self-abuse of any kind is a subjective issue in that the behaviour, although perhaps meaningless to an outsider, has meaning to the person involved, and is usually a question of the way the young person feels about herself and her social relationships. That in turn is rooted in the broader processes taking place in society. Young people who are poor, with uncertain prospects of joining the respectable adult world (and there must now be many such people in the big cities and also in countrysides dominated by rural elites), are extremely vulnerable to the lure of drugs of any kind.

The youth development worker can intervene, by exploring the meaning of the act for the deviant young person, but enabling the person in trouble to see her act from a broader perspective: to see that there are alternative sources of self development and self-fulfilment in collective action. The youth worker also is the best person to mediate

between an offended and threatened community and the young deviant.



Activity 6.2

(about 15 minutes)

The following questions look at how your community/society reacts to behaviour associated with drug use.

- 1 Are there any drug-related behaviours that are considered normal, but a health risk, e.g. smoking?
- 2 What drug related behaviours are considered deviant and a health risk, e.g. heroin abuse?

What strategies would you suggest to intervene in each case above? Describe a team of at least three (including yourself) that you would like to work with.

Explain the roles of each and how you could work together.

Write a response in your learning journal.

Drugs use and abuse by young people in different regions of the Commonwealth is common, as you will see from the next section.

What is drug abuse?

Before we look at the common drugs used by young people, we will explain the meaning of drug abuse in the context of this module. Drug abuse refers to repeated, non-medical use of potentially addictive chemicals and organic substances (Mburu, 1995). These substances are taken for various reasons:

- to relax the mind
- to be accepted by peers
- to relieve pain
- to induce sleep
- to alter feelings
- to boost morale and/or courage
- to make oneself happy
- for pleasure
- to experiment or have an experience of taking drugs.

More often than not, the subject of youth comes up parallel with drug abuse. As the UN World Youth Report 2003 notes, 'it is during the younger years that most substance use begins'. All youths, whether in

or out of school, employed or unemployed, and from all social and economic backgrounds are affected to some degree.

The drugs abused by young people vary from country to country, and choice is determined by various factors such as availability, cost, acceptability, easy access, perceived benefits. For example in Kenya, the most commonly abused drugs among youths are *khat*, alcohol, tobacco, cannabis (*bhang*), cocaine, heroin, glue and petrol (Mburu, 1995). In the Southern African region the most commonly abused drug is alcohol, followed by cannabis, *jenken* (glue) and *mantras*.

Common drugs

The common drugs reported to be used by youths are: alcohol, tobacco, *mantras* (methaqualone), sedating pills, stimulating pills, marijuana (*bhang* or cannabis), cocaine, heroin, *khat* (miraa), petrol and glue (*jenken*).



Activity 6.3

(about 10 minutes)

Identify four drugs that are commonly used by youths in your community/ country/region. Compare your list with the one above.

What do you think are the reasons for this wide use of drugs?

Make notes in your learning journal.

The following case study shows how widespread the problem of drug abuse is among young people in Commonwealth countries. You will notice that it is a problem that affects school children and university students as well.



Case study 6.1

Alcohol and drug abuse among youths.

Alcohol and drug abuse among youths is an increasing problem in many Commonwealth communities. Studies in the Commonwealth regions show that drug abuse is widespread among youths in and out-of-school and university. In Kenya, for example, one study showed that 21 per cent of children aged 10–14, 44 per cent aged 15–19, and 20 per cent of youths aged 20–24 smoked marijuana or *bhang*. (Mburu 1995).

In Zimbabwe, a study conducted on alcohol use among students at the University of Zimbabwe showed that 75 per cent of the students took alcohol regularly, and that alcohol drinking is associated with the use of other drugs. In another study of 421 secondary school students aged 16–19 in Zimbabwe, about a third reported using cannabis and about a tenth reported using inhalants.

Sinyani (1995) reported that in Namibia cannabis is mainly abused by children and youths in the 11–24 age group, and in Zambia youths sniff a new drug, *jenken* (Lungwangwa *et al*, 1996).

Cannabis, which is one of the commonly abused drugs, is grown illegally, distributed and trafficked in most of the Southern Africa countries (Botswana, Lesotho, Malawi, Namibia, South Africa, Zambia and Zimbabwe). Most of the cannabis grown in these countries is consumed by youths. For example, it is estimated that a fifth of the cannabis produced in Malawi is used at a domestic level by unemployed youths.



Activity 6.4

(about 15 minutes)

Reflecting on the above case study, answer the following questions in your learning journal:

- 1 Of the drugs you listed in Activity 6.3, which is the most abused in your community or country?
- 2 Is drug abuse a serious problem among school children in your country?
- 3 What do you think should be done to address the problem in your country?

As you have seen from the case study, alcohol is abused in many Commonwealth countries. Next, we examine factors that contribute to its abuse among young people, as well as the abuse of tobacco and use of illegal drugs.

Alcohol

Factors that contribute to alcohol abuse among youths are many. They include the following:

- alcohol is heavily advertised and very profitable, so is socially accepted by many communities and groups (some parents even buy their adolescent and young children alcohol)
- alcohol is easily available in most of our communities, sometimes even brewed in homes
- most countries have no really effective laws to prevent youths from purchasing and/or taking alcohol
- even if the laws were in place, business persons with ‘bottle stores’ and profit motives may have limited concern for the well-being of youth as a group, and may not restrain the youths from purchasing alcohol from their businesses.

Thinking along the lines of Taylor's seven issues, you will see that, when young people are open to a barrage of advertising in which their adulthood becomes associated with images of beer and wines and spirits, and when their parents and leaders quite normally take alcohol as a social stimulant and many of them are known to become frequently inebriated, then consuming alcohol is perceived to be socially desirable. It is also recognised that the social psychology of adolescents making rites of transition to adulthood become fused with the notion of being drunk. Youth development workers dealing with this in a youth club have to be highly aware of these complexities if they are to negotiate the social psychology and sociology of this situation, in order to decrease drunken behaviour and the tendency towards potential alcoholism.

Tobacco

You will remember that Unit 1 of this module explored the growing problem of tobacco abuse among women, with very serious consequences for the health of unborn and young children, and has related this to the power of the large tobacco companies' advertising and women's changing roles, alongside their increased levels of income and stress.

The political economy of nations dependent for tax revenue on tobacco sales and tobacco companies fighting in a competitive global market, have very clear causal links with the social psychology of women's search for identity. So the 'dangling fag' or the 'poised cigarette' become eloquent symbols of the new woman, defined by patriarchal big business interests. Unfortunately, a rather significant part of that definition will have to wait about twenty years before it appears, by which time it will be too late – the progressive lung diseases that now afflict so many middle-aged men.

What needs to be explained to young women (and to young men of course, who still smoke and drink more than women) is that the tobacco companies have targeted them. These companies are at last having to pay out through the courts for knowingly inflicting lung disease on men in the USA, who were not told twenty and thirty years ago of the dangers of smoking, when this was already well known to the companies.

It is clear that alcohol and tobacco abuse are not as yet definable as deviant, since they are so widespread and considered normal. Only severe examples are considered deviant, but those examples would be far fewer if the social ethos were different.

Illegal drugs

Illegal drug abuse is deviant. In pursuing the idea that deviance is socially constructed, we have to consider the effects of 'labelling' an activity as legal or illegal. Something illegal is automatically classed as deviant, even when most of the leaders of a society actually do it.

Classifying something in this way has consequences for its frequency of occurrence. Classed as 'deviant' it becomes attractive to young people trying to become adult. One of the ways in which some societies try to take the harm out of drug use (as in the way some Australian states deal with marijuana misuse) is to decriminalise it when people only use a small amount of the drug and do not sell it.

Case study 6.1 mentioned that children as young as 10 are involved in drug abuse. In the next section we will establish a comprehensive profile of drug users in terms of socio-economic characteristics.

Demographics and drug use

Drug use/misuse varies among people of differing socio-demographic characteristics, namely; age, sex, social class, religion, type of community (e.g. a big city like London, or a large town like Mombasa), health and the migratory patterns of people.

The purpose, frequency and degree of use vary among people as well. Even within the same population group, such as a rural population, different types of drugs may be abused at different levels by different groups. For example, although youths in a given country or in many countries may use the same drug, intensive use may be common only among a particular group of youths. Inhalant abuse may be concentrated among the children who live on the streets of large cities (Johnson, 1980). In Zambia, Lungwangwa *et al* (1996) found that street children in Kitwe, Copperbelt Province, were more likely to inhale petrol fumes than street children from the capital Lusaka and from Livingstone. In rural India Lai *et al* observed two types of opium users, namely the seasonal users and the habitual users who use opium throughout all the seasons.



Activity 6.5

(about 10 minutes)

Choose four commonly used drugs in your community.

Describe in your journal how their use is related to socio-demographic characteristics, i.e. age, sex, social class, and type of community.

We have already seen that different countries have different drug abuse problems. In the next section we explore why drug use varies within and between countries and communities.

Why does drug use vary?

The drugs that are used by young people vary between and within countries for several reasons:

- perceived social norms, attitudes and beliefs regarding the use of various drugs
- availability of drugs
- accessibility (legal restrictions)
- cost.

Social factors are always powerful causal factors. The following case study, which describes the situation in Rio de Janeiro, is one example.



Case study 6.2

Socio-economic status and drug abuse in a Brazilian city

Rio de Janeiro is a city divided between two quite different social groups:

- an affluent group living in heavily guarded and secure enclaves
- desperately poor people, many of whom who have migrated from the countryside.

The poor live in shantytowns close to the rich. They are ruled by drug barons who create employment, control the prevailing order and protect poor families against the police and other drug gangs.

Here, the desperate inequality of Brazilian society has generated two cultures, one of which is based on a drugs economy and therefore has a culture built on drugs; and the other which is not.

The situation here is particularly extreme, but many other cities and regions are divided along similar lines, the ultimate issue being the co-existence of wealth and poverty.

The situation described in Case study 6.2 may or may not be similar to your own city or country. However, despite the variations in drug use within and between countries, there are general factors that contribute to the problem of drug abuse among young people.

Factors that contribute to drug abuse

Several factors contribute to the problem of drug abuse among youths. These factors may vary between and within countries and include:

- lack of accurate information about the short-term and long-term dangers of drug abuse among youths
- increased and easy availability of narcotic drugs and psychotropic substances
- limited and/or ineffective law enforcement systems to prevent drug abuse and trafficking
- lack of awareness among policy makers and planners of the real magnitude and consequences of the problem
- commercialisation and liberal use of alcohol and other drugs (i.e. cannabis)
- easy availability of drugs, sometimes at low prices, as the poverty of Latin America and Afghanistan and the former Soviet Union grows
- groups of people advocating legalisation of certain drugs, where only some of the underlying issues are aired
- socio-economic problems associated with lack of education, employment and other social programmes for youth
- family problems or disruptions as in the cases of death or divorce of parents, and child abuse by family members
- societal norms that promote or permit the substance use.

At the personal level, youths may be motivated to use drugs because of:

- a desire to take risks and perceptions of risk associated with a particular drug
- a perception that substance use is common and/or 'normal'
- an inability to cope with the lack of basic rights and necessities such as food, clothing, shelter and education
- a desire to demonstrate autonomy and independence
- a need to be accepted by peers
- a desire to satisfy curiosity
- a desire for new and exciting experiences
- family problems or disruptions as in the case of death or divorce of parents, and child abuse by family members.

(Adapted from the UN World Youth Report, 2003)

A useful approach to understanding the process whereby an individual from a poor community becomes a drug misuser is to see it as an integrated process in which a number of factors are working with and against each other.

The general social ethos sets the stage, and all personal and community tensions react in co-ordination with that. Braithwaite (1989) sees the vulnerable age group for becoming a deviant as 15–25. Deviants are generally male, unmarried, unemployed, with low levels of educational attainment and therefore low aspirations. They tend to be urban dwellers who may well move around a bit, but their legitimate opportunities are systematically blocked. If they engage in deviant behaviour and are then socially shamed, they are at a ‘tipping point’.

This is critical, because, if intervention is carried out to reintegrate them with the community (and this is exactly what youth development workers are trained to do) then they can be brought back into the mainstream.

However, if they are mishandled at this point and stigmatised, their deviance is exaggerated and they may become integrated into the deviant sub-culture, which legitimates their tendency (and opportunity) to indulge.

Of course, if they are already in a mainstream culture that is in deviant opposition to the official culture (as in Rio), then that makes their drift into drug-taking socially acceptable.

Associated problems

There are many problems associated with drug and substance abuse. Some of these problems include:

- incidents of impulsive, reckless behaviour
- increased crime and violence among youths
- poor health, such as brain damage, hypertension and HIV/AIDS spread by sharing contaminated needles
- premature death
- social displacement or disruption
- a temporary state of identity confusion
- rejection by family and society at large
- exploitation by others.

For example, in some countries unemployed and/or homeless youths are very vulnerable to exploitation. Not only are they in need of money to survive, but many may also be drawn into criminal groups to satisfy their need to have a sense of belonging or family. Young people are used as cheap labour in alcohol industries and are used as drug couriers and peddlers. In Kenya, youths are involved in drug-

selling activities by pretending that they are selling sweets, roasting maize and posing as shoe-shine boys. In Zambia, youths are used as couriers of drugs, especially to neighbouring countries. Youths are also used in drug production. These activities expose youths to the risks of crime and drug abuse.

Drug abuse leads to physical and mental suffering, destruction of self-esteem and a loss of ability to reason and function effectively. As a result, drug abuse reduces the contribution that youths as a group can make to development.



Activity 6.6

(about 10 minutes)

Using the list of problems above, identify and list in ranking order the common drug-related problems in your community. Suggest reasons for the order of ranking of these problems.

Make notes in your learning journal.

So far, we have discussed the nature of the problem of drug abuse, the common drugs used by the youth and the factors that contribute to their abuse. The next section looks at strategies for preventing drug abuse and at how victims of drug abuse can be supported.

Prevention and support

In general, drug abuse reflects larger community socio-economic problems. Therefore, the general attitude of blaming and stigmatising drug abusers does not offer any solution to the problem. To prevent drug abuse among different population groups, the root causes of using drugs must be identified and addressed.

While prevention is the most desirable approach to solving the problems of drug abuse, many youths, who are already addicted to drugs, need support to overcome dependency and lead a normal life. Support may be provided through strong family relationships and parental guidance, as well as effective counselling which seeks to build the individual's self concept and social skills. But, as we have seen in most of the units in this module, education is of paramount importance in addressing issues of youth and health. It is particularly important in dealing with the problem of drug abuse among the youth.

Education

One of the most important approaches to drug prevention is education. It is a pro-active approach and prepares youths for choices and situations they are likely to face in their lives. Mechanisms for

education include schools, communities and the mass media. Mass media can be very powerful and effective tools in raising awareness, particularly through music/songs and television and radio messages.

The education should target young people who are both in and out of school, as well as their families and the community in general, in order to:

- increase awareness of the dangers of drug use and abuse among youths
- increase users' and their families' awareness about the risks of continued use
- inform the users, their families and the community about the availability and benefits of interventions to support people dependent on drugs
- motivate youths to adopt and maintain positive behaviours, such as controlling personal feelings and social responsibilities
- motivate and support youths to avoid drugs so that those who have not started using drugs do not start
- integrate drug-prevention education into formal school activities to reach in-school youth
- pressure governments to promote formulation of policies to prevent drug abuse among all young people
- educate parents in recognising signs and symptoms of drug abuse in early stages so that they can seek effective treatment for their children.



Case study 6.3

Youth Substance Abuse Service (YSAS), Victoria, Australia

The problem of drug abuse among young people in Australia has led to the establishment of an innovative, youth specific programme. YSAS is a recent (1998) government-funded initiative that provides a drug abuse service that is youth specific. It is run by a collaborative group of four organisations:

- St Vincent's Hospital
- Jesuit Social Services
- Turning Point
- Centre for Adolescent Health.

The approach is multidisciplinary, drawing on the skills of a range of health, social and youth practitioners, who focus on strategies that reduce drug-related risks and harm, and engage youths in more healthy and meaningful lifestyles.

Teams operate in eight specific regions that have been targeted, based on demographics and referrals. YSAS is run on a relationship-based model, where young people (aged 12–21) consult the same people who devise a programme based on their individual needs. It may include money, accommodation, psychological and medical support; it is very flexible.

YSAS provides three services:

- outreach services
- residentials
- training and support.



Now turn to Reading 12: ‘Youth Substance Abuse Service’, by YSAS.



Activity 6.7

(about 20 minutes)

Reflecting on what you have read in Case study 6.3 and in Reading 12, answer the following questions about how you, as a youth development worker, could contribute as part of a health team to help address prevention and support:

- 1 What could you do to complement the activities of other members of the team (e.g. teacher, doctor, and youth in development worker) in these two areas?
- 2 What problems do you think could arise from working in this type of partnership and how would you deal with them?

Write your responses in your learning journal

Working with the community

Apart from the activities of formal institutions, there is a lot that the community itself can do to prevent drug abuse among youths and to support youths who are dependent on drugs. It is well within the role of a youth development worker to mobilise this resource.

Braithwaite’s discussion (1989) of ‘reintegrative shaming’ as a crucial strategy for preventing young deviants from being cut off from the true sources of integration with their communities is very valuable for youth workers. We can try to ensure that families and communities do their best to draw deviants back into the community, while showing clear disapproval of the drug and substance abuse that has alienated them.

Your work in Module 2 has already provided you with several ideas on how you can work effectively with communities. The following points are in the context of drug abuse:

- Communities can participate in identifying youths at risk.
- Communities can participate in the planning, design, and implementation of interventions to prevent drug use and abuse and support people already dependent on drugs. This will allow sustainability of the programs.
- Communities have responsibility for educating youths in danger of drug use/misuse. Here, the use of popular theatre (mentioned in Module 1) is effective as it tends to break down barriers between audience and performers and demonstrates understanding of a shared culture and way of life. However, you must avoid the tendency to patronise, lecture or judge the audience.
- Community-based rehabilitation services can be provided for drug-dependent individuals.
- Communities can educate young people about sources of information. Some of the sources are news media, family counselling, community groups and magazines.

In an earlier section in this unit we looked at self-abuse as a symptom of deviant behaviour. In the next section, we explore self-abuse that is associated with injury and suicide.

Self-abuse through injury and suicide

Taking physical and emotional risks is not in any sense deviant for many young men, and not necessarily for young women. In some countries, accidents (often caused by high-risk behaviour) are the main cause of death for young men, followed closely by suicide. Suicide has been on the rise among young people for several decades around the world, and is now very high even among teenagers.

Hopelessness, despair, broken self-esteem – these are some of the marks of depression in young people, which is their most frequent psychological disorder. Given these conditions, it's not surprising that people turn to suicide.

Positivist theorists argue that it is the loss of positive reinforcement or the experience of negative reinforcement that makes people do this. They argue that young suicides fear that they will not be acceptable for marriage and family, will not have a successful career, will become ill, and choose death both as a way out and as a way of gaining attention from those who have downgraded them.

Baumeister (1990) argues that when society or the family sets standards that may be too high, young people experience setbacks.

Without positive reinforcement, they experience themselves as falling short of these standards, and therefore as worthless. This makes them much more self-aware, increasing their sense of pain. So, to escape these feelings, young people enter a state of 'cognitive deconstruction', where they narrow down their thinking into concrete immediate terms, losing any sense of philosophical reflection. They no longer search for a higher level of meaning in their lives and become weaker, drifting easily into drug misuse or sexual promiscuity. When even these things do not provide relief, they may seek escape from an unacceptable self-image through suicide.

This downward process can be reversed, however, if the young person can be assessed early enough, and can be challenged in the right way at the right point. Erwin Stengel (1964) made the point that attempted suicide that doesn't work is a cry for help. That cry must be heeded and help given.

Moreover, in development activity there must always be certain conditions to support the young and vulnerable, some of whom may well have suffered abuse earlier in their lives. Project work is one of the best ways to involve young people in creative, self-fulfilling activities that make them important to each other and to the community.

The approaches discussed above in the section on prevention and support, such as education, support and working with the community may also offer a way of addressing these issues and their underlying causes.



Activity 6.8

(about 15 minutes)

- 1 Is suicide among young people a serious problem in your country or region?
- 2 What are the main causes of suicide in your country/region?

Make reflective notes in your journal.

Unit summary

In this unit you have covered the following main points:

- Mental health is critical to our 'complete health' status, and lack of mental health is associated with the drug abuse that affects many young people today.
- Alcohol and drug abuse is increasingly becoming a very serious problem in many Commonwealth countries. The problem affects young people of between 10 and 24 years and of all socio-demographic backgrounds.
- Many young people resort to drug abuse (repeated non-medical use of potentially addictive chemicals) for a variety of reasons. These include the desire to relax the mind, to relieve pain, to boost courage and to experiment or have an experience of taking drugs.
- Drugs used by young people vary from country to country and the choice is determined by a number of factors such as availability, cost and perceived benefits. Some of the common drugs known to be used by youths are alcohol, tobacco, cocaine, heroin and cannabis. Others are glue, petrol and barbiturates.
- Perhaps alcohol is the single most abused drug. This is because it is heavily advertised and very profitable. It is easily available in most of our communities, and most countries have no really effective laws to prevent youths from purchasing alcohol. Even in countries where preventive laws exist, they are not strictly enforced.
- The factors that lead to drug abuse by youths include: lack of information about the dangers of drug abuse, limited and/or ineffective law enforcement systems and family problems or disruptions. Of course, these factors vary between and within countries.
- Drug abuse is associated with a number of health and social problems, such as increased crime and violence among youths, poor health, the spread of HIV/AIDS, social displacement and exploitation of young people by society.
- Drugs are used by young people who are in or out of school, employed or unemployed and from all social and economic backgrounds.
- Self-abuse through injury and suicide are on the rise among young people throughout the world, and such young people also need support through development activity and community approaches.

- Communities, and young people themselves, can do a lot to prevent drug abuse among youths and to support those who are dependent on drugs.

To check how you have got on, look back at the learning outcomes for this unit and see if you can now do them. When you have done this, look through your learning journal to remind yourself of what you have learned and the ideas you have generated.

Congratulations! You have completed all the six units of this module and you are ready to move on to your assignment.

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Summary

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Module summary

By studying this module *Youth and Health*, you should now have a clearer idea of the definition of youth and health, both as a social construct based on social norms, and as a subjective notion.

We have looked at why it is important to involve young people in the planning and implementation of any programme that targets youths, and how to promote youth participation. You should also now have a broad understanding of some of the contemporary health issues that affect young people, such as nutrition and diet, sexual and reproductive health, STDs and HIV/AIDS and mental health and drug abuse.

You should be able to compare the differences between the principles of youth development work and those of health professionals and educators. You will be aware of the need for appropriate alliances with various health agencies and non-governmental organisations (NGOs), and health practitioners and professionals. You will be able to recognise the different roles they and you will have, and recognise how to foster effective working relationships with them.

If you have successfully completed this module, you should be able to:

- identify the major health issues affecting young people
- outline health promotion strategies, particularly preventative strategies
- describe the specific role of youth development work in health promotion
- describe the roles of other agencies in this field
- acquire appropriate techniques to respond to health issues raised in the course of your youth development work
- develop specific programmes of health promotion
- use the distinctive methodology of youth development work within the environment of a primary health care agency
- work within complex partnerships created to achieve key objectives in the field of health promotion.

We wish you good luck as you complete the assignments and the final module of the Diploma – Module 13 *Sustainable Development and Environmental Issues*.

Glossary

| | |
|---------------------|--|
| Abortion | Termination of a pregnancy. |
| AIDS | Acquired Immune Deficiency Syndrome – a serious condition caused by HIV which leaves the body vulnerable to any infection. |
| Contraception | Various methods used to regulate fertility and conception (also called birth control, fertility control). |
| Drugs | Mind- or mood-altering substances such as alcohol and tobacco (legal drugs) and marijuana, cocaine and heroin (illegal drugs). |
| Family planning | Various methods that enable planning of pregnancies; it includes the use of contraceptives. |
| Foetus (fetus) | An unborn child. Generally considered to be viable (able to survive outside the mother's womb) from 28 weeks of gestation. |
| Good nutrition | A health-supporting diet and fresh, clean water. |
| Health | A state of complete well-being: physical, social, mental and spiritual. |
| HIV | Human Immunodeficiency Virus –the virus that often eventually leads to AIDS. The virus works by slowly destroying the body's defences (the immune system). |
| Malnutrition | Various conditions that result from poor diet; the term includes under-nourishment, over-nourishment and deficiencies of particular nutrients. |
| Participation | Being included in all social action related to oneself, including decision-making. |
| Pregnancy | The state of having conceived and carrying a child. A full-term pregnancy lasts 40 weeks. |
| Primary health care | Team-based health care at the community level; good opportunities for health promotion and prevention work. |

| | |
|------------------------|---|
| Reproductive rights | The right of couples and individuals to regulate their fertility, have safe sex, pregnancies and births (when they choose to); also freedom from coercion into population control programmes. |
| Social model of health | A social model of health looks at creating the social conditions that promote good health and make illness and disease less likely. |
| STD | Sexually transmitted disease, e.g. herpes, syphilis, AIDS. |

Further reading

The following list of books and texts is meant to support your learning throughout this module. We suggest you discuss with your tutor how and where to find some of these publications so that you can read widely from this list to enrich your understanding of the subject matter.

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Assignments

A final reminder about the assessment requirements for this module. Your work in this module will be assessed in the following three ways:

- 1 a written report of 2,000 – 2,500 words (worth 50 per cent of the final mark)
- 2 a review of the learning journal you keep (worth 20 per cent of the final mark)
- 3 a written examination set by the institution in which you are enrolled for this Diploma (worth 30 per cent of the final mark). As an alternative to the examination, you may be given the opportunity to complete a second written report of 1,000 words.

Note: make sure you discuss the assessment requirements with your tutor so that you are clear about what you are expected to do and when, and any particular requirements in your institution.

Assignment 1

This assignment counts towards your final assessment in this module and is worth 50 per cent of the final mark.

Complete a written report (of between 2,000 and 2,500 words) which records the initiation, design, delivery and evaluation of a health care project (either your own or an existing one) that you have undertaken with a group of young people.

The project might directly address a health problem such as poor nutrition, unwanted pregnancies, HIV/AIDS or drug abuse, or it might focus on other health-related issues such as developing a supportive environment, counselling, developing a health services directory or information/documentation centre, developing participatory skills, and so on.

The following is a suggested format for your report:

1 Initiation

- (a) Describe the group of young people and how you involved them. Discuss any activities you undertook or organised to develop the necessary skills for participation, to raise awareness of health issues, etc.

- (b) Describe the health problem that you and your group identified. Discuss the main causes and nature of the problem. Also discuss how you generated possible solutions.

2 Design

List the goals or desired outcomes and describe what action was planned. Describe what other agencies were involved (you must include an alliance of at least three agencies, including one or more from the health field).

3 Delivery

Put your plan into action and record what occurs, including successes, problems and any obstacles, and how you overcome them.

4 Evaluate

Evaluate the project. Include the opinions of others, and match the outcomes with those that were planned for.

Assignment 2

This assignment counts towards your final assessment in this module and is worth 20 per cent of the final mark. You should discuss with your tutor the exact requirements for your institution.

The assignment takes the form of your learning journal which contains the notes and records from the activities included in each unit.

Assignment 3

This assignment counts towards your final assessment in this module and is worth 30 per cent of the final mark. You should discuss with your tutor the exact requirement for your institution.

Assignment 3 may take the form of a written examination of up to 2 hours, worth 30 per cent of the final mark. The examination will test your understanding, not your memory. You may be asked to explain certain ideas and to relate them to work with young people.

If the university or college at which you are enrolled does not set an examination, a further assignment will be required in the form of a second written report, of around 1,000 words.

Alternatively, your institution may choose to use your work from Activity 2.4 or Activity 2.9 (in Unit 2) as a form of assessment. Check the requirements with your tutor or institution.

Readings

The readings in this section will help you develop your understanding of Module 12 *Youth and Health*. The reading numbers, their titles and author(s) and the unit in which they appear are listed below.

| | |
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Reading 1: Extract by David Werner quoted in *Third World Guide – The World as Seen by the Third World (1992)*

In recent decades, global planners made the unfortunate assumption that the solution to widespread poverty and poor health was economic development. The strategy imposed on poor countries by the foreign aid agencies and Northern banks was to foster national growth through large scale industry and agribusiness. While they realised this would mostly benefit big landholders, industrialists and bureaucrats, they theorised that by stimulating the growth of a poor nation's total gross national product (GNP), benefits would *trickle down* to the poor.

But in many countries this did not happen. As the economy and production grew, the gap between rich and poor widened. More *trickled up* than trickled down, and in the process the problems of poverty, under-nutrition, under-employment, homelessness and the diseases of poverty got worse.

In 1985 the Rockefeller Foundation sponsored a study called *Good Health at Low Cost*. Its purpose was to explore the reasons why certain poor countries have achieved acceptable health statistics in spite of very low national incomes, and specifically, to verify whether China, Kerala State of India, Sri Lanka and Costa Rica did indeed attain life expectancies of 65–70 years, with per capita gross national products of US\$300–US\$1,300.

The investigators concluded that *the four states did achieve good health at low cost. Furthermore, they concurred that (four) intersecting factors appear to have played a major role in the marked decline in infant and child mortality, commensurate with life expectancy approaching that of wealthy nations.*

The four determinants of this Southern paradigm for good health at low cost proved to be:

- political and social commitment to equity,
- equitable distribution and access to public health care, beginning at the primary level and reinforced by secondary and tertiary systems,
- uniform access to the educational system with a focus on the primary level,
- availability of adequate nutrition at all levels of society in a manner that does not inhibit indigenous agricultural activity.

Certainly this study provides one of the strongest arguments for an approach to meeting health needs that courageously addresses social and political issues.

Reading 2: Young people – partners in action on youth health

Edited by Philip Hope from the full report 'Youth health – analysis and action' (1995), Commonwealth Youth Programme, Commonwealth Secretariat.

Introduction

This is one of three advisory papers for people in organisations who wish to review their programmes and policies for youth health such as Youth and Health Ministries, UNICEF, non-governmental organisations and other agencies who provide youth or health services.

The papers are summaries taken from the handbook *Youth health – analysis and action* published by the Commonwealth Youth Programme. The handbook gives advice on how to undertake a comprehensive review of youth health services and policies. It also provides concrete ideas for key action points to promote the continuing development of youth policies and programmes.

Partnerships with young people

Young people comprise more than half of the population in many developing countries. Young people should have the opportunity to express their views on what needs to be done differently to ensure that health services are relevant to them.

A focus on the health of young people requires the development of partnerships between young women and men, national governments and development agencies, to tackle the broad range of health concerns in an effective and positive way. In their reviews of youth health services in four countries, as young people the consultants' perspectives on health services was central. Rather than seeing health needs and services through the eyes of health professionals or older people, they brought a new dimension – that of young people – into their observations, analysis and recommendations.

The consultants brought a youth approach to the process of conducting the reviews by talking to young men and women and using ways of working that were relevant to young people and which gained their active participation, such as role play and drama.

People not problems

There is a danger that a focus on youth health might stereotype young people as 'posing problems'. There is a risk of labelling young people as problems to be dealt with rather than as people with whom

relationships need to be developed and a resource with whom to work.

This attitude not only denies young people the right to have control over their own lives but carries within it the seeds of its own destruction. The scale of need and the reaction of young people to being treated in this way will inevitably result in a failure to achieve the outcomes that everyone in the community is keen to achieve.

A positive outlook towards young people by those engaged in planning health is more likely to generate a positive response by young people. It is also important to distinguish between the behaviour of some young people, which may be deemed to be inappropriate or even unacceptable, and young people themselves – who deserve not to be rejected or condemned. This is part of what is meant by taking a holistic approach to youth health. Treating young people as a resource rather than a problem is the starting point.

Making services relevant

Listening to young people: Services for young people need to start from an assessment of young people's health needs that is based on listening to the views and experiences of young people themselves. This assessment itself requires a range of methods and skills to match the culture and diversity of different young peoples' lifestyles, such as drama, role plays and spontaneous discussion on the streets and in bars and cafes that young people use.

Youth culture: Services aimed at improving young people's health also need to be accessible and relevant to them and their cultures. Styles of service delivery need to reflect the patterns of young people's lives and be pro-active in reaching out to young people. They need to promote the benefits of healthy lifestyles in a language and format to which young people can relate. Services need to be youth-centred in their style and method of working in order to be most effective.

Prevention: Youth health services are as much about prevention as cure. They are about educating young people, providing them with information and encouraging them to develop their behaviour towards safer and healthier lifestyles. Young people's health problems may be the result of exploratory and experimental behaviour which can include sexual experimentation and the use of substances as a normal part of human development. So it is important to develop materials which address these sensitive issues while respecting cultural traditions.

Integration: Policies for youth health need to be part of a wider, integrated strategy of services to meet the needs of young people. Most health problems are closely associated with other issues such as social and economic deprivation, the lack of education and unemployment. Many health problems are interlinked with a clustering of unhealthy behaviours and problems passing from one generation to the next. Youth health policy needs to recognise the

wider health context and the impact this has upon the lives of vulnerable young people.

Empowering young people

Active participants: Young people can be involved as active participants in the definition of the problems, and in the creation and implementation of the solutions. Young people are realistic about the problems they face, have initiative, energy and ideas and can organise themselves to take action. Services can be made to be relevant to young people by involving them in decision making at all levels. They have the insights and understand the behaviour which puts them at risk, and know what will motivate them to change.

Peer education and action: Young people require opportunities to talk about their concerns and questions – to interact and to explore feelings and concepts among themselves, in order to consider the personal implications of the messages. Young people can be enabled to educate and influence other young people. They can be role models to other young people to give them clear messages about health. Peer education among young people is key to achieving changes to attitudes and behaviour.

Communicating appropriately

Style: It is important to communicate messages to young people in a style and language that is attractive to them. This will capture their attention, be more interesting and motivating, and have a greater chance of it being understood and accepted. This may mean using language that older people find very difficult to accept or will find embarrassing or offensive in order that the messages are not ignored by young people as being dull, boring and patronising.

Content: The content of what is communicated needs to be relevant to young people, factually correct and culturally appropriate. The phrasing of a message needs to avoid telling young people what is right or wrong, or exaggerating risks, as this is likely to be counterproductive. The message needs to be based on what is important to young people and to be open to change as language and young peoples' needs are changing. Accurate information is a part of the process of enabling young people to make informed choices about their behaviour.

Methods: The way that messages are conveyed needs to be particularly relevant and appealing to young people – not simply producing pamphlets but using creative methods such as T-shirts, comics, magazines, badges, stickers, drama, dance music, youth gatherings and so on. In communities where literacy levels are low, it is important to find ways to communicate messages that don't rely on young people being able to read.

Mass media communication: The mass media exert powerful influences on young people and can be used in dynamic and interactive ways to

promote healthy development. Key principles to consider when using the mass media to promote youth health are:

- use the natural channels of communication that appeal to young people, which they trust and can identify with;
- use mass communication and mobilisation techniques to engage young people and their communities in dialogue and debate on the issues and problems involved, rather than simply providing information;
- focus on the key cultural and social norms and trends that underpin specific behaviours, and place individual behaviour in that context;
- centrally involve young people in planning, implementing and assessing communication and mobilisation programmes. Their perspective is vital;
- view communication and mobilisation as programmes in their own right and not as promotional tools for the 'real' programming. At the same time, be aware of the role communication and mobilisation can play in creating a positive climate for on-the-ground face work.

Young people in rural areas who do not have access to the mass media may benefit from traditional ways of communicating information, such as drama, poetry, puppets, dance, festivals, parades, story telling, and songs.

Sensitivity to diversity

Young people and adults: Many young people live in considerably different social settings to those which their parents and other elders experienced at a similar age. As a result of changes in communication systems, travel possibilities employment patterns, educational opportunities and living conditions, many of the issues and dilemmas that young people experience may be difficult to communicate with parents and other elders. They may be issues that are very sensitive or about which older people have little knowledge or awareness.

Different groups of young people: Young people should not be treated as all the same. Different groups of young people have different needs and experiences based on their gender, race, social position, location, abilities, age and sexuality.

Some young people may be more vulnerable than others – more at risk of physical, emotional, psychological and social disorders – leading to feeling different and powerless, having low self-esteem and being more susceptible to the adverse effects of stress.

Young people most in need of health care may often be those least likely or able to seek help or advice. Young people may be or may feel vulnerable because they:

- are different in some way to other young people around them such as having a disability, being a parent or belonging to a minority ethnic group;
- have experienced serious loss or other trauma such as the death of a parent, or physical or sexual abuse;
- live in difficult circumstances such as being homeless, unemployed, very poor or living in institutional care.

Health services need to recognise and be sensitive to these differences. For example, services should enable young people to discuss openly issues that are uncomfortable to others in order that the advice young people get is accurate and helpful. They should provide an open and safe environment for discussing issues comprehensively and without fear of recrimination. Services should reflect young people's diversity and be sensitive to the individual needs and expectations of different groups of young people.

Youth health action

The handbook *Youth health – analysis and action* contains a series of 'snapshots' of specific youth health topics. Each includes a summary of the issues involved in that topic, some key questions for discussion and a number of action points. The action points in this paper are taken from these snapshots and are intended for use with young people, service providers and policy makers to stimulate thinking, debate and action. They are not comprehensive or detailed. They might be discussed as individual youth health issues or as part of a wider review process.

Physical and mental health

Substance use and misuse – drugs in general:

- collect information about the **use** by young people of different kinds of drugs, and the trends. Talk to young people directly about their experiences and their knowledge about the effects of drugs;
- undertake an intensive drug education programme in schools and in the community aimed at young people, alongside other initiatives such as employment programmes, and training and recreation activities, to prevent substance use and misuse. Consider using informal peer education methods such as drama and street theatre;
- review the extent to which wider social policies affect substance misuse.

Substance use and misuse – smoking:

- conduct a strong youth-centred anti-smoking campaign in schools and the community. Use drama, radio plays, music and posters to

promote an anti-smoking message and promote alternative recreation;

- collect information on the type of advertising used to sell tobacco and alcohol products and identify what groups in society are being targeted. Introduce tax policies to reduce incentives and increase the cost of smoking. Reduce the acceptability of smoking in public areas;
- develop peer education projects and encourage positive public role models. Arrange a display for World No Smoking Day every year in schools and the community.

Substance use and misuse – alcohol:

- conduct a youth-centred campaign in schools and in the community against excessive drinking. Develop alcohol education through peers using story telling, song and dance. Provide alternatives to alcohol as a stimulant, such as sport and recreation;
- introduce new price controls, taxes and legislation to increase the cost of imported alcohol and reduce the availability of local brews through public outlets to reduce **excessive** alcohol consumption;
- provide education to elders on the risks associated with encouraging young people to drink and on being a role model for young people during social functions and cultural festivities. Provide an alternative to alcohol for drinking at social events.

Physical, sexual and emotional abuse:

- collect information on the nature and levels of physical, sexual and emotional abuse among young people. Discuss the issues and produce a policy to provide support to young people and reduce its occurrence.

Injury and suicide:

- gather information about the nature and causes of accidents, injury, attempted suicide and suicide among young people. Identify what strategies might reduce the number of accidental injuries or deaths;
- discuss with young people and health workers how relevant existing health services are for the particular needs and circumstances of young people who become injured or who attempt suicide.

Nutrition and diet:

- gather information on the actual eating habits of young people and assess the impact on their health. Find out what motivates young people to eat some foods and not to eat others;

- produce materials that challenge stereotypes about how young people 'should look'. Develop a youth-centred campaign in schools and the community to promote a diet that is trendy and healthy.

Diseases:

- develop a communicable disease profile for your community. Use it to identify why people's experience of illness is different at different ages.

Spiritual health:

- work with local spiritual leaders and ask how they would answer questions about the meaning of life and death to young people. Discuss with local spiritual leaders what would help young people to live in harmony with themselves and the world. Encourage young people to consider what they mean by spiritual health and how it might be achieved.

Sexual and reproductive health

Sexual activity and contraception:

- conduct a survey of sexual activity among young people through focused interviews on the knowledge, attitudes and practices of young people in order to plan services;
- discuss and provide information in schools and informal settings about contraception and the prevention of HIV/AIDS, Hepatitis B and other sexually transmitted diseases (STDs).

Teenage pregnancy and parenthood:

- collect information about the incidence of pregnancies, abortion and parenthood among young people, to assist the planning of counselling and parenthood programmes;
- provide counselling to give support and reduce isolation. Provide parenthood programmes in schools and informal settings to improve young people's parenting skills.

Relationships:

- provide social education programmes in schools and informal settings that enable young people to reflect on all their relationships, discuss their aspirations and future responsibilities, and consider the roles they will play in the home and at work.

Sexually transmitted diseases:

- target programmes on suspected transmission routes for STDs, e.g. sexual transmission from people who travel heavily outside the area/country, injecting drugs and so on. Use non-judgmental

prevention programmes on all forms of sexual behaviour and other behaviour that carries a risk of transmission. Increase accessibility to condoms as a preventative measure;

- implement a comprehensive sexuality education programme in schools as well as community-based programmes aimed at young people no longer in the education system that includes prevention of sexually transmitted diseases including HIV/AIDS and Hepatitis B;
- encourage local musicians and artists to produce music with an anti-AIDS message. Use peer education programmes that train young people in villages, churches, community groups and schools to lead sessions with their peers about HIV/AIDS.

Social health

Work and life skills:

- develop skill based programmes in schools and in other educational institutions that combine skills training and information in order to change social behaviour and to increase employability, e.g. entrepreneurship skills and vocational education;
- introduce job creation schemes. Create jobs and facilities for young people in remote, rural, or island areas rather than encourage their movement to urban areas. Create low cost credit schemes to support youth enterprises.

Relationships with parents, elders and the community:

- hold community seminars for parents, elders and young people to share their understanding of teenagers. Develop skills programmes in schools on communicating with parents.

Youth health policy

The key elements of general youth health policies include:

- ***a national youth health policy*** – political commitment to the healthy development of young people; laws and policies to promote the healthy development of young people; and establishing clearly defined lines of accountability for taking action;
- ***co-ordination and consultation*** – properly co-ordinating and leading the various initiatives to promote youth health; avoiding duplication and overlap; improving or creating new structures and mechanisms for consulting young people and involving them directly in decision making about health services;
- ***resources*** – re-allocating existing resources and providing new resources to improve existing services; introducing new services

to meet the health needs of young people; recording what is happening to young people's health and evaluating the success of policies, services and campaigns to bring about improvements;

- **training** – improving the knowledge, skills and awareness of people working in health services to understand young people better, to understand health issues and to improve their practice and management in order to be more responsive and relevant to young people and their health needs;
- **health campaigns** – creating single issue campaigns and using mass communication on specific health themes to promote healthy ways of behaving;
- **health education** – skill-based programmes combining information and skills training; peer education programmes; school-based interventions and wider community-based activities aimed at students, parents, teachers and health workers;
- **rehabilitation programmes** – assisting people who have conditions which limit their level of physical, mental and social functioning. These include programmes for young people with physical disabilities, psychiatric disabilities, mental disabilities, problems associated with substance addictions and those in trouble with the law or who have spent time in prison.

CYP gratefully acknowledges the support and contribution of UNICEF in developing both the full report and the summaries. © Commonwealth Secretariat 1995

Reading 3: Best Practice Initiatives – Youth to Youth in Health

Source: RMI Embassy, USA. Copyright © 2004 Secretariat of the Pacific Community.

What is Youth to Youth in Health?

Since 1986, Youth to Youth in Health has sponsored an active peer and community outreach education program in the Marshall Islands. The project started under the auspices of the Division of Population and Family Planning of the government's Ministry of Health in an effort to get youth involved in helping to slow the staggering annual growth rate of 4.24 per cent.

Youth to Youth in Health (YTYIH) trains peer educators (13 to 25 years old) to lead health education and cultural promotion outreach activities, counsel youth clients at health clinics, and share, with elementary and high school and out-of-school youth, knowledge about family planning, contraceptives, sexually transmitted diseases and AIDS, nutrition and malnutrition, suicide prevention, the hazards of alcohol consumption and smoking cigarettes, and other topics of concern to adolescents and the community at large. YTYIH is a youth leadership program that is stimulating pride among young people in their own culture as the basis for consciousness-raising and action. The YTYIH believe that the key to improving deteriorating family health and tackling urgent social problems in the Marshall Islands requires young peoples' involvement and action. To accomplish this, young people must take pride in their identity and their country. The three-pronged program emphasizing appreciation of culture, knowledge of health, and an understanding of ecumenical religious values and responsibility is striking a responsive chord with young people in the Marshall Islands. Since 1986, the YTYIH program has provided a unique role model of young people who are proud of their culture and taking action to improve health and social conditions in their islands. Youthful volunteers between the ages of 14-25—high school students, college students and out-of-school youth are the core of the YTYIH program. More than 230 youth peer educators have been trained between 1986 and 1993. Many of the trained youth have been hired by offices within the Ministry of Health, become paid staff of the YTYIH program, or continue with the program as volunteers.

The YTYIH started without fanfare in 1986, but has grown into a major activity of the Ministry of Health. In 1989 the youth group was incorporated as a chartered non-government organization and began to seek and receive its first overseas grants in an effort to multiply its activities. A significant expansion of the program occurred in 1992, when YTYIH received a three year grant allowing it to hire five youth

staff, increase youth leadership training and expand outreach. During its first eight years, the YTYIH has functioned through the support of the Ministry of Health, which provides office space, supplies and materials, equipment, and a variety of other in-kind contributions. The close association with the Ministry of Health was formalized in August 1992 with the signing of a memorandum of understanding that spells out the cooperative relationship between the Ministry and YTYIH.

The adoption by the Marshall Islands government in December 1990 of a National Population Policy has given a boost to the YTYIH by mandating an aggressive government program of promoting youth health and social needs. An example of the impact of YTYIH is the substantial increase in the number of teenage youths seeking family planning assistance and counselling since the YTYIH formed. In 1986, before the YTYIH started, barely five teenagers visited Family Planning each month; by 1989 the number had jumped to more than 21 per month; and by 1990 the number of youth Family Planning clients was above 35 each month—a statistic Family Planning staff attribute directly to the involvement of the YTYIH in peer health promotion.

A key to the success of the YTYIH program is the support and involvement of the families of the youth members in the program's activities.

Why Youth to Youth in Health?

Young People listen to other young people. With the vast majority of the population under 25 years of age, it makes sense to involve youth in health promotion. The Marshall Islands had one of the world's fastest growing populations during the mid-1980s. This compounded many of the 'lifestyle' changes caused by rapid Westernization and urbanization in this island nation of 50,000 people. About two-thirds of the population reside in the two urban centers, Majuro (the capital) and Ebeye, living crowded on less than two square miles of land. In 1993 it was estimated that 70 percent of Marshall Islanders were 25 years and under. Teenage mothers account for about 15 percent of the babies born every year. Marshall Islanders once lived nearly entirely on a subsistence diet from the lagoons and land. On many of the remote, rural outer atolls, that is still largely the case today. But, as urbanization has overtaken the islands, people are abandoning the outer islands in droves for the urban centres, where overcrowding is rife and a host of problems have arisen as a result of the rapid urbanization.

Malnutrition in islands where food is abundant has been the leading killer of children under five years of age, and treatment of malnourished infants and children represents a substantial burden on hospital services; alcohol abuse is widespread among young Marshall Islands men, youth gang activity, fuelled invariably by alcohol, is on the increase; sexually transmitted diseases remain a problem, and

warn of the threat of AIDS, the first case of which was confirmed in early 1993; cultural values and pride are disintegrating in the urban areas, as youth turn away from their unique and rich cultural heritage and social system in favour of Western role models, music, violent videos and alcohol; and suicide continues to be a leading killer of young men 15-30, with the Marshalls (and the rest of Micronesia) having a suicide rate many times higher than the United States.

Although 70 percent of the population is 25 and under, there are few facilities and organized programs for young people in the Marshall Islands. Government agencies have been overwhelmed by the sheer numbers of the population. Youth to Youth in Health was launched as a non-governmental organization in 1986 precisely because of the need to involve youth in primary health care. The community demand for youth health services and leadership training programmes has fuelled the growth of the project since then.

Youth to Youth in Health's Action Agenda

Goals

Increase the access of adolescents and young adults (13-25 years of age) in the Marshall Islands to primary health services, with an emphasis on preventive health education and action, including family planning and population, sexually transmitted diseases, nutrition and malnutrition, smoking, youth suicide, family abuse, and other issues of concern to the community.

Support the Ministry of Health and Environment's policy of primary health care by promoting health awareness and action with young people and the community, and involving young people and the community in Ministry of Health primary health programs and services.

Combine the promotion of cultural identity and pride, awareness of health needs, and youth responsibility as the basis for empowering youth to be 'change agents' throughout the Marshall Islands.

Objectives

Train young Peer Educators in health leadership seminars to develop their social consciousness about health and environmental issues, stimulate pride in their identity, and develop skills to improve their communities.

Expand community health outreach activities in Majuro, Ebeye and the outer lying atolls to raise awareness of primary health care by using creative means of communications such as skits, drama, music, dance, and audio visuals. Through these outreach activities promote a strong cultural identity in the community, focused on youth, by using traditional and contemporary Marshall Islands music and dance.

Produce video films, slideshows, radio programs, posters and leaflets on youth/community concerns (e.g., population and family planning,

sexually transmitted diseases, teen pregnancy, suicide, women's issues and the environment) to raise awareness about what youth can do to improve their society.

Cooperate with different government ministries and other agencies to assist programmes aimed at meeting the needs of young people. Specifically to assist Ministry of Health clinics and outreach services by providing youth counsellors for adolescent clients and peer educators for school and related outreach programmes.

Operate an adolescent health clinic in Majuro in conjunction with Ministry of Health staff and the Division of Adolescent Health to meet the needs of the growing urban youth population.

Youth to Youth in Health Organizational Structure

Youth to Youth in Health is an incorporated, non-profit, non-governmental agency in the Marshall Islands. YTYIH is a membership organization open to any young person in the Marshall Islands who attends a Youth Health Leadership Seminar, actively participates in outreach programmes and YTYIH meetings during the year, and pays monthly membership dues.

YTYIH has a two-tier organizational structure. The members elect an Executive Board from among the membership at an annual general meeting every July. The seven member Executive Board—a chairperson, vice-chairperson, secretary, treasurer, two members at-large, and the YTYIH director (who is non-voting)—sets policy, prepares budgets, plans fundraising and trainings, and insures that the objectives of the organization are being met by staff. The Executive Board reports to the members at regular membership meetings.

A community-based Advisory Committee reviews plans and programs of YTYIH, offers advice and suggestions, and has authority to hire and fire paid staff. From 1989, when YTYIH was incorporated, to 1993, the Advisory Committee was comprised of three community members, the chairperson and treasurer of YTYIH, and the YTYIH director. In 1993, the Advisory Committee was expanded to seven community members.

Reading 4: The Commonwealth Youth Credit Initiative

Africa

The Commonwealth Youth Credit Initiative (CYCI), CYP's pilot micro-credit project, facilitates equal access to credit by young men and women wishing to establish and expand micro-enterprises. The project is now up and running in three of the four CYP regions in association with partner NGOs.

In Africa, CYCI is being pilot-tested in Zambia where 45 young women and men from the Chawama, Matero and Chilenje urban compounds of Lusaka are currently setting up their own businesses in tailoring, hairdressing, carpentry and building. The majority of the young people are in the age range 25 to 29 years.

CYCI is being implemented in Lusaka through the National Savings and Credit Bank (NSCB) which has branches in rural and urban areas and which caters for young women and men operating in the informal sector. The implementation of CYCI is built into the NSCB branch operations. The branch managers in the three locations are front-line workers with responsibility for the orientation of young men and women to CYCI, loan delivery and recovery, and counselling them in drawing up business plans for viable micro-enterprise development and monitoring the management of savings.

A three-day training workshop for the participants, held in November 1996, focused on small-scale enterprise development and credit management and covered all the major areas required for successful implementation of CYCI, including business skills, marketing and group cohesion. The workshop was facilitated by the CYP Africa Centre, two trainers from the Zambian International Labour Organisation Start Your Business Programme (SYB), and two officials from the ILO Regional Office in Harare, Zimbabwe. Branch managers and a project officer from the NSCB also attended.

The 45 young people operate in groups of five. Each group has its own rules regarding leadership, maintaining cohesion and regulations about default of payment. Branch managers have identified key leaders in the groups who facilitate monitoring, promote group cohesion, and serve as peer educators and mentors for future CYCI entrepreneurs.

Asia

CYCI is being piloted by CYP in India, in partnership with the International Centre for Entrepreneurship and Career Development (ICECD) in three contrasting areas of Ahmedabad, Gujarat: an urban slum, a rural area and a tribal village. The project will cover

over 800 unemployed young men and women in the three year period from July 1996.

Urban Slum Programme

Thirty-six young women and 35 young men from an urban slum were selected and given basic training in entrepreneurship and enterprise management. Nine groups of five members each were then formed and savings activities were agreed. Further training, given in the local language, covered credit and finance management, product selection, preparation of project proposal, and market survey. Most of the young people have already started their businesses and loan repayments are on schedule.

The Rural Programme

A rural credit programme has been set up in six villages in three blocks in the periphery of Ahmedabad. Promotional work on CYCI has been carried out through personal visits, the use of videos and sensitisation workshops, providing information on the self-employment support facilities available under the CYCI project. Out of 700 applications, 64 young women and men were selected and given training. Groups were formed and loan applications processed and the pilot project began at the end of January 1996. Enterprises include bicycle repair, shops, clothes repairing, nurseries (for children), retail outlets for groceries, electrical and household goods, bakeries, and marble cutting.

The Management Advisory Board meets regularly to give guidance on the implementation of the project. The CYP Asia Centre is conducting overall monitoring and evaluation.

Caribbean

The CYCI pilot project was launched by CYP in Guyana in June 1996, in collaboration with the Global Trust and Investment Company. Fifty-two young people – 18 young women and 34 young men – were selected out of a total of 133 applications. A number of participants took part in an ‘adventure-type activity’ as part of personal development sessions designed to encourage teamwork, trust, personal awareness, and the development of leadership skills.

Further training was conducted over a period of three months, covering small business management skills, communication skills, developing a business plan, marketing, bookkeeping, gender relations, and the implications for business development. On completion of the training, participants will submit their business plans for assessment and loan disbursement. It is expected that 30 micro-enterprises will be established by June 1997.

South Pacific

A pilot CYCI project for the South Pacific region is on course to begin in the Solomon Islands later this year.

From *In Common*, Issue 17, May 1997, Commonwealth Secretariat.

Reading 5: Table of Nutrients

By the module authors.

| Nutrient | Main functions | Healthy food sources | Too much | Too little |
|--|--|--|---|---|
| Protein | growth, maintenance, repair of body tissues | fish, poultry, milk, nuts, eggs, meat, beans and pulses. | put on body fat | irritability, lower resistance to infections |
| Carbohydrate (includes fibre - see end of table) | major source of energy; moves materials through intestinal tract | <i>complex:</i> pasta, bread, rice and other cereals <i>simple:</i> vegetables, fruit | diarrhoea, dental decay, put on body fat; | lack of energy; weight loss; constipation; bowel cancer |
| Fats (includes saturated and unsaturated) | minor energy source; stores energy; transports Vitamins A, D, E, K | dairy products, oils, almonds, peanuts and other nuts, eggs, meat | put on body fat; high cholesterol levels | scaly skin and other skin disorders; weight loss; fatigue |
| Minerals: - Iron | carrier of oxygen, red blood cell formation | legumes, eggs, liver, meat, leafy vegetables, enriched cereals, prunes | nausea; constipation | anaemia |
| - Calcium | bone strength, promotes clotting of blood and water balance | milk, eggs, dark green leafy vegetables, legumes, sesame seeds, broccoli, dried beans | kidney stones | brittle bones |

| Nutrient | Main functions | Healthy food sources | Too much | Too little |
|---|---|---|------------------------------------|--|
| - Phosphorus | calcification of teeth, energy production | eggs, legumes, poultry, meat, fish, dairy products, whole grains | disrupts body's chemical balance | poor bone, teeth formation |
| Vitamin A (fat soluble) | maintains normal vision; aids night vision; promotes normal growth of bones; helps keep skin clear and smooth; increases resistance to infections | liver, lentils, beans, eggs, deep yellow and green vegetables and fruit, butter, milk and certain fish oils | aching limbs; insomnia; headache | poor night vision; decreased resistance to infections; dry scaly skin; |
| Vitamin B1 (Thiamine) (water soluble) | stimulates metabolism for energy production; necessary for healthy nerves | whole grain cereals, meat, fish, poultry, nuts, legumes | excreted | decreased appetite; weight loss; loss of energy; nervous disorders |
| Vitamin B2 (Riboflavin) (water soluble) | helps in energy production; aids in production of red blood cells and breakdown of fatty acids | milk, cheese, eggs, fish, green vegetables, lean meat, yeast | excreted | skin disorders; inflammation of tongue and lips |
| Vitamin B3 (Niacin) (water soluble) | active enzyme in metabolism of other nutrients | Yeast, wheat germ, eggs, soybeans, corn, whole grain cereals | flushing; tingling; gout; diabetes | nervous disorders; headaches |

| Nutrient | Main functions | Healthy food sources | Too much | Too little |
|--|---|---|--|--|
| Folic Acid (water soluble) | blood cell formation | green leafy vegetables, mushrooms, whole grains, yeast, legumes, oranges, bananas | none | anaemia |
| Vitamin B6 (pyridoxine) (water soluble) | helps energy production | yeast, wheat germ, whole grains, organ meats, eggs, milk, cheese | excreted | skin disorders; inflammation of intestinal tract; mucosa |
| Vitamin B12 (water soluble) | necessary for healthy nervous tissues; important in formation of blood | liver, kidney meat, fish, poultry, milk and milk products | excreted | anaemia; nervous system disorders; cracked skin |
| Vitamin C (Ascorbic acid) (water soluble) (destroyed by heat) | important in formation of teeth and bones; important in strengthening blood vessel walls; aids in absorption of iron; helps give immunity to infections | citrus fruits, tomatoes, strawberries, cabbage, green leafy vegetables, broccoli, cauliflower | stored | scurvy; sore and bleeding gums; delayed wound healing |
| Vitamin D (Calciferol) (fat soluble) | helps bones and teeth use calcium and phosphorus | direct exposure of skin to sunlight, fish, fish liver oils, egg yolk, cream, butter | vomiting; artery disease; possible calcification | soft, weak bones; enlarged joints; rickets; muscle spasm |

| Nutrient | Main functions | Healthy food sources | Too much | Too little |
|-----------------------------------|---|---|-------------------------------------|--|
| Vitamin E | helps stabilise cell membranes; aids in circulation of blood; antioxidant | wheat germ oil; egg yolk; leafy vegetables; dairy products; fish; meat | | changes in nervous system; fat malabsorption ; deterioration of cells; possible hastening of aging process |
| Vitamin K (fat soluble) | necessary for normal clotting of blood | alfalfa, dark green leafy vegetables, liver, tomatoes, egg yolk | possible rupture of red blood cells | delayed clotting of blood |
| Water | transport of other nutrients within the body; heat control within the body; necessary for elimination | water | increased urination | thirst; constipation, dehydration, death |
| Fibre | important in digestion; binds waste with water; moves material through intestinal tract | wholegrain pasta, bread, rice and other un-processed cereals, raw vegetables, fruit, especially with skin on. | diarrhoea | constipation, bowel cancer |

Reading 6: The functions of nutrients

By Michael C. Latham, *Human Nutrition*, Microsoft (R) Encarta. Copyright (c) 1994
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The functions of the various categories of nutrients are described below.

Proteins

The primary function of protein is to build body tissue and to synthesise enzymes, some hormones such as insulin that regulate communication among organs and cells, and other complex substances that govern body processes. Animal and plant proteins are not used in the form in which they are ingested but are broken down by digestive enzymes called proteases into nitrogen-containing amino acids. Proteases disrupt the peptide bonds by which the ingested amino acids are linked, so that they can be absorbed through the intestine into the blood and recombined into the particular tissue needed.

Proteins are usually readily available from both animal and plant sources. Of the 20 amino acids that make up protein, 8 are considered essential – that is, because the body cannot synthesise them, they must be supplied ready-made in foods. If these essential amino acids are not all present at the same time and in specific proportions, the other amino acids, in whole or in part, cannot be used for metabolising human protein. Therefore, a diet containing these essential amino acids is very important for sustaining growth and health. When any of the essential amino acids is lacking, the remaining ones are converted into energy-yielding compounds, and their nitrogen is excreted. When an excess of protein is eaten, which is often the case with heavy meat diets in the United States, the extra protein is similarly broken down into energy-yielding compounds. Because protein is far scarcer than carbohydrates and yields the same 4 calories per gram, the eating of meat beyond the tissue-building demands of the body becomes an inefficient way to procure energy. Foods from animal sources contain complete proteins because they include all the essential amino acids. In most diets, a combination of plant and animal protein is recommended: 0.8 grams per kilogram of body weight is considered a safe daily allowance for normal adults.

Many illnesses and infections lead to an increased loss of nitrogen from the body. This needs to be replaced by a higher consumption of dietary protein. Infants and young children also require more protein per kilogram of body weight. A protein deficiency accompanied by energy deficits results in a form of protein-energy malnutrition called kwashiorkor, which is characterised by loss of body fat and wasting of muscle.

Minerals

Inorganic mineral nutrients are required in the structural composition of hard and soft body tissues; they also participate in such processes as the action of enzyme systems, the contraction of muscles, nerve reactions, and the clotting of blood. These mineral nutrients, all of which must be supplied in the diet, are of two classes: the major elements such as calcium, phosphorus, magnesium, iron, iodine, and potassium; and trace elements such as copper, cobalt, manganese, fluorine, and zinc.

Calcium is needed for developing the bones and maintaining their rigidity. It also contributes in forming intracellular cement and the cell membranes, and in regulating nervous excitability and muscular contraction. About 90 percent of calcium is stored in bone, where it can be reabsorbed by blood and tissue. Milk and milk products are the chief source of calcium.

Phosphorus, also present in many foods and especially in milk, combines with calcium in the bones and teeth. It plays an important role in energy metabolism of the cells, affecting carbohydrates, lipids, and proteins.

Magnesium, which is present in most foods, is essential for human metabolism and is important for maintaining the electrical potential in nerve and muscle cells. A deficiency in magnesium among malnourished people, especially alcoholics, leads to tremors and convulsions.

Sodium, which is present in small and usually sufficient quantities in most natural foods, is found in liberal amounts in salted prepared and cooked foods. It is present in extracellular fluid, which it plays a role in regulating. Too much sodium causes oedema, an over-accumulation of extracellular fluid. Evidence now exists that excess dietary salt contributes to high blood pressure.

Iron is needed to form haemoglobin, which is the pigment in red blood cells responsible for transporting oxygen, but the mineral is not readily absorbed by the digestive system. It exists in sufficient amounts in men, but women of menstrual age, who need nearly twice as much iron because of blood loss, often have deficiencies and must take in absorbable iron.

Iodine is needed to synthesise hormones of the thyroid gland. A deficiency leads to goitre, a swelling of this gland in the lower neck. Low iodine intakes during pregnancy may result in the birth of cretinous or mentally retarded infants. Goitre, which used to be common in the United States population, still remains prevalent in certain parts of Asia, Africa, and South America. It is estimated that worldwide more than 150 million people suffer from iodine deficiency diseases.

Trace elements are other inorganic substances that appear in the body in minute amounts and are essential for good health. Little is known

about how they function, and most knowledge about them comes from how their absence, especially in animals, affects health. Trace elements appear in sufficient amounts in most foods.

Among the more important trace elements is copper, which is present in many enzymes and in copper-containing proteins found in the blood, brain, and liver. Copper deficiency is associated with the failure to use iron in the formation of haemoglobin. Zinc is also important in forming enzymes. A deficiency of zinc is believed to impair growth and, in severe cases, to cause dwarfism. Fluorine, which is retained especially in the teeth and bones, has been found necessary for growth in animals. Fluorides, a category of fluorine compounds, are important for protecting against demineralisation of bone. The fluoridation of water supplies has proved an effective measure against tooth decay, reducing it by as much as 40 percent. Other trace elements include chromium, molybdenum, and selenium.

Vitamins

Vitamins are organic compounds that mainly function in enzyme systems to enhance the metabolism of proteins, carbohydrates, and fats. Without these substances, the breakdown and assimilation of foods could not occur. Certain vitamins participate in the formation of blood cells, hormones, nervous system chemicals, and genetic materials. Vitamins are classified into two groups, the fat-soluble and the water-soluble vitamins. Fat-soluble vitamins include vitamins A, D, E, and K. The water-soluble vitamins include vitamin C and the B-vitamin complex.

Fat-soluble vitamins are usually absorbed with foods that contain fat. They are broken down by bile which is produced by the liver, and the emulsified molecules pass through the lymphatics and veins to be distributed through the arteries. Excess amounts are stored in the body's fat and in the liver and kidneys. Because fat-soluble vitamins can be stored, they do not have to be consumed every day.

Vitamin A is essential for the health of epithelial cells and for normal growth. A deficiency leads to skin changes and to night blindness, or a failure of dark adaptation due to the effects of deficiency on the retina. Later, xerophthalmia, an eye condition characterised by dryness and thickening of the surface of the conjunctiva and cornea, may develop; untreated, xerophthalmia can lead to blindness, especially in children. Vitamin A can be obtained directly in the diet from foods of animal origin such as milk, eggs, and liver. In developing countries, most vitamin A is obtained from carotene, which is present in green and yellow fruits and vegetables. Carotene is converted to vitamin A in the body.

Vitamin D acts much like a hormone and regulates calcium and phosphorus absorption and metabolism. Some vitamin D is obtained from such foods as eggs, fish, liver, butter, margarine, and milk, some of which might have been fortified with vitamin D. But humans get

most of their vitamin D from exposure of the skin to sunlight. A deficiency leads to rickets in children or osteomalacia in adults.

Vitamin E is an essential nutrient for many vertebrate animals, but its role in the human body has not been established. It has been popularly advocated for a great variety of afflictions, but no clear evidence exists that it alleviates any specific disease. Vitamin E is found in seed oils and wheat germ.

Vitamin K is necessary for the coagulation of blood. It assists in forming the enzyme prothrombin, which, in turn, is needed to produce fibrin for blood clots. Vitamin K is produced in sufficient quantities in the intestine by bacteria, but is also provided by leafy green vegetables such as spinach and kale, egg yolk, and many other foods.

The water-soluble vitamins, C and B complex, cannot be stored and therefore need to be consumed daily to replenish the body's needs. Vitamin C, or ascorbic acid, is important in the synthesis and maintenance of connective tissue. It prevents scurvy, which attacks the gums, skin, and mucous membranes, and its main source is citrus fruits.

The most important B-complex vitamins are thiamine (B1), riboflavin (B2), nicotinic acid or niacin (B3), pyridoxine (B6), pantothenic acid, lecithin, choline, inositol, para-aminobenzoic acid (PABA), folic acid, and cyanocobalamin (B12). These vitamins serve a wide range of important metabolic functions and prevent such afflictions as beriberi and pellagra. They are found mostly in yeast and liver.

Carbohydrates

Carbohydrates provide a great part of the energy in most human diets. Foods rich in carbohydrates are usually the most abundant and cheapest, when compared with foods high in protein and fat content. Carbohydrates are burned during metabolism to produce energy, liberating carbon dioxide and water. Humans also get energy less efficiently from fats and proteins in the diet, and also from alcohol.

The two kinds of carbohydrates are starches, which are found mainly in grains, legumes, and tubers, and sugars, which are found in plants and fruits. Carbohydrates are used by the cells in the form of glucose, the body's main fuel. After absorption from the small intestine, glucose is processed in the liver, which stores some as glycogen, a starchlike substance, and passes the rest into the bloodstream. In combination with fatty acids, glucose forms triglycerides, which are fat compounds that can be easily broken down into combustible ketones. Glucose and triglycerides are carried by the bloodstream to the muscles and organs to be oxidised, and excess quantities are stored as fat in the adipose and other tissues, to be retrieved and burned at times of low carbohydrate intake.

The carbohydrates containing the most nutrients are the complex carbohydrates, such as unrefined grains, tubers, vegetables, and fruit,

which also provide protein, vitamins, minerals, and fats. A less beneficial source is foods made from refined sugar, such as candy and soft drinks, which are high in calories but low in nutrients and fill the body with what nutritionists call empty calories.

Fats

Although scarcer than carbohydrates, fats produce more than twice as much energy. Being a compact fuel, fat is efficiently stored in the body for later use when carbohydrates are in short supply. Animals obviously need stored fat to tide them over dry or cold seasons, as do humans during times of scarce food supply. In industrial nations such as the United States, however, with food always available and with machines replacing human labour, the accumulation of body fat has become a serious health concern.

Dietary fats are broken down into fatty acids that pass into the blood to form the body's own triglycerides. The fatty acids that contain as many hydrogen atoms as possible on the carbon chain are called saturated fatty acids and are derived mostly from animal sources. Unsaturated fatty acids are those having some of the hydrogen atoms missing; this group includes monounsaturated fatty acids, which have a single pair of hydrogens missing, and polyunsaturated fatty acids, which have more than one pair missing. Polyunsaturated fats are found mostly in seed oils. Saturated fats in the bloodstream have been found to raise the level of cholesterol, and polyunsaturated fat tends to lower it. Saturated fats generally are solid at room temperature; polyunsaturated fats are liquid.

Reading 7: Methods of contraception: how to use them

The information used in this reading was produced by the Family Planning Services project, Zambia.

Oral contraceptives

There are two types of contraceptive pill, the low-dose or regular pill, and the mini-pill, which is best for women who are breast-feeding.

The low-dose pill

What it is: the pill is a small tablet that a woman takes every day to prevent pregnancy.

How it works: the pill has chemicals called hormones inside it which keep a woman's body from releasing an egg every month. Without the egg a woman can not become pregnant.

Advantages/benefits:

- Very effective when taken every day.
- Easy to use.
- Does not get in the way during sexual intercourse.
- Periods are usually regular and lighter, many women have less menstrual cramping.
- May help protect the reproductive system against some diseases.

Who should not use it:

A woman should not use it if she-

- has unexplained vaginal bleeding
- may be pregnant
- is over 35 years and smokes
- has high blood pressure
- has heart problems
- has had liver disease (yellow-looking eyes or skin) within the past year
- has blood clots or swellings in the legs
- has severe headaches very often
- has diabetes (sugar in urine)

- is breastfeeding an infant under six months old (she can use pregestin-only (mini) pills).

How to use:

- The woman starts to take the pill during her bleeding (menstrual) period, or immediately after she has an abortion.
- The woman takes the pill every day, preferably at the same time.
- When the packet is empty, she starts taking pills from a new packet immediately.
- If a woman wants to get pregnant, she should stop taking the pills.
- If she forgets a pill, she should take a pill as soon as she remembers, even if she takes two the same day.
- If she forgets three or more white or yellow pills in a row, she should keep taking the rest of her pills as usual and also use a condom, or foam, for seven days, for extra protection. Forgetting brown iron pills is not a problem for contraception.

Possible side-effects:

- Nausea (urge to vomit).
- Slight weight gain or loss.
- Mild headache or dizziness.
- Breast tenderness.
- Slight bleeding between periods.

Things to report immediately:

- Severe, constant pain in belly, chest, or one leg.
- Severe headache with trouble speaking, seeing, or moving.
- Yellow-looking eyes or skin.
- Vomiting more than three times in a day.

Follow-up:

- Return to the clinic whenever you need more pills.
- Come any time you have any questions, warning signs (see above) or problems.

The mini-pill

What it is: The mini-pill is a special small tablet that a breastfeeding woman can take every day to prevent pregnancy.

How it works: The pill has a chemical called pregestin inside it which keeps a woman from releasing an egg every month. Without the egg a woman cannot become pregnant.

Advantages/benefits:

- Very effective when taken every day.
- Easy to use.
- Does not get in the way during sexual intercourse.
- Does not affect milk production.
- May help protect the reproductive system against some diseases.

Who should not use it:

A woman should not use it if she:

- has unexplained vaginal bleeding
- may be pregnant
- is over 35 years and smokes
- has high blood pressure
- has had an ectopic pregnancy in the past
- has had liver disease (yellow-looking eyes or skin) within the past year
- is taking rifampicin or griseofulvin, anticonvulsants or barbiturates
- is breastfeeding an infant under six weeks old.

(**Note:** Combined oral contraceptives should not be used by mothers breastfeeding a child under six months.)

How to use:

- The woman takes the pill any time starting two weeks postpartum.
- The woman takes one pill every day, preferably at the same time.
- When the packet is empty, she starts taking pills from a new packet immediately.
- If a woman wants to get pregnant, she should stop taking the pills.
- If she forgets a pill, she should take a pill as soon as she remembers, even if she takes two the same day.
- If she forgets three or more white pills in a row, she should keep taking the rest of her pills as usual and also use a condom, or foam, for seven days for extra protection.

Possible side-effects:

- Nausea (urge to vomit).
- Slight weight gain or loss.
- Mild headache or dizziness.
- Breast tenderness.
- Slight bleeding between periods.

Things to report immediately:

- Severe, constant pain in belly, chest, or one leg.
- Severe headache with trouble speaking, seeing, or moving.
- Yellow-looking eyes or skin.
- Vomiting more than three times in a day.

Follow-up:

- Return to the clinic whenever you need more pills.
- Come any time you have any questions, warning signs (see above) or problems.

The Condom

What it is: A condom is a close-fitting rubber sac that a man wears over his erect penis during sexual intercourse, to capture and hold his sperm. Condoms prevent pregnancy and sexually transmitted diseases.

How it works: It prevents pregnancy by holding back the sperm so that it cannot enter the vagina and meet the egg.

Advantages/benefits:

- Highly effective for most people if used properly every time.
- Easy to get.
- Inexpensive.
- Easy to use.
- No prescription necessary.
- Easy to carry in a handbag.
- Helps prevent STDs, including HIV/AIDS.
- Encourages male involvement in family planning.
- Seldom any side-effects.

How to use:

Store condoms in cool, dry, convenient place. Do not store against your body (in pocket or wallet) for a long time as this will make the condom weak and may cause it to break.

Before sexual intercourse, carefully take the condom out of the package. Do not unroll.

Inspect condom. Do not use if it is discoloured or has a bad odour.

Possible side-effects:

- May lessen the degree of physical sensation during sex.
- May cause irritation if allergic to rubber.

The IUCD (Intra Uterine Contraceptive Device)

What it is: The Intra Uterine Contraceptive Device (IUCD) is a small plastic device that fits inside the uterus (womb) to prevent pregnancy. The newer, more effective IUCDs have copper wire or bands wrapped in plastic.

How it works: The IUCD keeps sperm from reaching and fertilising the egg.

Advantages/benefits:

- Highly effective.
- Once inserted, gives at least ten years of protection.
- Does not interfere with sexual intercourse.
- Can be put in right after childbirth by specially trained doctors and used during breastfeeding.
- Can be inserted immediately after abortion (first trimester) or miscarriage, if the womb is not infected or damaged.

Who should not use it:

A woman who:

- may be pregnant
- has an active cervical or pelvic infection, including sexually transmitted diseases
- has had a pelvic inflammatory disease in the past three months
- has abnormal bleeding of unknown origin
- is at high risk of exposure to sexually transmitted diseases
- has any medical condition that lowers resistance to infection (including HIV).

How to use it:

- A trained doctor or nurse puts the IUCD into the uterus (womb). It takes only a few minutes, and is easy for them to do.
- At anytime, a woman can reach inside her vagina with her fingers to feel the strings of the IUCD. That will help her make sure it is there.
- There is nothing else to do. It works by itself.

Possible side-effects/problems:

- Some women have more monthly bleeding and cramps.
- Some women have spotting (small bleeding) between periods.
- Women who get STDs are more likely to get pelvic infection.
- Sometimes IUCDs come out of the uterus into the vagina.

Things to report immediately:

- Suspected pregnancy.
- Extremely heavy vaginal bleeding (twice as much bleeding or twice as long as usual).
- Pain after insertion that lasts more than eight hours.
- Possible exposure to STD.
- If client wants IUCD removed for any reasons.
- Strings bother her partner.
- Signs of infection: abnormal vaginal discharge, chills, fever, pain.
- IUCD strings are missing.

Follow-up:

Client should return to the clinic for a check-up 4–6 weeks after insertion, when not menstruating. She should come any time she has any questions or problems.

Contraceptive Norplant implants

What it is: Norplant is a set of six small plastic capsules filled with a hormone. It is inserted just under the skin in a woman's arm to prevent pregnancy.

How it works:

Norplant is placed just under the skin of a woman's lower or upper arm. The capsules slowly release a hormone that causes temporary changes in the woman's reproductive system such as thickening of the cervical mucus which makes it difficult for the sperm to reach the egg.

Once inserted, Norplant prevents a woman from getting pregnant for up to five years.

Advantages/benefits:

- Highly effective.
- Immediate return to fertility after removal.
- Decreases amount of menstrual flow.
- Does not affect breastfeeding.
- Does not interfere with sexual intercourse.
- Is effective for five years.

Who should not use it:

Women who:

- may be pregnant
- have active liver disease or jaundice (yellow-looking skin or eyes)
- have unexplained vaginal bleeding
- have cancer of the liver or the breast
- are uncomfortable, for whatever reasons, with menstrual change
- have cancer of the reproductive system
- have a history of heart disease
- have high blood pressure.

How to use:

- Norplant should be inserted during the first seven days following the start of menstrual periods, immediately after abortion, or six weeks after childbirth.
- In a short, simple procedure, a trained provider makes a very small cut on the inside of a woman's upper or lower arm.
- The trained service provider inserts six capsules through the cut.
- The capsules remain in a fan shape at the spot where they were inserted.
- The place where the small cut has been made should be kept clean and dry until it is healed.
- Once a week after the insertion the woman should return to the clinic for a check-up.
- Norplant is immediately effective after insertion.
- If a woman wants to become pregnant, she must have Norplant removed by a trained service provider. Removal follows almost the same procedure as insertion but takes a little longer.

- Norplant must be removed at the end of five years.

Disadvantages:

Requires minor surgical procedure by trained personnel for insertion and removal.

Causes menstrual changes, especially spotting and more days of bleeding.

Follow-up:

- Client should return to clinic after insertion for check-up as instructed or anytime she has problems or questions.
- Client should report to the clinic if her address changes or she is planning to leave the service site.

Things to report immediately:

- Severe pain in lower belly.
- Heavy vaginal bleeding.
- Arm pain.
- Pus or bleeding at insertion site.
- Norplant comes out of body.
- Repeated headaches and/or trouble seeing.
- High blood pressure.
- Excessive weight gain.

The injectable

What it is: The injectable is an injection of a chemical called a hormone given to a woman to prevent pregnancy. There are two kinds of injectables – Depo-Provera (DMPA) given every three months, and Noristerat (NET-EN) given every two months.

How it works: The hormone in the injectable prevents the woman's ovaries from releasing an egg every month, and/or thickens the cervical mucus, which blocks the sperm from entering the womb.

Advantages/benefits:

- Highly effective when taken on schedule.
- Easy to use.
- Does not interfere with sexual intercourse.
- Can be used by breastfeeding mothers six weeks after delivery.

Who should not use it:

A woman who:

- may be pregnant
- has breast cancer
- has unexplained abnormal vaginal bleeding
- is breastfeeding a baby less than six weeks old
- has had liver disease (yellow-looking eyes or skin)
- has high blood pressure
- has had heart disease or stroke
- is at risk of getting or giving a sexually transmitted disease, including HIV/AIDS.

How to use:

- A trained service provider gives the injection during the first seven days of the woman's menstrual period.
- The injection is usually given in the upper arm or in the buttock.
- The woman should return to the clinic for the next injection as advised by medical workers.
- If a woman wants to become pregnant, she should stop taking the injection.

Possible side-effects:

- Temporarily stops monthly menstrual periods (amenorrhoea) in many women. This is not harmful, and does not mean permanent infertility.
- May cause heavier menstrual periods or bleeding between periods.
- Mild headaches.
- Slight weight gain.
- May take 3–6 months to become pregnant after stopping the injectable.

Things to report immediately:

- Frequent headache that causes trouble speaking, seeing or moving.
- Infection at the injection site.
- Extremely heavy or prolonged menstrual bleeding.

Follow-up:

- Client should return to the clinic for the next injection as scheduled.

- Client should return any time if she has any questions, warning signs or problems.

Spermicides

What they are: Spermicides help to stop pregnancy by killing sperm and blocking the opening of the womb so sperm cannot meet the egg.

How they work: They contain a chemical called a spermicide that kills sperm. They also create a barrier to block sperm from meeting the egg.

Advantages/benefits:

- Effective if used every time, especially when combined with a condom or diaphragm.
- No harmful side-effects.
- Convenient and easy to use.
- No prescription needed.
- Available at the clinics and chemists.
- Provides more lubrication (wetness) during sex.

Who should not use it:

Any woman:

- who must avoid pregnancy for medical reasons
- who feels irritation or discharge from the vagina from spermicides
- whose partner feels irritation of the penis from spermicide.

How to use:

If using foam tablets:

- 1 Insert one or two tablets high into the vagina.
- 2 Wait 5–7 minutes to allow tablets to dissolve before intercourse.

If using foam:

- Shake the tube very well.
- Put the applicator over the nozzle of the tube.
- Gently tilt the applicator to depress the nozzle and fill to the marked place on the tube with foam.
- While lying down, insert the foam-filled applicator into the vagina as far as it will go.
- Push on the plunger to release the foam and remove the applicator.

If using cream or jelly:

- Screw the applicator over the opening of the tube.
- Squeeze the tube until the applicator is full to the marking.
- Insert the applicator into the vagina as far as it will go.
- Push on the plunger to release the cream or jelly and remove the applicator.
- Insert the spermicide deep into the vagina before sexual intercourse.
- Additional spermicide must be used before each round of sexual intercourse.
- If sexual intercourse does not take place within one hour repeat the application of spermicide.
- Wash the applicator with soap and water after each use.
- When not using spermicides, store them in a cool dry place out of the reach of children.

Possible side-effects:

- May cause minor irritation of penis or vagina.
- Some people think it makes the woman feel too wet.

Things to report immediately:

- Pelvic or genital infection.
- Irritation of penis or vagina.

Follow-up:

- Client should return to the clinic or chemist, for resupply as necessary.
- If client has problems with the method or forgets to use it for each round of sexual intercourse, she should return to the clinic for counselling on another method.

Voluntary female sterilisation

What it is: Female sterilisation is permanent contraception for women who do not want any more children. It is a simple and safe procedure.

How it works: The doctor makes a small cut in the abdomen and blocks the fallopian tubes so sperm cannot reach and fertilise the egg.

Advantages/benefits:

- Very effective.
- Permanent, single operation provides life-long contraception.

- Does not interfere with sex.
- May help protect against ovarian cancer.

Possible side-effects:

- May be some complications from surgery such as bleeding or infection; these are usually very minor.
- May be some pain for a few days after surgery.

Who should not use it:

- Any client who thinks she may want more children.
- May be pregnant.
- Has untreated pelvic infection, including a sexually transmitted disease.
- Has blood clotting disorder.

Follow-up:

- Rest for 2–3 days after surgery.
- Keep the cut clean and dry for 2–3 days after surgery.
- Return to the clinic in a week if stitches need to be removed.
- Do not have sex until all pain is gone.

Things to report immediately:

- Severe pains in the belly (abdomen).
- Bleeding or pus from the cut.
- Fever.

LAM – lactational amenorrhea method

What it is: LAM is a natural method of preventing pregnancy that a breastfeeding woman can use in the first 6 months after childbirth.

How it works: LAM is based on the way breastfeeding affects a woman's body. The baby's suckling stops the release of the hormones that cause the release of eggs.

Advantages/benefits:

- Highly effective if breastfeeding is done exclusively (this means giving your baby only breast and no food or water in addition).
- Encourages healthy breastfeeding practices.
- Nothing to buy.
- Does not interfere with sexual intercourse.

Who should not use it:

Any woman:

- who is not breastfeeding exclusively
- whose child is past six months old
- whose menstrual period has returned.

How to use LAM:

You can rely on breastfeeding to protect you from pregnancy for UP TO SIX MONTHS following the birth, **IF**:

- (a) It is less than six months after delivery.
- (b) You breastfeed at least every four hours during the day and every six hours during the night *and give no other food or drink (even water) to the baby.*
- (c) You make sure that your menses (menstrual discharge) has not returned. If it does return – even in the first six months – you are at risk of getting pregnant again.

Use another method if your period starts.

Possible problems:

- The woman must breastfeed at least every four hours during the day and at least every six hours at night.
- Woman will give extra food and drink to the baby, thinking it needs it. It doesn't. This may reduce the child's demand for milk which will reduce lactation and may make the woman fertile.

Follow-up:

- When any one of the three conditions for LAM use changes, client should use another family planning method that does not interfere with breastfeeding.
- Counsel client on proper nutrition!

Things to report immediately:

- Breastfeeding difficulties such as swelling, plugged ducts, redness and sores should be treated immediately.
- Suspected pregnancy.

Scientific natural family planning**What it is:**

Scientific Natural Family Planning methods are a way to prevent pregnancy without using modern contraceptive methods. They depend on identifying what period during a woman's menstrual cycle

she is most likely to get pregnant. The couple can avoid sex during this period to avoid unwanted pregnancy.

Types:

- 1 Symptothermal Method (observing mucus and temperature).
- 2 Cervical Mucus Method (observing mucus only).
- 3 Rhythm, Calendar or Safe Period Method (calculating based on record of past menstrual cycles).

Advantages/benefits:

- Effective, if used correctly and consistently.
- No drugs, devices, chemicals or surgery needed.
- No health risks or side-effects.
- Can help to strengthen bonds of marriage in some couples.
- Little or no cost.
- No need for prescriptions.
- Improves knowledge of reproductive system.

Who should not use it:

- Women whose health would be endangered by another pregnancy
- Women who cannot avoid sexual intercourse during the most fertile days of their cycle (at least seven days in each cycle).

Disadvantages:

- More difficult to use correctly all the time than most modern methods. Incorrect and inconsistent use can significantly lower effectiveness.
- Menstrual cycles can sometimes change unexpectedly. Requires daily monitoring.
- Can get in the way of sexual spontaneity (having sex whenever one wants).

How it works:

A woman's body goes through a natural cycle of fertility every 28 days or so. A woman is at risk of pregnancy only about 7 to 10 days during this cycle. Women can have a good idea when these risky days are by paying close attention to their bodies. Women who use a combination of the following methods have success in correctly predicting their fertile phase.

1. A woman who has very regular periods can keep a record of when her bleeding (menses) starts. If she counts from this day,

she can know that from the ninth to the eighteenth day, she will probably be the most fertile. NOTE: The length of some women's cycles can shorten or lengthen without warning, therefore this method does not always work.

2. A woman who has a thermometer can take her waking-up temperature every morning. She can record her 'lower' and 'higher' temperature days in her menstrual cycle. (Higher days are at least 0.2 degrees Celsius above lower days). By learning to read the patterns of temperature changes, she can know when she has gone past her fertile phase. She knows she is no longer fertile during her cycle from the evening of the third higher temperature day until when her next menses starts. However, this will not help her know when the fertile phase starts, so she would have to avoid sex from the time she menstruates until her temperature rises again.
3. A woman can see and feel changes in her cervical mucus. She can learn to read these changes and predict when her fertile period starts. These changes are sometimes difficult to learn to read correctly, but with good training, a woman can learn to do this quite well.

How to use scientific natural family planning to avoid unwanted pregnancy

During early dry days: (days just after menstruation when a woman feels dry inside).

No sex during day. If you have been dry all day, you can have sex that night. If you start to feel wet during the day, you should avoid sex.

During fertile days: (days when a woman feels wet, plus three days after the last day she felt wet).

Avoid sex on all mucus/wet days and until three days after Peak. 'Peak' is the last day that a woman feels wet or has the most stretchy mucus.

During late infertile days: (fourth morning after 'Peak' until beginning of menstruation (bleeding). Have sex as desired.

During menstruation: Have sex as desired. Note: Risk of HIV transmission is higher at this time.

Counselling alert!

Do your clients know about how STDs, including HIV/AIDS, are spread?

Do they know what protection this method does or does not offer against STDs?

NOTE: A client who takes her temperature every morning on waking will be able to know when she is no longer fertile in that cycle. A woman has 'lower' and 'higher' temperature days in her menstrual

cycle. Higher days are at least 0.2 degrees Celsius above lower days. A woman is no longer fertile during her cycle from the evening of the third higher temperature day until her next menses starts.

Reading 8: Contraceptive methods: their effectiveness

By the module authors

Non-Prescription Methods

Abstinence

How effective is abstinence:

Almost 100 percent, unless semen and vaginal fluids are exchanged by other means e.g. manually.

Popular Myths

Abstinence causes 'blue balls' or swollen testicles in males; a female who abstains is sexually repressed; abstinent teens will be unpopular; 'nobody' practices abstinence.

Additional information:

Abstinence is readily available to both males and females for no cost, no medical side effects, no risks, no worry and no conflicts with parents. A person who has had sexual intercourse in the past may decide to abstain at any time, in any relationship. For a youth who has had intercourse, it is still possible to encourage 'a second virginity.'

Abstinence protects health and reproductive capacity by reducing or eliminating the risk of HIV infection, STD and pelvic inflammatory disease.

Abstinence completely eliminates the chance of an unintended pregnancy and therefore does not interfere with future goals.

Withdrawal

How withdrawal works: Prevents the ejaculation of semen into the female's body.

How withdrawal is used: Requires the penis to be removed before ejaculation.

Failure rate (range) 4-19 per cent

Additional information: Even though the penis is withdrawn before ejaculation, preseminal or vaginal fluid may contain sperm cells that can cause pregnancy and may contain organisms that cause STD/HIV infection.

Using this method requires a high degree of control and motivation. It is not an ideal method, but it is definitely better than no method.

Natural Family Planning (NFP also known as periodic abstinence)

Types of NFP: Calendar, basal body temperature and cervical mucus.

How NFP methods are used: The time of ovulation is determined by changes in the woman's body temperature or the cervical mucus; then intercourse is avoided for a specific number of days before and after ovulation.

Failure rate (range) Between 2 – 30 per cent

Where to obtain NFP instructions: Usually from a specially trained physician, a professional NFP counsellor or family planning clinic.

Additional information: NFP does not prevent the spread of STDs or HIV/AIDS infections. It requires training from a qualified professional. It is often unreliable, particularly in women younger than 20 years, whose menstrual cycles may be irregular. NFP is also difficult for some couples to use, as it requires the couple to refrain from intercourse for many days during each cycle and, therefore demands motivation and control and a lot of partner cooperation.

NFP should be used with another method of contraception if intercourse occurs close to the time of ovulation.

Prescription Methods

Male Condom (Rubber/Socks)

How the male condom works: Prevents semen from entering the partner's body.

How the condom is used: Before sexual intercourse begins, a condom is placed over the erect penis; space must be left at the end to collect the sperm (some condoms have a special tip for sperm collection); air should be squeezed out of this space before intercourse. After ejaculation, the condom should be held in place when removing the penis so semen does not spill out of the open end of the condom into the partner's body. Condoms can be used with a spermicide containing nonoxynol-9. Condoms must be properly disposed of after one use; they should never be re-used.

Failure rate (range) 2 – 12 per cent

Where to obtain the condom: Chemists, some 'duskas' (small roadside stalls), some grocery stores, CBD agents, family planning clinics, clinics, hospitals and some school-based health centres or school nurses' offices, vending machines in some bars, hotels.

Additional information: Vaseline will destroy the condom. Condoms deteriorate so check the date of manufacture and expiry

date on the box, before use. When stored properly, condoms are good for about 5 years from date of manufacture. Do **not** use a condom if: the package is broken or unsealed, the condom is brittle, dried out or sticky, or the colour is changed; or the expiry date on the package has passed. The latex condom is a relatively inexpensive method and, if used correctly and consistently every time one has sex, is very effective in preventing unwanted pregnancy and STDs, including HIV/AIDS. Lambskin condoms are not effective for preventing some STDs including HIV/AIDS.

Female Condom (Reality or Femidon)

How the female condom works: Prevents semen from entering the woman's uterus and protects male partner from contact with vaginal fluids.

How the female condom is used: Before sexual intercourse begins, it is inserted into the vagina. The female condom is a polyurethane sheath with two flexible rings at either end. One of the rings is used to insert the device and hold it in place, much like a diaphragm. The other ring stays outside of the vagina.

The female condom must be removed immediately after intercourse and must be thrown away after **one** use; it should never be re-used.

Failure rate (range) 5 – 21 per cent

Where to obtain the female condom: Family planning clinics, some chemists.

Additional information: The female condom helps to prevent the spread of most sexually transmitted diseases. It provides women with a way to protect themselves if they are with a partner who refuses to use a male condom. Additional research is being carried out to assess the effectiveness of the female condom.

Contraceptive foams and other spermicides

How foam and other vaginal spermicides work: Temporarily blocks the opening of the uterus and coats much of the vagina; kills sperm. Foam, which contains nonoxynol-9, has been proven to protect against most STDs, but not HIV/AIDS.

How foam is used: A can of foam is shaken approximately 20 times before the foam is removed; one or two applications of foam are placed into the vagina immediately before intercourse. A foaming tablet is placed high in the vagina about 10 minutes before intercourse (so it has time to dissolve).

Failure rate (range) 6 – 30 per cent

Where to obtain foam: chemists, some 'duka' or small shops, family planning clinics, district hospitals.

Additional information: The quality of foams vary. Foam must be available and used each time intercourse occurs. Since foam dissolves

in the vagina, douching is unnecessary, but if it is desired, wait until at least six to eight hours after intercourse. However, girls should note that douching is not healthy. Foam is an inexpensive method. It may cause minor irritation in some women and men.

Note: All prescriptive methods are effective in preventing a pregnancy but, apart from condoms, they do not provide protection against STDs including HIV/AIDS.

Contraceptive implant (Norplant)

How the contraceptive implant works: Prevents release of an egg from the ovary (ovulation) and thickens cervical mucus, blocking sperms that are released into the vagina during intercourse.

How the contraceptive implant is used: During a minor surgical procedure, six flexible, matchstick-sized capsules are implanted just under the skin on the underside of a woman's upper arm. Each capsule contains a small amount of a female hormone, progestin, which is also used in oral contraceptives. The hormone is absorbed into the woman's blood stream very slowly for a long time as the capsules remain in place for up to five years.

Failure rate (range) 0.09 -0.2 per cent

Where to obtain the contraceptive implant: Private physician or family planning clinic. Availability may be limited in areas where few practitioners have been trained to insert it.

Additional information: The method is effective for up to five years and requires no additional action by the user once it is in place. Once the implant is removed, normal fertility is restored by the next menstrual cycle. This method may be used to prevent pregnancy by women who want a long-term method but who find it difficult to use other contraceptive methods. The common side effects are intra-menstrual spotting and bleeding, or amenorrhea. The method does not protect against STDs including HIV/AIDS.

Injectables: Depo-provera or Net-en

How the injectable works: An injection (a shot) of the hormone progestin stops eggs from being released by the ovaries for up to three months and thickens cervical mucus, blocking sperm from entering the uterus.

How the injectable is used: Depo-provera is injected into the muscle of the arm or buttocks by a trained practitioner. The first shot is usually given during the first five days of a woman's menstrual cycle to ensure that she does not become pregnant. Shots must be repeated every 12 weeks or months. If the woman is using Net-en, shots are repeated every 8 weeks or 2 months.

Failure rate (range) 0 – 0.7 per cent

Where to obtain Depo-Provera: Family planning clinic, some district hospitals, some private doctors.

Additional information: Depo-provera provides very effective pregnancy prevention for 12 weeks with minimal side effects. The most common side effects are irregular periods, amenorrhea or intra-menstrual spotting/bleeding. It may be more difficult to become pregnant in the months immediately following the termination of Depo-Provera use, but normal fertility usually returns within 6 to 12 months. The method does not protect against STDs including HIV/AIDS.

Intrauterine Device (IUD or IUCD)

How the IUD works: IUDs interfere with ovum and sperm movements, prevent fertilization of the egg, and cause changes in the uterine lining which prevent implantation in the event that a fertilized egg enters the uterus.

How the IUD is used: A trained medical person inserts the IUD into the uterus with an attached string left hanging into the vagina. The woman should check the string after each menstrual period by feeling deep inside her vagina. IUDs can remain in the uterus for up to 10 years.

Failure rate (range): 0.4 – 2.5 per cent

Where to obtain the IUD: Private physician, family planning clinic, district hospitals and some health centres.

Additional information: The IUD is one of the easiest contraceptive methods to use. The IUD is not recommended for women with more than one sex partner (or whose partners have multiple partners) as it may put such women at risk of PID (pelvic inflammatory disease). IUDs offer no protection against STD transmission. The most common types of IUDs are the copper-bearing IUDs known as the TCU 380 A, TCU 220C, Multiload 375, Multiload 250 and Nova T.

Oral Contraceptives (The Pill)

How oral contraceptives work: Prevent release of an egg from the ovary (ovulation) and implantation of the fertilized egg in the uterus (if ovulation should occur).

How oral contraceptive pills are used: Some are taken daily for 21 days and stopped for seven before starting a new package. Other kinds are taken continuously for the 28-day cycle; the last seven of these days are actually iron pills designed to keep the woman in the habit of taking a pill everyday. Oral contraceptives should be taken in the recommended order, at a convenient and consistent time each day/evening.

If a woman forgets to take a pill, she should take it as soon as possible, and take her next pill at the regular time. She should then

use a *backup method* to prevent pregnancy through the rest of that menstrual cycle. The backup is necessary for most women because of the low dosages of oestrogen in the pill today. The woman should ask her doctor for specific instructions for using oral contraceptives.

Today there are two main types of pills: Combined oral contraceptives (COCs) and Minipills, which are progestin-only pills (or POPs) This means they contain no estrogen, the hormone responsible for most of the pill's side effects. But they are also not quite as reliable as the COCs. That is why most health providers prefer to prescribe COCs first to most new users.

Failure rate (range) 0.1 per cent-8 per cent

Where to obtain the pill: Family planning clinic, CBD agents, district hospitals, chemists, private doctors.

Myths about the pill: Pills cause deformed babies; you take the pill only on the days that you have intercourse; pills cause cancer or sterility.

Additional information: The pill does nothing to protect a woman from STDs including HIV/AIDS. It should be used with a condom if the woman thinks she might be at risk of contracting an STD. Ordinarily, women with certain physical problems, such as high blood pressure, history of blood clots and heart disease should not use the pill. Women over the age of 35 and women who smoke are not good candidates for the pill. Possible side effects of taking the pill include irregular menstrual bleeding, swollen or tender breasts, headaches, slight weight gain and nausea.

Pills protect women against iron-deficiency anaemia, ovarian and endometrial cancer, benign breast tumours, uterine fibroids, and some forms of pelvic inflammatory disease (PID). Most users experience decreased menstrual cramping or pain and blood loss, and increased menstrual regularity.

Emergency contraception

Emergency contraception (ECP) refers to methods women can use, soon after having consensual unprotected sexual intercourse or when there has been condom breakage and/or rape, in order to avoid unwanted pregnancy. The most common method is the COC, or *combined oral contraceptive* pills, taken in a much higher dose than when OCs are used for regular contraceptive protection. Certain pills containing only progestin – POPs or mini-pills – can also be used. The effectiveness of mini-pills, also taken in a much higher dose when used for an emergency, is similar to COCs, but these progestin-only pills generally cause fewer side effects. In some cases, a copper IUD can also be used as emergency contraception.

How emergency contraception works: Depending on when you use ECP during your monthly cycle, the medication will either stop the

release of an egg, prevent fertilization of an egg, or stop a fertilized egg from becoming attached to the uterus.

How emergency contraceptive pills are used: The first dose must be taken within 72 hours (three days) after unprotected sex. A second dose is taken 12 hours after the first dose.

Failure rate (range) 1–5 per cent.

Where to obtain emergency contraception: Public and private family planning clinics, district hospitals and some health centres.

Additional Information: Emergency contraceptives should not be used routinely to prevent pregnancy. They do not protect against STDs, including HIV/AIDS.

Reading 9: Common sexually transmitted diseases

By the module authors

Chlamydia

Symptoms: Although it is very prevalent today, chlamydia is difficult to diagnose because the disease often coexists with others. In addition to gender-specific symptoms described below, the eyes may become infected, producing redness, itching and irritation. Infection of eyes can result from an infected person touching her or his genitals and then her or his eyes. A mother can infect her baby's eyes during delivery if she is infected.

Males: Twenty-five percent of men have no symptoms; when they have symptoms, men may experience a painful or burning sensation when they urinate and /or a watery or milky discharge from the urethra.

Females: Seventy-five percent of women have no symptoms; for women with symptoms, these may include abnormal vaginal discharge, irregular vaginal bleeding, abdominal or pelvic pain accompanied by nausea and fever. May also cause painful urination, blood in the urine, or a frequent urge to urinate.

Diagnosis: A sample of genital excretions is cultured to detect Chlamydia.

Damage: If left untreated, chlamydia may cause severe complications, such as a non-gonococcal urethritis (NGU) in men and pelvic inflammatory disease (PID) in women. If untreated, PID often leads to infertility. If a baby's eyes become infected, the baby can become blind if left untreated.

Treatment: Chlamydia is caused by bacteria that are effectively eliminated by tetracyclines or erythromycin; penicillin will not eliminate chlamydia.

Gonorrhoea

Symptoms: May occur 2 to 10 days after contact with infected person.

Males: A cloudy (thick, grayish-yellow) pus-like discharge from the penis and a burning sensation during urination. Some males show no signs.

Females: Usually show no signs. Some women have a pus-like vaginal discharge, irregular bleeding, painful urination and lower abdominal pain 2 to 10 days after contact.

Damage: Sterility, pelvic inflammatory disease (PID) in women which can recur even after the gonorrhoea and original PID have been cured. A baby can become blind if infected.

Diagnosis: The client should inform the health worker of all points of sexual contact (genitals or mouth).

Males: Medical practitioner examines genitals, mouth and/or anus for signs of irritation, soreness or discharge and may take a bacteria culture from any infected area (if lab equipment is available.)

Female: Medical practitioner examines genitals, mouth, lymph glands and cervical discharges and takes a bacterial culture from any infected area. Note: These days many health workers diagnose based on symptoms and a flow chart that advises them what medication to prescribe for which symptoms. This is true for most STDs; but HIV/AIDS is one important exception.

Treatment: Penicillin or similar antibiotic that kills the bacteria within one to two weeks.

Genital herpes

Symptoms: Caused by the herpes simplex virus and transmitted through direct skin-to-skin contact during vaginal, anal or oral sex. Although some people have no symptoms, most experience an itching, tingling or burning sensation, often developing into painful blister-like lesions on or around genitals or in anus; first symptoms appear 2-10 days after exposure and last 2-3 weeks. Some people have no symptoms.

Damage: Recurring outbreaks of the painful blister occur in one third of those who contract herpes. Herpes may increase the risk of cervical cancer and can be transmitted to a baby during child birth.

Diagnosis: Microscopic examination of blister tissue or syndromic diagnosis. (See information under 'gonorrhoea' section.)

Treatment: Genital herpes is caused by a virus and has no cure at present. Available drug treatments are aimed at relieving the pain of active sores and reducing the frequency and duration of outbreaks.

Syphilis

Symptoms: Painless chancre sore on or in genitals, anus, mouth or throat. Appears 10 days to three months after contracted. If left untreated, the sore will disappear and a skin rash will develop, often on the hands and soles of feet, 3-6 weeks after the chancre appears. It then usually disappears. Other symptoms may include hair loss, sore throat, fatigue or mild fever.

Damage: If left untreated after a rash appears, it can eventually, after many years, cause heart failure, blindness and damage to the brain and spinal cord.

Diagnosis: Health worker examines chancre site, throat, eyes, heart, lungs and abdomen; performs a microscopic examination of chancre pus and a blood test. Or the health worker follows the syndromic approach and treats via a diagnosis/observation of symptoms.

Treatment: Penicillin or similar antibiotic that kills the bacteria.

Chancroid

Symptoms: Soft painful sores that bleed easily on or around the entrance to the vagina, penis, or anus. May also cause enlarged painful lymph nodes in the groin, slight fever.

Females: May have pain upon urination or defecation, rectal bleeding, pain on intercourse or vaginal discharge. May have no symptoms.

Damage: People with chancroid are highly susceptible to HIV because the sores bleed easily and allow the virus to pass easily into the body.

Diagnosis: Health worker examines vagina, penis and anus for ulcers, and groin area for enlarged lymph nodes. Following syndromic approach, health worker treats based on observation of symptoms.

Treatment: Erythromycin or other antibiotics that kills the bacteria.

Human papilloma virus

There are many types of HPVs. In human beings they cause different diseases depending on the type.

Genital warts

Symptoms: Genital warts are the result of a virus spread during sexual contact. They often grow together in little clusters on and inside the genitals, anus and throat. Depending on location, they can be pink, brown or grey and soft, or small, hard and yellowish-grey.

Damage: Genital warts disfigure the genitals and are ugly looking. It is, however, possible to treat them without having permanent damage. They are not common.

Diagnosis: Usually made by direct eye exam. A nurse or doctor may ask for other laboratory investigations when not certain about the diagnosis.

Treatment: Locally applied treatments or surgery can be used to remove the warts, but cannot kill the virus. It is important to remove the warts to keep the virus from spreading. Genital warts may return after removal, especially if the treatment is only partial.

Re-infection may also occur.

Cancer of the cervix

Symptoms: Early precancerous changes on the cervix are usually symptomless. However, established cancer presents a vaginal discharge, usually foul smelling or irregular bleeding, especially during intercourse. This disease is rare in adolescents and occurs later in life.

Damage: Although early cancer is curable, later cancer cannot be cured. Cervical cancer will spread and damage other body organs, if left untreated. It eventually leads to death.

Diagnosis: Precancerous changes in the cervix can be detected through regular pap smears. Established cancer can be seen by the naked eye using a speculum. Diagnosis is confirmed by taking pieces of suspicious tissue for laboratory examination.

Treatment: Precancerous changes can be cured by simple local surgery, burning, or freezing. Established cancer requires external surgery or radiotherapy. Very advanced cancer is not curable, but tender loving care is still necessary. This includes relief of accompanying pain.

Pelvic Inflammatory Disease (PID)

An infection that affects the fallopian tubes, uterine lining and/or ovaries. It is usually caused by sexually transmitted diseases that enter the reproductive system through the cervix and which have not been treated (chlamydia or gonorrhoea).

Symptoms: While the symptoms vary from person to person, the most common identifying factor is pain in the pelvic regions. Other symptoms may include frequent urination and/or burning with urination, sudden fevers, nausea or vomiting, abnormal vaginal discharge, and/or pain or bleeding after intercourse.

Damage: If left untreated, PID can cause infertility or ectopic pregnancy.

Diagnosis: In order to make a diagnosis, it is necessary to determine the original source of the infection. It can also be diagnosed and treated via reported symptoms.

Treatment: Both partners must be treated with antibiotics.

Yeast Infections (Monilia, Candida or Fungus)

Note: These infections are often NOT transmitted sexually.

Symptoms: A yeast infection caused by an imbalance of the vaginal organisms.

Males: Inflammation of the penis.

Females: Itching, burning, dryness of the vagina, whitish and lumpy (cottage cheese-like) discharge that smells like yeast.

Diagnosis: Microscopic analysis of vaginal secretions.

Treatment: Locally applied cream or vaginal suppositories.

Trichomoniasis

Symptoms: A vaginal infection that is most often contracted through intercourse, but can also be transmitted through moist objects such as wet clothing, towels, washcloths and so on.

Males: Usually have no symptoms but might have a slight discharge, itching and/or lesions.

Females: A burning sensation at urination and an odorous, foamy discharge, along with a reddening and swelling of the vaginal opening.

Damage: Can cause urinary infections.

Diagnosis: Usually diagnosed by microscopic analysis of vaginal discharge.

Treatment: Oral medication.

HIV Infection and AIDS

For further information about HIV/AIDS, see the section in Unit 5 on HIV and AIDS.

Symptoms: One to two months after infection, some people experience a brief illness similar to a cold or the flu. An average of 5 – 10 years later, symptoms such as weight loss, yeast infections, night sweats, swollen lymph glands, persistent cough, diarrhoea, fatigue and loss of appetite may begin to occur.

Damage: People with HIV infection eventually develop AIDS and become ill with one or more serious diseases called opportunistic infections that target individuals whose immunity has been weakened. The long-term outcome is gradual debilitation and, ultimately death.

Treatment: At this time there is no cure. Those people who take care of themselves – eat plenty of fruit and vegetables, walk or get other exercise and get enough sleep, seem to live longer with the virus before getting AIDS. People are now living with AIDS much longer than they did in the 1980s, due to the development of drugs that treat some of the opportunistic infections. Medical treatment may also alleviate short-term symptoms.

Reading 10: AIDS Prevention and Health Awareness Program (APHAP)

By Mark Young

AIDs Prevention and Health Awareness Program (APHAP, Victoria Australia), formally NSEP, was initially funded in March 1990 as part of the Department of Human Services STD/Blood Borne Viruses Program's strategy to reduce the harmful effects associated with injecting drug use (IDU) and to prevent the spread of HIV/AIDS, Hepatitis and other blood borne viruses to injecting drug users and the wider community.

In its sixth year, APHAP has developed into a cross-regional program, with its services responding to identified needs of service users and the community in the north-west suburbs of metropolitan Melbourne. It has been an exciting and interesting 12 months for the program, with the establishment and consolidation of the 7 nights outreach North West Needle Availability & Disposal Service (NADS) and the development of the Foot Patrol and Safe Syringe Disposal Project in the Central Business District (CBD) of Melbourne.

NORTH WEST NADS

The outreach component of the program began officially operating the 7 nights service in January '96 and currently responds to requests in the municipalities of Moreland, Hume, Moonee Valley, sections of Maribyrnong, Brimbank and outlying north-west suburbs. The Outreach Team offers direct service provision, HIV/AIDS, Hepatitis, Safer Using Safer Sex information, education and referral to service users via an after hours off-site service that operates nightly between 8pm and 12pm. They also respond, where possible, to concerned residents, schools and local business who have experienced inappropriately discarded needles.

Outreach has had a busy year with 2,237 contacts being made via the after hours service, with 53 per cent of those accessing the program being 25 years or younger. Educating service users around safe disposal and encouraging them to return their used equipment has resulted in an increase in the return rate to 64 per cent.

FOOT PATROL

This unique and innovative service came about as a result of considerable negotiation between APHAP, Family Planning Victoria–Action Centre and the STD/BBV Program to provide needle availability and address the issues associated with safe disposal in the CBD of Melbourne. With the closure of two of the NADS in the city, the Action Centre, being the only outlet, became inundated with

requests for needles and syringes. To assist them in dealing with this increased demand, APHAP employed Kathy Don (KD) as an off-site worker in February '96, to be based at the Action Centre, to alleviate some of the pressure being experienced by the Centre's staff and services. Unfortunately, this was not sufficient to prevent the closure of the Action Centre's secondary outlet and the Foot Patrol was born as a means of providing a needed service in the CBD.

The Foot Patrol Team began their street beat around the city on May 27 and between then and June 30 '96 they saw 467 people requiring needle availability and disposal services. The Foot Patrol Team is a valuable service provider and resource on the street. Two team members were instrumental in providing assistance to a young man who had overdosed, and their quick response contributed to saving his life: 'Just another day on the street'.

SAFE DISPOSAL PROJECT

Attached to the Foot Patrol is the Safe Syringe Disposal Project which aims to monitor concerns within the CBD regarding disposal issues and to adopt measures that encourage appropriate disposal options. Belinda Mawby was appointed on May 11, 1996 as Community Development Worker on the Syringe Disposal Project.

A strong relationship has been achieved between the Project Worker and Melbourne City Council (MCC), which has resulted in more effective reporting mechanisms in regard to needle and syringe activities. This relationship has also set in place the process for monitoring and placing public disposal 'sharps' bins in the city area.

Belinda, in conjunction with MCC Health Services, has commenced undertaking training workshops on safe handling, needle stick injury, HIV/AIDS and Hepatitis. She has been working with city traders, churches, community groups, city dwellers and consumers on such concerns and allaying community fears.

In response to an identified need and lack of local resources, APHAP set up the North West Hepatitis C Support Group for those infected by the virus and their families, providing mutual peer support, updated information and periodic public forums.

Maryanne's interest in health strategies being developed for Hep C saw her being invited to the Victoria Infectious Disease Reference Laboratory. She currently represents APHAP and Youth Projects on the Hepatitis C Foundation and attended the invitation-only National Injecting Drug Use Education Forum held in Sydney, July 1996.

In March, thanks to the STD/BBV Program, the writer was able to attend the 7th International Conference On The Reduction Of Drug Related Harm, held in Hobart. Over 600 delegates from 35 countries gathered to discuss the global experiences related to IDU, HIV and health issues.

APHAP has continued its networking and support of secondary outlets and local government. The writer participated in the City of Morelands Municipal Health Plan and is in the process of discussions with the City of Brimbank regarding disposal and health issues.

Community education, information and training is still a focus for the program and has seen the Team disseminate information to the local Community School, Koori Health Workers, students from Secondary and Tertiary Institutions, and individuals at the Coburg Street Festival and World AIDS Day.

In concluding, I would like to thank all those who have participated and assisted in APHAP services throughout the year, especially the Sessional Staff who are our silent achievers. It is my belief that the team approach, effort and commitment adopted by a unique group of individuals is the basis for the program's success. My special gratitude to Vikki Sinott (Action Centre) for her assistance, input and support throughout the establishment of the Foot Patrol project.

A special thanks to the Front Desk and other Staff who take time out of their busy schedules to respond to service users requesting Youth Project's 'In House' NADS.

Thank You.
Stay Safe!

Mark Young
Co-Ordinator, AIDS Prevention and Health Awareness Program.

Reading 11: Advice to AIDS sufferers

By the module authors.

The following information might be helpful to answer questions about living with AIDS. This might be useful to young people who are AIDS free or AIDS infected. It might also be useful when talking, in the course of your work, with parents, authorities, church officials or others.

What can I do to live with AIDS?

Below are some things that you can do to live positively with HIV/AIDS.

Adopt a healthy lifestyle. You can maintain health and live longer if you are willing to adapt your lifestyle and follow advice from medical and social therapists.

Practice good hygiene. Where possible, bathe daily using soap and water; clean your teeth every day; eat only freshly cooked food; drink clean water—boil drinking water if the water supply is not safe; keep the house and surroundings clean so that bacteria cannot easily breed there.

Eat well. We know that sometimes it is not possible to eat well because there is little money and poor food. But some people just have bad eating habits: they miss meals and/or eat non-nutritious foods. Eating well balanced meals is important. If you lose weight and become weak, your body will find it much more difficult to fight the HIV. If you are ill and large meals are difficult for you to take, eat small nourishing snacks every 2–3 hours throughout the day. When you recover from an opportunistic illness, try to eat more to regain your weight. Try to eat a variety of foods every day from each of these 3 groups: 1. a corn or wheat based **carbohydrate** such as chapattis or mealie-meal (nshima), or rice or potatoes; 2. **protein** in the form of eggs, chicken, fish, meat, beans or ground-nuts, pulses; 3. local **fruits and vegetables**. An example of a well balanced meal could be nshima, beans and rape or for a lighter meal you could take a piece of bread, eggs and an orange. If your appetite is poor or you have diarrhoea and lose weight, ask your health worker for advice.

Exercise. Try to get some exercise regularly as keeping fit helps to improve your health.

Learn more about AIDS. It is important to know more about AIDS. Medical workers are there to help you with more information. Do not be afraid to ask about anything that is worrying you. Report any illness to your health worker as soon as possible so that you can be treated quickly. It is important not to allow any illness to become severe. There

are so many other practical issues you should discuss with your counsellor or health-care worker, such as the possibility of getting antiretroviral drugs, disposal of your property when you pass away, the future care of your children in the event of serious illness.

Cut down on drinking alcohol and stop smoking. Drinking too much alcohol and smoking cigarettes can weaken you even further and make it more difficult for your body to fight HIV.

Rest. You may feel weak and tired from time to time. Make sure that you have enough rest and sleep.

What can I do to avoid spreading HIV to others?

HIV spreads through sex, through blood (by transfusion and by using contaminated sharp instruments) and from mother to baby.

To protect others if you are HIV positive, you:

- cannot be a blood donor
- must not share razor blades or other sharp instruments which can pierce the skin
- must wash all cuts and sores with antiseptic solution (such as Dettol or Savlon) and keep them covered with clean, dry dressings until they heal
- must dispose responsibly of used materials soiled with blood and/or body fluids, dressings. Tampons, dressings and other materials should be put in plastic bags and thrown into rubbish pits or burnt in a fire, and anything to be used again cleaned properly first. Use hot water and soap to wash sheets and clothes stained with blood, vomit, urine or with excreta on them; dry them in the sun. When blood, vomit, faeces or urine spill on the floor, pour freshly prepared JIK solution (one part of JIK to three parts of water) on it. After about 15 minutes, wipe up with a paper and throw into a latrine or toilet. (In places where there is no JIK available other detergents can be used including soda ash).

What if my spouse or regular partner is not infected?

If your regular partner is not infected by HIV you must take every care to avoid passing on HIV to him or her. In order to do this you may decide to stop having sexual intercourse altogether. This is the only way of being certain that you are not spreading HIV to anyone. If you do have sexual intercourse, always use a condom with your spouse or regular partner: this reduces the risk of passing on HIV to your partner. But you must take great care to use condoms correctly each time you have sex. Ask your peer educators/health worker for more information on the correct use of condoms, and your health care worker or counsellor will also discuss with you other ways of

enjoying sex which do not carry as much danger of passing on the HIV infection as conventional sex.

What about sex with a partner already infected?

Even if you have a regular partner such as husband or wife who is already infected with HIV, it is still wise to use condoms. This is because you should avoid passing on any other infections to one another, and using condoms is a useful method of avoiding having any more children who may become infected. If you do not know how to use a condom, do not be shy about asking a health care worker or counsellor, as they have been trained to give advice about this.

What about sex with a casual partner or a stranger?

It is not advisable at all to have casual unprotected sex, because it is wrong to pass on HIV to others and condoms can break during sex or may not be used correctly. At the same time you could be exposed to the germs that cause syphilis, gonorrhoea or other sexually transmitted diseases if you have casual sex. This can have harmful effects on your body. Repeated infections with such germs could hasten the progress of AIDS.

Where can I get help?

Now that you know you are carrying HIV infection in your body, you may feel angry, guilty, depressed or frightened. You may find that it helps to talk to someone who understands how you feel. There are people and organisations in most countries who provide counselling support for people with HIV infection or AIDS. They will listen to you, help you discuss your situation and give you correct information so that you can learn to cope with your problems in order to live positively with HIV/AIDS. Try to find if there is an AIDS counsellor at your nearest clinic or hospital and/or community. The pastor or priest at your church may also offer counselling. And there are other organisations offering information and counselling in all communities.

Reading 12 Youth Substance Abuse Service (YSAS)

YSAS is at: <http://www.ysas.org.au/links.html>

Outreach Services

YSAS Outreach Services operate with teams of two or three professional staff, each supervised by a senior practitioner, in eight locations. Each team provides services to complement rather than duplicate the existing services in each area. Therefore, the precise role of Outreach workers varies according to identified local needs.

Outreach Teams have been established in 'hotspots' that have been identified using a range of data including area demographics, arrest data, and agency demand.

Outreach work involves providing alcohol and drug interventions in environments where young people spend their time. This means that YSAS teams make contact with people on the streets, in shopping malls, in parks, clubs and so forth. Many young people refer themselves, or are referred to, YSAS by family, carers and friends. YSAS accepts referrals from a wide range of other service providers who work with *young people* aged between 12 and 21 years.

YSAS Outreach workers provide a holistic assessment of the person's drug use and life circumstances. They then tailor interventions according to the needs and wishes of the young person, linking them into other services where appropriate, and assisting them to develop a sense of future hope. The relationship between an Outreach worker and a young person continues for as long as the young person experiences problems associated with his or her use of alcohol or drugs.

On 30 June, 2,673 brief contacts had been made with young people on the streets by YSAS Outreach staff. This number does not represent individual young people as each may have a number of brief contacts without becoming registered clients of YSAS. In this time 279 individual young people went on to become registered clients of YSAS. Of these, 34 (12 per cent) were under 16 years of age. 114 were from non-English speaking background and over a third were young women. 98 per cent of all referrals were responded to within 48 hours.

YSAS Outreach Teams expect to provide approximately 1200 assessments and responsive interventions to young people with problematic substance issues over the next 12 months.

Residential Service

The Residential Service provides short-term respite and/or withdrawal for 12–21 year olds requiring residential support for their drug use. The service offers both medical and non-medical withdrawal support where required. Over 95 per cent of these young people who have come through the centre required support in withdrawal from heroin. Over 75 young people have been through the centre in the last five months, with the youngest being 13 and the oldest 21 years. The average age of the young person currently staying at the service is 17 years. It is expected that over 360 young people will use the residential service each year. The service is already experiencing an average wait of 2 weeks to enter the service.

Access to the Residential Service is achieved via referral to the local Outreach Team. All young people accessing the Residential service are case managed by YSAS Outreach workers providing that continuity of service both pre and post withdrawal/respite.

The Residential Service offers a therapeutic programme which includes a range of individual and group work activities, health information sessions, counselling, art therapy, massage, naturopathy and tai chi, as well as recreational activities. Young people stay an average of 10 to 14 days, which enables them to adequately deal with withdrawal issues. They are then moved on to more appropriate and longer-term support and accommodation options developed by YSAS.

The VSAS Residential Service can be accessed following referral to and assessment by an Outreach Team.

Training and support

The Training and Support Team provide a range of training programmes for professionals and organisations on young people and alcohol and/or other drug use. These include the identification of local and agency specific training needs and the development and implementation of training courses such as skills for health and welfare professionals on how to work with young people; understanding youth substance use; and effective interventions for organisations and professionals working with young people with problematic substance use issues.

YSAS also provides ‘boutique’ style training programmes for individual agencies, further covering the range of drug/alcohol issues and problems experienced by young people.