HACEY

YOUTH AMPLIFY TRAINING MANUAL

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A practical guide to support adolescents, young people and program managers in promoting SRHR information and services.

HACEY Health Initiative

www.hacey.org

EXECUTIVE SUMMARY

Access to affordable sexual and reproductive health services for everyone, women, men, couples, and adolescents, supports the health and well-being of individuals and has positive economic, environmental, and social benefits for families and communities. Studies have shown that there is a gap in adolescents and young people's access to adequate information to enable access sexual and reproductive health services without bias and discrimination irrespective of the location and emergence of a crisis.

COVID- 19 has created a negative impact on every nation's health system and not left out is young people's access to SRH services, there is a need more than ever before to have a deliberate action towards improving young people's access to youth-friendly services.

This Manual will provide a comprehensive guide on accurate and practical guidance to support youth, adolescent in gaining knowledge on the available SRHR services and their rights, inform the SRH champions on their roles in helping other young persons to make an informed decision on the utilization of SRH services and promote positive information on available youth-friendly centres in their respective communities using digital media.

Rhoda Robinson

Executive Director

A comprehensive guide on accurate and practical guidance to support youth, adolescent and program managers in promoting sexual and reproductive health information and services.

ACKNOWLEDGEMENT

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ACRONYMS

SRH - Sexual and Reproductive Health
PLWHA - People Living with HIV/AIDs
STI/D - Sexually Transmitted Infection/Disease
PrEP - Pre-exposure prophylaxis
ART - Anti-retroviral
MTCT – Mother – To – Child Transmission
VCT – Voluntary Counseling and Testing
IDUs – Intravenous Drug Users
CEDAW - Convention for the Elimination of all Forms of Discrimination Against Women
SBCC - Social Behaviour Change Communication
PLHA – People Living with HIV/AIDS
CRPD - Convention on the Rights of Persons with Disabilities
PWDs - Persons with Disabilities
RHR - Reproductive Health Right
VAPP - Violence Against Persons Prohibition Act
WWD - Women and Girls with Disabilities
ICPD - International Conference on Population and Development
CEDAW - Convention for the Elimination of all Forms of Discrimination Against Women
CFRN – Constitution Federal Republic of Nigeria
AIDS- Acquired Immunodeficiency Syndrome
AYFS - Adolescent and youth-friendly Services
COCs -Combined Oral Contraceptives
ECPs -Emergency Contraceptive Pills
FGM -Female Genital Mutilation
FP -Family Planning
HIV- Human Immunodeficiency Virus
IPPF- International Planned Parenthood Federation
IUD -Intra-Uterine Device
POPs- Progestin Only Pills
RH -Reproductive Health
SRH- Sexual and Reproductive Health
UN -United Nations
UNFPA- United Nations Population Fund
VCT -Voluntary Counseling and Testing
WHO- World Health Organization
YFS -Youth Friendly Services
YFCs -Youth Friendly Clinics
RHR - Reproductive Health Rights

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HIGHLIGHTS

MODULE 1

INTRODUCTION

This introductory module provides an overview of the Youth Amplify workshop, information on the manual usage, as well as useful facilitation tips. For significant results, information sharing with participants will be necessary when commencing the workshop.

The guide aims to create youth well versed in sexual reproductive health and rights (SRHR) issues and equipped with leadership skills to disseminate SRHR information and encourage their peers to make full use of the SRH services available to them.

OUTLINE:

- Help participants understand the purpose of this training.
- Define workshop ground rules.
- Break the ice.
- Evaluate participants' knowledge levels so that training can meet their needs.

PREPARATION:

Read through the whole manual before starting the training.

Prepare a selection of 'ice breakers' which will help the group to feel relaxed and get to know each other.

PREPARATIONS AND MATERIALS:

- Flipchart and Markers
- Overhead Projector and set of transparencies or data show and Power point presentation.
- Pre-test
- Writing materials

> *"It is a necessity for young people to have access to youth-friendly SRHR services."*
>
> Kemi Omole
>
> (SRHR team lead HACEY

WHO NEEDS THIS MANUAL?

This workshop manual is developed for the purpose of Youth Amplify SRHR champions program. However, anyone seeking general information on SRHR can use this manual. Still, it has been specifically designed as a training guide for a group of young people who will serve as advocates in improving young people's access to SRHR information and services using digital media techniques such as story-telling, photography videography to be promoted on social media platforms such as Instagram, Facebook, Twitter, tik-tok, telegram e.t.c.

This manual will serve as a guideline for these individuals and young people to disseminate accurate information on SRHR to other young people, and to become leaders in championing young people's SRHR rights.

It can also serve as a resource and reference material to a service provider.

HOW TO USE THE MANUAL?

The manual is based on a training philosophy that emphasizes principles of participatory learning and prioritizes active participation. The training activities have proven effective in achieving specific session objectives. However, experienced facilitators should be able to adapt the sessions to suit various target groups and situations as they see fit.

Module objectives and any recommended preparatory work are detailed at the beginning of each module as a guide for facilitators, encouraging meaningful participation and enhanced learning amongst participants. By enabling this style of participant-led knowledge generation, the training aims to build confidence amongst participants as well as ensure that they gain the required knowledge.

GETTING STARTED - BREAK THE ICE

Organize games or songs as ice breakers to build a sense of community and help participants relax, feel more confident and have some fun.

Ask participants to give their expectations about the workshop and explain the objectives.

Agree on ground rules, e.g. confidentiality, active participation, listening, cell phones off, etc. Ask the whole group to help enforce, the ground rules and identify a timekeeper.

TRAINING LANGUAGE

- Work in the language with which most participants are comfortable
- Allow participants to use whichever language they are comfortable with.
- The use of vernacular makes a big difference in helping participants get a better understanding of complicated issues. Let the group help determine the language for each session.

OPENING

- Pass round copies of the pre-test for all participants
- Effective facilitation requires tailoring the training content and methods to the needs of the group. Suppose the group already has good knowledge about SRHR issues, the focus of your training should be on supporting them to become SRHR champions and equipping them with good communication skills to disseminate accurate SRHR information amongst their peers. Suppose there are gaps in the group's knowledge. In that case, you need to allow time to train them on these issues before moving on to strengthening their communication capacities.

THE RESPONSIBILITIES OF YOUTH SRHR CHAMPIONS

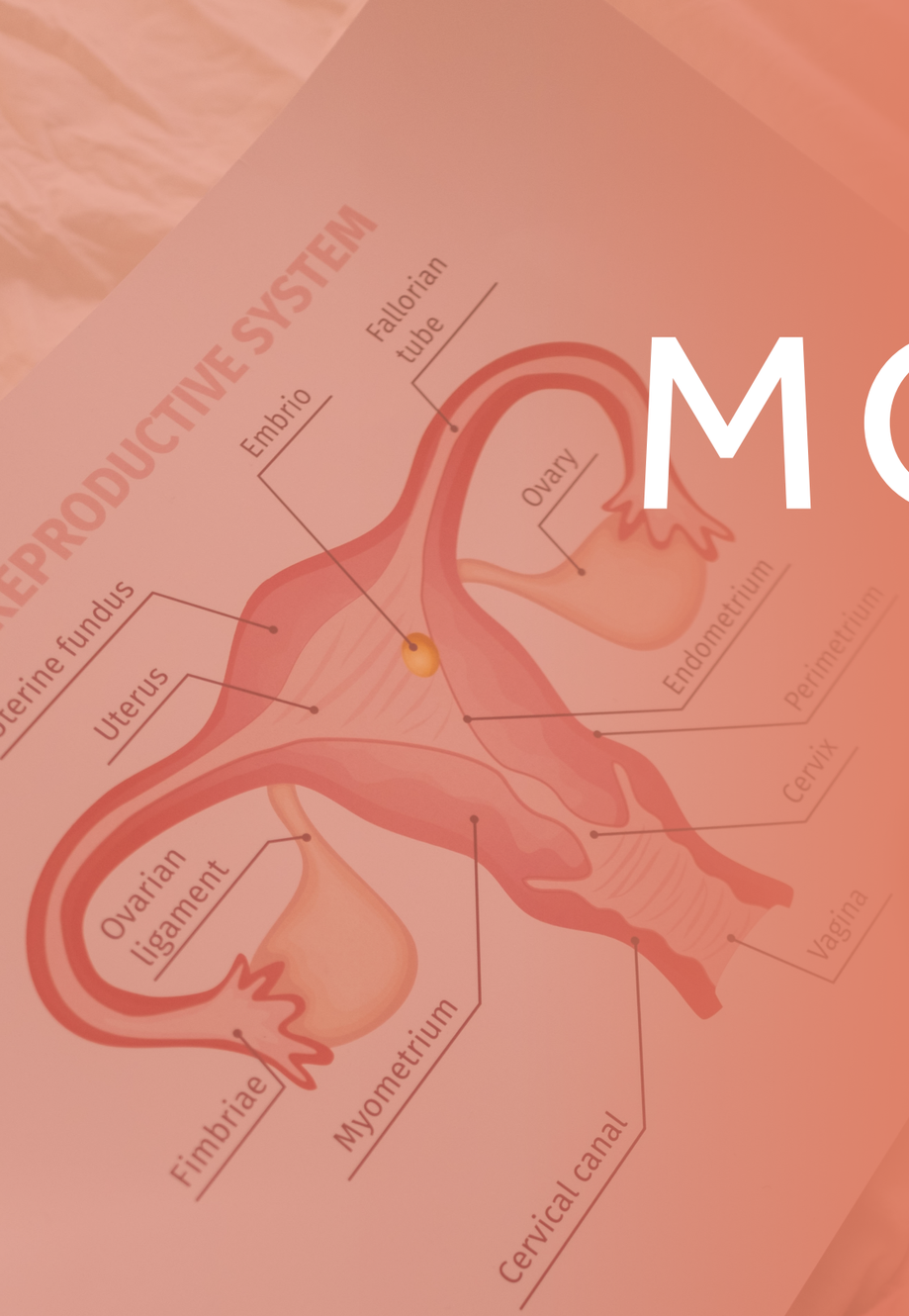
- Provide accurate information about SRH and rights to young people.
- Help young people with information to nearby youth-friendly centres in their communities and how to access other support services.
- Champion the SRH rights of young people in their communities.
- Address young people's SRHR challenges and advocate for improved SRHR of young people in their communities to the government.

To be a leader in addressing the SRHR challenges/ issues of young people in their community by advocating for improved access and availability of youth-friendly SRHR services.

SRHR Champions are people who themselves make use of SRH services; have a good understanding of SRHR issues, HIV and STI, and have the skills to help other young people achieve their SRHR by accessing SRH services. SRHR Champions are usually volunteers.

QUALITIES OF AN SRHR CHAMPION

- SRHR champions must be very well informed about SRHR issues so that they can share accurate information with other young people.
- SRHR champions need excellent communication skills to enable them to impart.
- SRHR champions must be able to listen to the challenges of other young persons concerning accessing SRH services and provide useful and practical advice to support them to overcome these issues.
- SRHR champions also have an essential role in supporting young people living with HIV or disability, including providing them with emotional support.



MODULE 2

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

OBJECTIVES

At the end of this module, you should be able to:

1. Define essential terms in sexual and reproductive health and rights
2. Identify critical issues and the factors responsible for them.
3. Identify ways to overcome challenges in SRHR.
4. Understand the situation in Nigeria as it pertains to SRHR.

Step 1

Review the session learning objectives with participants.

Step 2

Thank everyone for choosing to be an SRHR Champion! Remind them that they have a unique opportunity to help adolescents & youths to have greater access to more effective SRHR services and information, including protecting against unplanned pregnancy, HIV, or STI infection.

Step 3

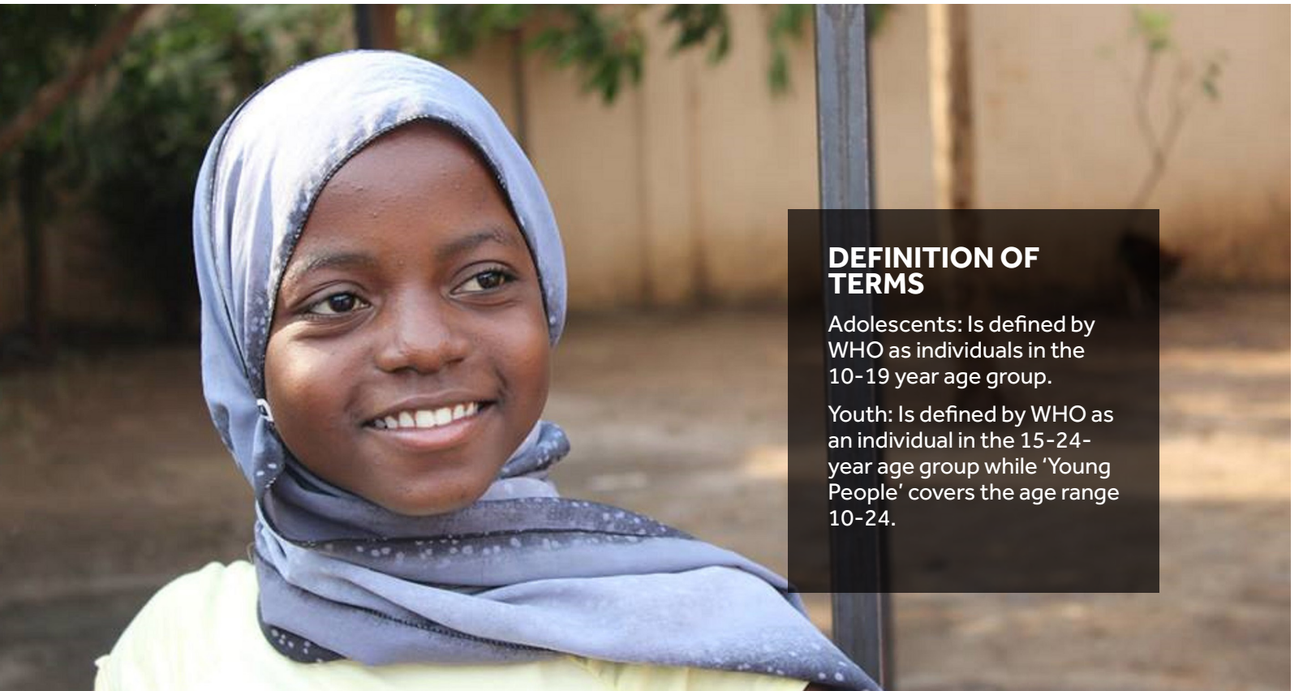
Allow the participants to explain what they understand by the term 'reproductive health'. Write their responses on a flip chart. Let them explain what they know as their reproductive health and sexual rights.

Step 4

Ask participants to list some of the challenges that they experience in accessing SRH services in their community. Ask participants to brainstorm some of the ways these challenges affect their sexual health. Write responses on the flip chart and fill in content as needed.

Step 5

Ask their opinion on what can aid sexual and reproductive health and services in their institution and state. Write down the responses on a flip chart and compare them with the manual.



DEFINITION OF TERMS

Adolescents: Is defined by WHO as individuals in the 10-19 year age group.

Youth: Is defined by WHO as an individual in the 15-24-year age group while 'Young People' covers the age range 10-24.

2.0 REPRODUCTIVE HEALTH

Is defined 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 systems and its functions and processes".

Reproductive health or sexual health addresses the reproductive processes, functions, and system at all stages of life.

The components of Reproductive Health, as adopted by Nigeria, include:

- Family planning information and services.
- Prevention & management of infertility, and sexual dysfunction in both men and women.
- Prevention and management of complications of abortion.
- Prevention and management of reproductive tract infections especially sexually transmitted infections (STIs), including HIV infections and AIDS.
- Promotion of healthy sexual maturation from pre-adolescence, responsible and safe sex throughout life and gender equality.
- Promotion of healthy sexual maturation from pre-adolescence, responsible and safe sex throughout life and gender equality.
- Elimination of harmful practices such as female gender mutilation (FGM), child marriage, domestic and gender violence against women.
- Management of non-infectious conditions of the reproductive system, such as genital fistula, cervical cancer, complications of FGM, and reproductive health problems associated with menopause.

2.2 SEXUAL HEALTH

This is a part of reproductive health that includes: Sexual development, equitable and responsible relationships, sexual fulfillment, freedom from illness, disease, disability, violence, and other harmful practices related to sexuality.

For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled."

Sexual and reproductive health and rights encompass efforts to eliminate preventable maternal and neonatal mortality and morbidity, to ensure quality sexual and reproductive health services, including contraceptive services, and to address sexually transmitted infections (STI) and cervical cancer, violence against women and girls, and sexual and reproductive health needs of adolescents and young people.

2.3 SITUATION OF SRH IN NIGERIA

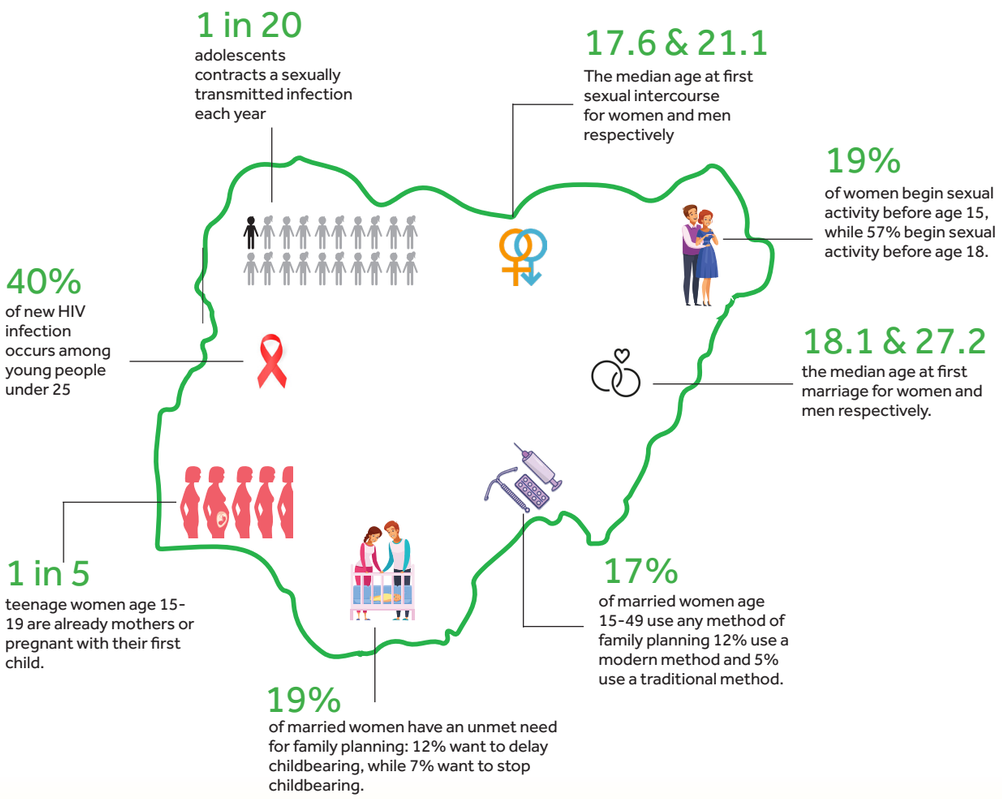
Nigeria has a population of 200,963,599 people with a reproductive age of 15-49 years and making up about 50% of the people in Nigeria, available statistics show that the reproductive health status of men, women, and adolescents has remained low in Nigeria

Today in Nigeria, young people have been caught between traditions and changing culture. The influence of urbanization, globalized economies, the internet, and media is fast eroding traditional mechanisms for coping with and regulating sexuality. This has resulted in risky sexual behaviors which are responsible for the increasing teenage pregnancies, out-of-school girls, baby dumping, infant mortality, and even death. These adverse situations put their health, education, life, and total well-being at risk. Sexual debut is pegged at 15years in Nigeria. Among Nigerian adolescents:

- 1 in 5 teenage women age 15-19 are already mothers or pregnant with their first child.
- Nineteen percent of women begin sexual activity before age 15, while 57% begin sexual activity before age 18.
- Seventeen percent of married women age 15-49 use any method of family planning 12% use a modern method and 5% use a traditional method.
- The unmet sexual and reproductive health needs of Nigerians are high. More than half of young people are not using any method of contraception due to lack of adequate information and access to quality reproductive health services.
- Unmet need for family planning is defined as the proportion of married women who want to delay or stop childbearing but are not using family planning.
- In Nigeria, 19% of married women have an unmet need for family planning: 12% want to delay childbearing, while 7% want to stop childbearing.

2.4 RECENT STATISTICS AND SITUATION ANALYSIS

Nigeria, with an estimated population of more than 200 million people (World Bank 2019) is the most populous country in sub-Saharan Africa. Available data on sexual and reproductive health (SRH) outcomes in Nigeria shows the importance



of focusing on adolescents.

One in 20 adolescents contracts a sexually transmitted infection each year, and about 40% of new HIV infection occurs among young people under 25 in Nigeria (UNICEF 2017). This could result from the early sexual debut and early marriage which increase adolescents' HIV vulnerability. The median age at first sexual intercourse is 17.6 and 21.1 years for women and men respectively, while the median age at first marriage is 18.1 and 27.2 years for women and men respectively.

Unwanted pregnancies are another problem facing adolescents especially the unmarried. Although the abortion law and policy in Nigeria prohibits access to abortion services, about 1.25 million commits induced abortion yearly by unskilled providers and many have serious complications without obtaining the post-abortion care needed. These indicate that the utilization of SRH services by adolescents in Nigeria is low, arising from disparities in both provision and accessibility of the services and also lack of priority to adolescents' SRH. Availability and accessibility of quality and affordable SRHS ensure adolescents' sexual and reproductive health wellbeing. This suggests the need for adequate attention to adolescents' sexual and reproductive health.

2.5 NATIONAL POLICIES ON SRHR

According to the updated national policy on the health & development of adolescents & young people in Nigeria published by the Federal Ministry of Health in 2007, adolescents are a distinct population group with unique potentials as well as peculiar needs. Addressing the health and related needs of adolescents and young people requires specific interventions that take due cognizance of their developmental context, tasks, and responsibilities.

The recognition of the potentials and importance of investing in the health and development of adolescents and young people has given considerable attention and increasing priority to this important population group in her National agenda over years. Among others, the country acknowledges the need for an effective policy framework as an instrument of collective national aspirations and a guide for appropriate programmatic actions and interventions aimed at improving the health and well-being of adolescents and young people.

In that regard, Nigeria developed the following policies:

- 1995: 1st National Policy
- 2007: 2nd National Policy

The policy identified major areas of adolescent health care needs and described broad strategies for intervention in the following areas: sexual behavior; reproductive health; nutrition; accidents; drug abuse; career and employment, parental responsibilities and social adjustment; and education. Between 1995 and 2006, several important changes have occurred in the area of adolescent health and development nationally and internationally, which has necessitated a revision of the policy to reflect the new realities, hence the revised policies:

- 2010: National Action Plan
- 2013: National guidelines for the integration of adolescent/ youth-friendly health services into primary health care
- 2019: 3rd National Policy

2.6 SRH ISSUES AND CHALLENGES

Young people should have adequate access to relevant and correct information about their sexual and reproductive health and rights. However, some identified factors are responsible for preventing this, namely:

i. Cultural and social norms: some cultures still perform harmful traditions such as female genital mutilation and early marriage. Workers at SRHR centres may refuse to provide service to young people because of social norms.

ii. Religious beliefs: Some religions speak against the use of contraception. Young people may be discouraged from picking up contraception if their faith speaks against premarital sex for fear of being found out.

iii. Illiteracy: A lack of formal education reduces the access of young people to sexual health and rights information. Uneducated girls are also likely to marry early and get pregnant in their teenage years.

iv. Non-availability of SRH services

v. Low awareness of when and where to access SRH services

When these services are not available or accessible, several problems develop that affect the lives of young people, these include:

i. Early and Unwanted Pregnancies

ii. Unsafe abortion

iii. Sexually Transmitted Infection/ HIV/AIDS

iv. Female Genital Mutilation

v. Gender-Based Violence (GBV)

2.6.1 EARLY/UNWANTED PREGNANCIES

There is a high prevalence of unmet need for contraception among women, mostly unmarried young women. In Nigeria, about 25-34% of sexually active, unmarried women age 15-24 are not on any contraceptive.

This contributes immensely to the high rate of teenage pregnancies in Nigeria. According to UNFPA, 29.1% of women aged 20-24 had given birth before the age of 18. Adolescent pregnancy has adverse effects on the health and future of young girls as it predisposes them to severe birth complications and could even be fatal.

2.6.2 UNSAFE ABORTION

In spite of Nigeria's high restrictive abortion law, an estimated 1.25million abortions occurred in 2012. The estimated abortion rate was 33 abortions per 1000 women aged 15-49 in 2012. The slow uptake of family planning has contributed to the high levels of unintended pregnancy and the resulting social stigma and lack of support from family may drive young women to seek unsafe abortion. Complications of unsafe abortion range from pain and bleeding to more serious conditions including sepsis (systemic infection), pelvic infections and injury from instruments and even death. About 40% of women undergoing abortion experience complications serious enough to require medical treatment. (Guttmacher Institute 2015)

Note: Items iv, and v are discussed in subsequent chapters.

2.6.3 STRATEGIES TO COMBAT SRHR ISSUES

In overcoming SRHR issues, the following should be considered and implemented:

- Educating young people about their sexual and reproductive health and rights to arm them with the right information to make healthy choices.
- Educating the community about the harmful effects that certain traditional practices have on the health of young people.
- Creating awareness on when and where to access youth-friendly services.
- Enhance publicity through jingles, TV advert, radio, and television programs.
- Ensuring availability and affordability of SRHR commodities.
- Creating youth-friendly environment such as recreational and vocational training centres
- Effective training of SRHR services providers
- Engaging stakeholders (Religious leaders, community leaders, and influencers) to support the uptake of SRHR services/ program.
- Service providers should be trained on how to deliver these services professionally without cultural or religious bias.
- Young people should be made aware of the availability and accessibility of such services.
- Laws regarding SRHR should be reviewed and updated to reflect the right terms and definitions of sexual offences.
- The government should make specific laws against harmful traditional practices, and special attention is given to implement the regulations.
- "All young people - male and female - have equal rights to health and development"

2.7

Ronke is a 16-year-old first-year student in a tertiary institution in Nigeria. Raised in a family where sex was a taboo topic, and her questions were never fully answered by her biology teacher who always stammered when he had to teach reproductive health. Her first semester went by in a blur, and by the second semester, she was well settled and had time for a social life. She met David, a third-year student who was five years older than her and was immediately drawn by his sweet charm. Soon they started engaging in midnight calls and after started dating. As the relationship became more serious, Ronke trusted David enough and they started to have sex, she found out she was pregnant three months into the relationship and was scared of social stigma and rejection from her family. So, she took a pill that David got from a friend.

Ronke lost a lot of blood and was lucky to have escaped with her life.

REFLECTION

a. What do you think are some of the factors responsible for Ronke's predicament?

b. How do you think these factors could have been prevented?

MODULE 3

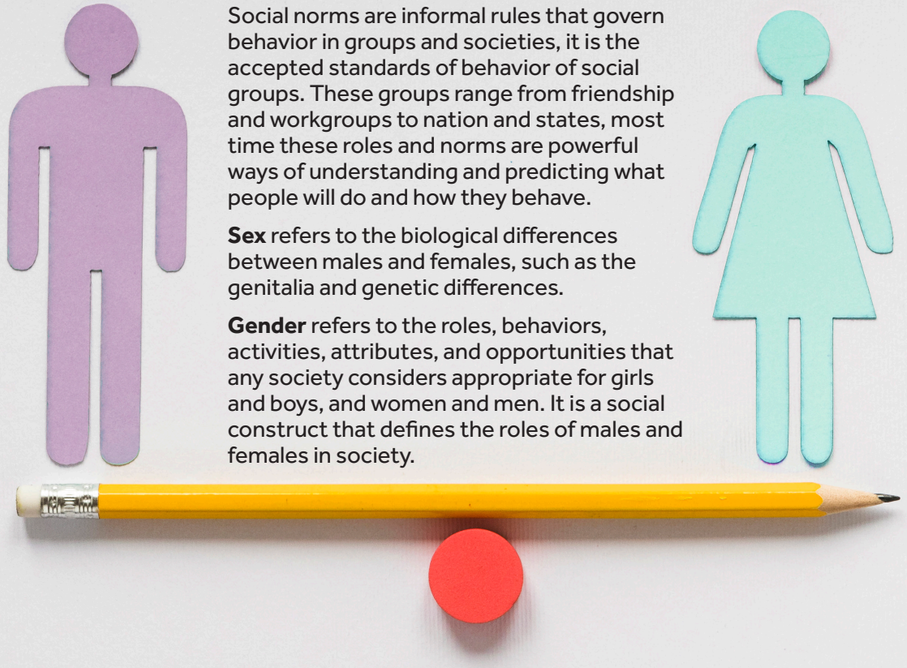
SEX, GENDER AND SOCIAL NORMS

OBJECTIVES

At the end of this session, you should be able to:

1. Define and differentiate between sex and gender.
2. Identify the consequences of social norms on the SRHR of young people.
3. Understand the peculiarities associated with sex roles, gender roles, and gender identity

3.1 DEFINITION OF TERMS



Social norms are informal rules that govern behavior in groups and societies, it is the accepted standards of behavior of social groups. These groups range from friendship and workgroups to nation and states, most time these roles and norms are powerful ways of understanding and predicting what people will do and how they behave.

Sex refers to the biological differences between males and females, such as the genitalia and genetic differences.

Gender refers to the roles, behaviors, activities, attributes, and opportunities that any society considers appropriate for girls and boys, and women and men. It is a social construct that defines the roles of males and females in society.

TABLE 3.2 DIFFERENCES BETWEEN SEX AND GENDER ROLES

Sex	Gender
Sex refers to the biological and physiological differences between men and women	Gender refers to the social and cultural differences between men and women
Sex has two main categories: Male and Female	Gender has two main categories: masculine and feminine
Sex remains the same, regardless of time and culture	Gender roles, expectations may differ across time and culture
Sex is created by the reproduction needs that are biological features	Social norms create gender distinction
Sex is determined at birth	Social, cultural, and behavioural factors are what influence gender.

Sex Roles	Gender Roles
Sex roles are essentially biologically determined (ensuring successful reproduction and forming the basis of a sexual division of labour, in which women are associated with childbearing)	Gender roles (behaviour that is considered “masculine” or “feminine”) are culturally determined
Sex roles are mainly the same regardless of time.	Gender roles are highly fluid and can shift substantially over time.
Sex roles are natural to men or women.	Gender roles are not natural to men or women; instead, they are learned and imposed by social values
Examples of sex roles: females menstruate, become pregnant, or breastfeed while males impregnate a woman or become fathers	Examples of gender roles: women will take care of the children, cook, and clean the home, while men take care of finances, work on the car, and do the home repairs.

3.2 GENDER IDENTITY

Gender identity is the personal sense of one’s gender. Gender identity can correlate with a person’s assigned sex at birth or can differ from it. Gender expression typically reflects a person’s gender identity, but this is not always the case. While a person may express behaviors, attitudes, and appearances consistent with a particular gender role, such expression may not necessarily reflect their gender identity.

Transgender is an umbrella term for people whose gender identity is different from the sex assigned at birth.

3.3 GENDER INEQUALITY

Gender inequality is the idea that men and women are not equal. It refers to the unequal treatment or perceptions of individuals based on their gender.

These differences arise from socially constructed perceptions of gender roles; therefore, gender inequality is experienced differently across different cultures.

Gender inequality in Nigeria is affected by different cultures and beliefs. In most parts, women are considered subordinate to their male counterparts. They are excluded or disadvantaged in decision-making and access to economic and social resources. This is evident in households, workplaces, and the government. This affects the opportunities available and the quality of life of women.

3.3.1 WHAT IS GENDER-BASED VIOLENCE?

Gender-based violence (GBV) is violence that is directed at an individual based on his or her biological sex OR gender identity. It

includes physical, sexual, verbal, emotional, and psychological abuse, threats, coercion, and economic or educational deprivation, whether occurring in public or private life.

3.3.2 WHY DO WE TALK ABOUT GBV?

Gender-based violence is an issue faced by people all over the world. Women are disproportionately harmed by gender-based violence. That is why hundreds of organizations focus on ending violence against women. According to the United Nation's Population Fund, 1 in 3 women have experienced physical or sexualized violence in their lifetime. That is not including emotional, financial, or verbal abuse. Despite being so prevalent, gender-based violence is mostly under-reported because of stigma and lack of access to resources and support systems. GBV can impact anyone regardless of their geographical location, socio-economic background, race, religion, sexuality, or gender identity. While women and girls are the most at risk and the most affected by gender-based violence, boys, men, and sexual and gender minorities also experience gender-based violence. GBV can have serious physical, mental, economic, and social repercussions. For example, sexualized violence can lead to unwanted pregnancies, unsafe abortions, and STI transmission, as well as isolation and depression. It can also prevent survivors from achieving economic prosperity because of stigma or physical and psychological trauma caused by the violence.

3.4 HARMFUL TRADITIONAL PRACTICES IN NIGERIA AND THEIR EFFECT ON YOUNG PEOPLE

Harmful traditional practices are forms of violence that are committed primarily against women and girls by the society that is seen as part of the cultural way as they have been passed from generation-to-generation. These traditional practices are considered harmful as they have a huge impact on the health and well-being of the victims, and violate their human rights.

The traditional practices considered in this section are Female genital mutilation, forced/early marriage, and son preference.

3.4.1 FEMALE GENITAL MUTILATION (FGM)

The World Health Organization defines female genital mutilation as all procedures involving partial or total removal of the external female genitalia or other injuries to the female genital organs, whether for cultural or other non-therapeutic reasons. It is also known as female circumcision. Despite several campaigns against the practice of FGM in Nigeria, it still practiced in some societies. According to UNFPA, 3 in 10 women between the ages of 15-49 have undergone some form of FGM in Nigeria. FGM rises from and perpetuates gender inequality.

There are four major types of FGM based on the amount of tissue damaged:

Type 1: this is the partial or total removal of the clitoral glans or the clitoral hood

Type 2: this is the partial or total removal of the clitoral glans and the labia minora with or without removal of the labia majora.

Type 3: Also known as infibulation, this is the narrowing of the vaginal opening by cutting the labia minora and Majora and suturing of the vulva. The clitoris may also be cut.

Type 4: This includes all other harmful procedures to the female genitalia for non-medical purposes

FGM has no health benefits. It interferes with the normal functioning of the victims' bodies and violates their human rights. Victims are at risk of immediate and long term complications which include:

i. Excessive bleeding
ii. Severe pain
iii. Infections
iv. Infertility
v. Urinary problems
vi. Painful menstruations
vii. Sexual problems (pain during intercourse, decreased satisfaction, etc.)
viii. Increased risk of childbirth complications

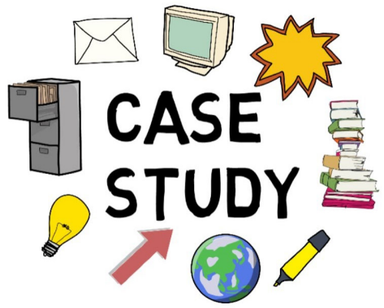
"A world where girls are respected, valued, and empowered to fulfill their dreams is a world without Female Genital Mutilation."

Child marriage is a violation of human rights, and despite laws against it, it continues to happen in Nigeria. Girls are forced into marriages with much older men who invariably puts an end to their schooling. Early marriage threatens the health and lives of girls, exposing them to the complications of teenage pregnancy and childbirth, which include: obstructed labour, hemorrhage, fistula, death, etc. Early marriage jeopardizes the future of girls as they are deprived of an education and economic power.

3.4.3 SON PREFERENCE

Many cultures in Nigeria regard the male child as king while the female child is treated with less respect and given fewer opportunities. The girl is trained to take care of the home and prepared for marriage while forfeiting a chance at education and inheritance. This is a violation of the girl child's rights, and it cripples her chances of living to her full potential.

3.7



Fatima and Rahman were childhood friends who did everything together – from attending the same school to running errands. However, things changed after Fatima was circumcised at age 9. She stopped going to school and stayed indoors more in preparation for her marriage to Alhaji Gaddo, which took place two years later. Fatima almost lost her life, giving birth to her first child due to complications from the circumcision and the immaturity of her organs. She went on to have three more children within the space of 5 years.

Rahman, on the other hand, finished school and went on to work as the managing director in her father's textile company.

Reflection

i. How many harmful traditional practices can you identify?

ii. How did these practices affect the life of Fatima?

MODULE 4

SRHR SERVICES FOR YOUNG PEOPLE

OBJECTIVES

At the end of this module, you should be able:

1. To identify youth-friendly centres for young people in your community.
2. To know and be able to access the SHR services and centres.

"Young people of all backgrounds deserve access to accurate, comprehensive, and age-appropriate sexual health education and care."

— Nicole Sheitz, PPNCNY

4.1 YOUTH-FRIENDLY SRH SERVICE

Adolescent and youth-friendly services (AYFS) are clinics designed to deliver a comprehensive range of sexual, and reproductive health services in ways that are responsive to the specific needs, vulnerabilities, and desires of young people while also addressing barriers usually faced by young people in accessing this services.

Youth-friendly services should be:

Accessible to all adolescents and young people regardless of age, marital status, HIV status, sexual orientation, gender identity, occupation, social status, geographical location, or ability to pay.

Services need to be provided in places that young people can reach and at time feasible to them. This may involve holding special clinics in youth centers, or other places where young people go. Clinical staff can take shifts to be available in late duty hours and weekends when young people are not at school, college or working.

These services must be confidential, non-judgmental, and private.

4.1.1 QUALITIES OF A YOUTH FRIENDLY SERVICE PROVIDER

YFS providers must:

Be technically competent in adolescent specific areas

Be able to offer health promotion, prevention, treatment and care relevant to each client's maturation and social circumstances

Have interpersonal and communication skills

Be non-judgmental, considerate, easy to relate to and trustworthy

Devote adequate time to clients or patients

Act for the best interests of their clients

Treat all clients with equal care and respect

Provide information and support to enable each client to make the right free choices for his or her unique needs

4.2 BARRIERS FACED BY ADOLESCENTS AND YOUNG PEOPLE IN ACCESSING YFS

• Structural barriers, such as laws and policies requiring parental or partner consent, distance from facilities, costs of services or transportation, long wait times for services, inconvenient hours, lack of necessary commodities at health facilities, discrimination and judgment by friends, parents, and religious leaders and lack of privacy and confidentiality.

• Socio-cultural barriers, such as restrictive norms, and stigma around an adolescent, and youth sexuality; inequitable or harmful gender norms; and discrimination and judgment by communities, families, partners, and providers.

• Individual barriers, such as incomplete or incorrect knowledge of SRH, including myths and misconceptions around contraception, constrained ability to navigate internalized social and gender norms; and lack of access to information about SRH services available and where to seek assistance.

These services can only be youth-friendly when young persons are involved in the structure and quality of the services provided. This is what we have called Meaningful Youth Participation.

4.3 PERCEPTION TOWARDS SEXUAL AND REPRODUCTIVE HEALTH (SHR)

The identified perceptions & beliefs of people towards the use of SRH services are categorised into the following themes: Fear of side effects, religious beliefs, and cultural norms.

The WHO (2018) found that family planning reinforces people's right to determine the number and spacing of their children, preventing deaths of mothers and children in developing countries, and provides dual protection against pregnancy and STIs. In spite of these beliefs, people's decision to use or not use family planning has been attributed to the fear of the possible dangers associated with such services. A lot of people fear that such services could result in health complications such as irregular menstrual periods, excessive bleeding.

4.3 Perception towards sexual and reproductive health (SHR) services

Religious Beliefs

Religious beliefs have been noted as a barrier to effective SRH service utilisation. The use of contraceptives, abortion, and participation in sex talks are regarded as sinful among followers of such faith. The Christian faith, for instance, admonishes believers to "Be fruitful and increase in number; fill the earth and subdue it. Rule over the fish in the sea and the birds in the sky and over every living creature that moves on the ground." (Genesis 1:28). Similarly, Islam regards abortion as wrong and haram (forbidden). Such

religious teachings and beliefs influence how individuals, particularly young adults, perceive and react towards sex education and family planning services.

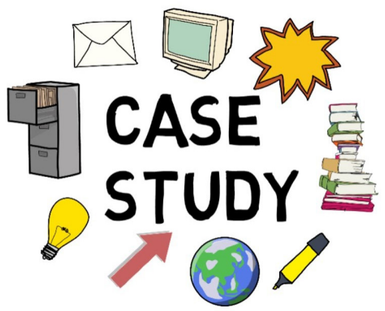
Cultural norms and social values

Many societies discourage premarital sex, discussions of sexual issues in public, and are concerned about the negative impacts of sex education. It is believed that sex education promotes promiscuity among young adults. As a result, many people suffer stigma and embarrassment when using sexual health services or seeking information. Taboos surrounding sexuality are the major socio-cultural factors influencing the utilisation of sexual health education and services by adolescents. In Africa, there are significant studies that identified culture as a barrier to sex education and service utilisation.

Fear of Side effects

"Having access to information is important, but the quality of information and services is equally so"

4.4



Tina is a 20-year-old lady who had just gained admission into the University of Love. She met a handsome looking guy named Patrick who she spends time with and loves so much. Patrick and Tina share the same hobbies and enjoy going to the cinema and playing video games together. Patrick has at different times requested to have sex with Tina, but she has always replied that she could not go against her mom's wishes. They both agreed to have sex on a fateful night.

Tina, realising that she has been told severally by her mom not to have sex or get pregnant before marriage decided to visit a health centre located at about 50 km from her school. She had to wait for 45minutes before she was able to see a service provider who started to ask a series of questions for another 15 minutes and wanted to know if her mother had given her consent to use a contraceptive.

She was after that, given an emergency contraceptive pill.

Tina vowed never to revisit the service provision centre.

REFLECTION:

1. What do you think made Tina arrive at her decision?

2. What do you think could have happened differently?

"Having access to information is important, but the quality of information and services is equally so"

MODULE 5

REPRODUCTIVE LIFE PLANNING

OBJECTIVES

At the end of this module, you should be able to:

1. Know all that life planning entails.
2. Know and identify different types and method of contraception and its uses
3. Differentiate between the truth and the myths behind the usage of contraception.
4. Have the access and know more about post-abortion care.

Step 1

Ask participants to explain what they understand as “family planning” or contraception”

Step 2

Let participants brainstorm and list some of the myths they have heard about contraception and how this has affected their use of the service.

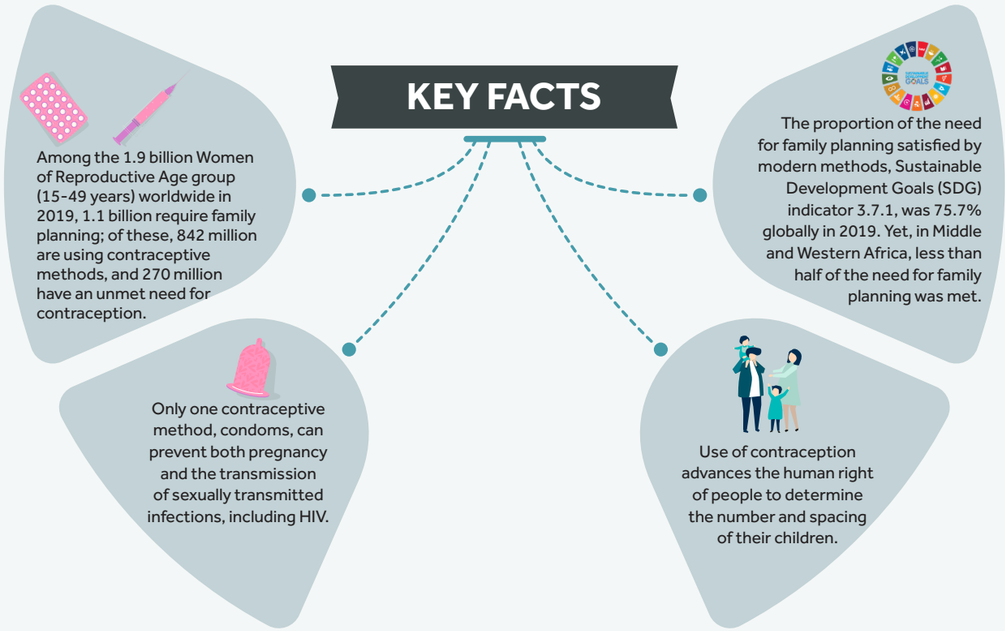
Step 3

Let participants list some of the types of contraception methods they know. Write them out on a flip chart.

5.1 DEFINITION OF TERMS

Family planning: The concept or a program of limiting the size of families through the spacing or prevention of pregnancies.

Contraceptives: The deliberate use of artificial methods or other techniques to prevent pregnancy as a consequence of sexual intercourse.



5.2 MYTHS ABOUT CONTRACEPTION

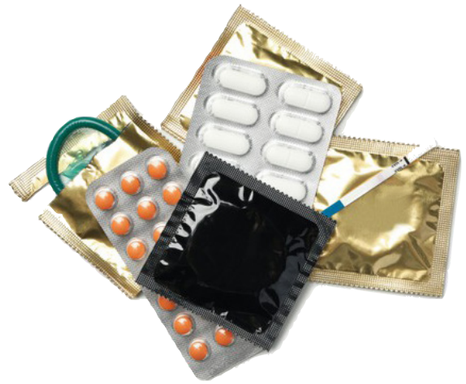
Myths are widely held beliefs or ideas that are false. In medicine, tales have been proven over and over to be invalid, but for inertia, the views are still maintained. At the same time, contraception, also known as birth control is a method designed to prevent pregnancy. Modern contraception is a product or medical procedure that interferes with reproduction from acts of sexual intercourse.

There are quite a lot of myths about contraception which has posed some challenges in people's needs for contraceptives. This is an issue that needs to be addressed to ensure people who need the services have hindered access to it.

In respect to this, listed below are some of the myths and the truth about contraception.

5.2.1 BIRTH CONTROLS CAUSE WEIGHT GAIN

There are takes that birth control generally causes weight gain; this isn't exactly true. Apart from the fact that individuals differ, scientists have not been able to find a direct relationship between weight gain and birth control pills. While the very first set of birth control developed contained 150mcgs of Estrogen which typically resulted in the women being nauseous, having breast tenderness and water retention which could lead to weight gain, today pills contain as low as 20mcgs - 50mcgs which is not significant enough to cause weight gain. This is the same for implants and other hormonal IUDs.



Weight while using contraceptives, is most likely as a result of other factors such as; natural body growth, change in diet, reduced physical activities, change in lifestyle, changes in body metabolism etc.

“It's long been accepted as fact that the availability of family planning services saves lives”

Martha Plimpton

5.2.2 BIRTH CONTROLS CAUSE HORMONAL IMBALANCE

While there are claims that birth control causes an imbalance of hormones, it is always advised that all women check their blood pressure prior to initiating combined hormonal contraception. Most oral contraceptives are made with combinations of synthetic estrogen and progestin, a synthetic

form of the hormone progesterone

After taking the pill, these synthetic hormones enter the brain and act as endocrine disruptors, interfering with the signaling process that is necessary for ovulation.

Natural hormones bind to specific receptors and keep your body in balance however when a synthetic hormone binds to the wrong receptor, that receptor may convey inaccurate signals, which throws the body off balance.

Because synthetic hormones may bind to the wrong receptors, birth control pills may cause hormone imbalances and detrimental side effects. Not all women experience these problems.

5.2.3 BIRTH CONTROLS CAUSE CANCER

There are myths that birth control causes cancer. These claims are unfounded.

Most studies conducted are observational which cannot definitively establish that an exposure in this case, oral contraceptives cause (or prevents) cancer. That is because women who take oral contraceptives may differ from those who don't take them in ways other than their oral contraceptive use, and it is possible that these other differences rather than oral contraceptive use are what explains their different cancer risk.

Overall, however, these studies have provided consistent evidence that the risks of endometrial, ovarian, and colorectal cancers are reduced.

5.2.4 BIRTH CONTROL CAUSES INFERTILITY

Myths that birth control, either long-term or short-term causes infertility in the long-run have left some people with the decision not to use birth control. However, this claim is unfounded.

Research and experiences shared from other women have shown that after ending a birth control plan, a woman can get pregnant almost immediately. That's why women who use the pill regularly but accidentally forget to take it for a few days can get pregnant that month. Once women stop using contraception, their periods and fertility will usually soon return to normal.

Infertility, however, is common and could be caused by several factors. STIs are a common cause of infertility, someone having difficulty getting pregnant when not on contraception, should see a doctor for the best advice.

5.2.5 IUDS CAN CAUSE PELVIC INFLAMMATORY DISEASE (PID)

The risk of getting PID after the insertion of IUD is very low. PIDs are caused by STIs commonly Chlamydia and gonorrhea. IUDs are generally safe and if properly handled free from germs. If a woman should develop or have PID while using IUDs, there are high chances she has one or more STIs.

To avoid this, cervical infections must be screened before the IUD is inserted, and proper sexual behavior followed.

5.2.6 IUDS CAUSES ECTOPIC PREGNANCY

IUDs don't cause ectopic pregnancy. An IUD reduces the overall chance of pregnancy, therefore, may lower the overall risk of ectopic pregnancy.

5.3

Myths also exist regarding the different methods of contraception, namely:

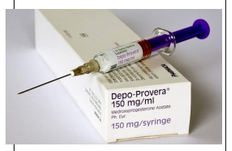
Myths	Truth
Pills and Condoms are the only Methods	Some people assume that pills and condoms are the only methods of contraception mostly because of how common they are and how easily they can be gotten over the counter. Well, there are other methods of contraception such as The shots/ Injections (Depo Provera, Sayana press, Noristerat) the arm implant, the vaginal rings, and the IUDs.
The vaginal ring falls out	If appropriately inserted, the vaginal ring does not fall off. They are held firmly by the muscles of the vagina and will stay in place until you take them out. It should not fall out during daily activities.
IUDs tear through the uterus lining	Although this may happen, it is infrequent. It happens to less than 1 in 1000 IUD cases. If you suspect that there is uterus perforation, you should visit your doctor immediately. Factors such as; the type of IUD, the uterine size and position, the timing of the insertion to the last delivery or abortion may result in uterus perforation. Perforation is often suspected or diagnosed when the IUD string is no longer visible at the external organ. If you sustain a perforation, you are at that time not protected against pregnancy.
IUDs should only be for women with children	Some people believe that IUDs should be for women with kids because they think it may lead to infertility in the long run. This isn't true. IUDs are safe for women with and without children. IUDs are usually recommended as long-lasting reversible birth control options for young women and they can last up to 10 years. doctor or expert to let you know the method best suited for you. Using a method not suitable for you may lead to unpleasant outcomes.
Everyone will be able to see the Implant	Some people are discouraged from going for the implants because they assume people would notice they are using them. It is thus essential to know that the implants are well hidden in your body. So long you aren't drawing attention to it, no one will know you have the implant.
There are now male shots/ male pills	As of the time of writing this, the only available and approved contraceptive for men is the condom. While drugs and other methods are currently developed, none have been approved yet.
All contraceptive methods are appropriate for all women	It is important to note that as individuals differ, so does the proper way for women differ. When seeking contraception, you must speak to your

Emergency contraception is only useful in the morning	There are assumptions that emergency contraceptives are only helpful in the morning after unprotected sex. Although sometimes called 'morning-after-pill', the ECP should be taken as soon as possible after unprotected sex. There are two types of ECP, e.g. Ella, that works for up to five days after sex, and they are both effective when taken as soon as possible. Postinor 1 and 2 are effective when taking before 72 hours. The ECP is not an abortion pill. If you are already pregnant, ECP will not work. ECPs are over the counter drugs and do not need a doctor's prescription.
The pill serves as protection from sexually transmitted infections	The pills offer no protection from sexually transmitted infections (STIs.) The only birth control method available that protect against STIs is the male and female condom.
The pill is effective immediately after you begin taking it	The pills do not exactly work like that. Having unprotected sex immediately after you start taking the pill will likely result in pregnancy. In most women, at least one week is needed for the hormones in the pill to work with the woman's natural hormones to prevent ovulation. To be effective, the pill must be taken as directed.
I don't need birth control because my partner pulls out	The withdrawal method isn't an effective way of birth control. It has just a success rate of 73 percent. In every 100 women that engage in the withdrawal method, 27 will get pregnant. This is because it is still possible for sperm to be present at the tip of the penis before ejaculation, which can result in a pregnancy. Also, some ejaculate (a fluid that contains sperm) might be released before the man actually begins to climax. In addition, some men might not have the willpower or be able to withdraw in time.

5.4 TYPES OF CONTRACEPTION

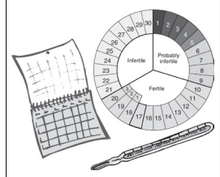
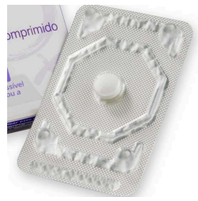
In this section, we review the methods that are available to help you understand the options and help you narrow down the choices. You can always talk over your choices with your health care provider/counsellor.

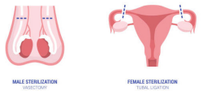
S/N	Method	What is it? How does it work?	Chances of getting pregnant	Side effects	Pros	Cons
1	LONG ACTING REVERSIBLE CONTRACEPTION ARM IMPLANT 	Progestogen is released from 1 or 2 rods implanted under the skin of the arm. Mucus in cervix and may stop ovaries from releasing an egg each month.	less than 1%	No serious risk	lasts 3 - 5 years - fit and forget. Useful for women who can't take combined pill. Useful for those who forget pills or injection appointments.	Irregular bleeding which often gets better with time and can be controlled with medication
2	INTRA UTERINE DEVICE - IUD 	Placed inside the womb. Copper IUD or progestogen-releasing IUD (Mirena or Jaydess). Stops sperm from reaching an egg.	less than 1%	Very small chance of pelvic infection when IUD put in	Can stay in place for 3 years or more - fit and forget. Doesn't interfere with sexual intercourse. Mirena lighter periods or no period at all, suitable for women with heavy periods.	Needs to be inserted by an experienced doctor or nurse. Copper IUDs may cause heavier periods or cramping. Hormone releasing IUDs may cause irregular bleeding in the first few months.

S/N	Method	Method	Chances of getting pregnant	Side effects	Pros	Cons
3	HORMONAL CONTRACEPTION DEPO PROVERA 	An injection of progestogen. Stops ovaries from releasing an egg each month.	Typically 3% but less than 1% if next injection given on time	No serious concerns	One injection lasts 12 weeks. Doesn't interfere with sexual intercourse. Usually no periods. Useful for women who can't take combined pill.	Irregular bleeding, no periods or occasional heavy bleeding. Periods and fertility take an average of 6 months to return after stopping the injection. May have change in weight.
4	COMBINED ORAL CONTRACEPTIVE PILL 	Pill made of two hormones, oestrogen and progestogen. Stops ovaries from releasing an egg each month.	Typically 8% but less than 1% if used perfectly	Very small chance of blood clots, heart attacks and strokes. More likely in women above 35 who smoke, are overweight or have a family history of the above conditions. Very slight increased risk of cervical cancer.	Very small chance of blood clots, heart attacks and strokes. More likely in women over 35 who smoke, are overweight or have a family history of the above conditions. Very slight increased risk of cervical cancer.	Should not be used by women over 35 who smoke. Must remember to take it daily. May have irregular bleeding.

S/N	Method	What is it? How does it work?	Chances of getting pregnant	Side effects	Pros	Cons
5	PROGESTOGEN ONLY PILL 	Pill made of one hormone – progestogen. By thickening mucus in cervix and may stop ovaries from releasing an egg each month.	Typically 8% but less than 1% if used perfectly	no serious risk	Doesn't interfere with sexual intercourse. Can be used at any age. Can be used by breastfeeding women. Useful for women who can't take a combined pill.	May have irregular bleeding
6	VAGINAL RING 	NuvaRing contains two hormones, estrogen, and progestogen. Sits inside the vagina. Stops ovaries from releasing an egg each month.	Typically 8% but less than 1% if used perfectly	very small chance of blood clots, heart attacks and strokes. More likely in women over 35 who smoke, are overweight or have a family history of the above conditions	Lasts for 3-4 weeks. Useful for those who forget pills.	Should not be used by women over 35 who smoke

S/N	Method	What is it? How does it work?	Chances of getting pregnant	Side effects	Pros	Cons
7	MALE CONDOM 	A thin rubber barrier. Fits over erect penis and catches sperm when the man ejaculates. Best used with lubricant (water based)	Typically, 15% but 2% if used perfectly every time. DO NOT USE oil-based lubricant or some anti-thrush creams.	None known	Easy to use, easy to carry. Used only when needed. Helps protect against STIs. Available from Family Planning clinics and other health care providers. Can be gotten from pubs, clubs, pharmacies and many shops. Cheaper on prescription.	Some people are allergic to rubber. Must be put on when penis is erect and before sexual intercourse. Some people say it reduces sexual feeling. Can slip off or break
8	FEMALE CONDOM 	A thin polyurethane barrier. Goes into the vagina and prevents sperm from entering the woman's body.	Typically 21% but 5% if used perfectly	None known	Helps protect against STIs. Easy to use.	Relatively expensive. Need to insert every time.

S/N	Method	What is it? How does it work?	Chances of getting pregnant	Side effects	Pros	Cons
9	FERTILITY AWARENESS 	Woman checks body temperature, cervical mucus and periods. These body signs show when you are more likely to get pregnant	Typically 25% but can be 3% if used perfectly	None	After learning method, no further costs or visits to health professionals required. Helps you understand how your body works.	Expert instruction needed to learn method. No sexual intercourse during fertile time. Must chart temperature and cervical mucus daily. Body signs can be difficult to recognise and may vary.
10	EMERGENCY CONTRACEPTION Emergency Contraceptive Pills (ECP) 	Emergency Contraceptive Pills (ECP) used after unprotected sexual intercourse. Delays ovulation or stops sperm reaching an egg.	2% for women of average weight, 6% if overweight	None known	Reduces chance of pregnancy after unprotected sexual intercourse. ECP – can be used up to 72 hours after unprotected sexual intercourse. Can have ECP at home for future use. Can be used if other method fails, eg. broken condom or missed pill. Can buy from pharmacies.	ECP should be taken within 72 hours of unprotected sexual intercourse. ECP may not be effective for heavier women.

S/N	Method	What is it? How does it work?	Chances of getting pregnant	Side effects	Pros	Cons
11	PERMANENT CONTRACEPTION VASECTOMY & TUBAL LIGATION 	Permanent contraception. An operation. Vasectomy – male tubes cut to stop the sperm getting to the penis. Tubal ligation – clips put on female tubes to stop the egg getting to the uterus.	less than 1%	Vasectomy – rare possibility of long term scrotal pain. Tubal ligation – very slight risk from reaction to anaesthetic or damage to internal organs.	Once only. Permanent.	Not easily reversible. Requires an operation. May have short term side effects, e.g. pain, bruising.

5.5 SAFE ABORTION CARE

DEFINITION OF TERMS

Abortion – whether spontaneous or induced – can be unsafe, leading to death and injury for women. Treatment of abortion complications or post-abortion care (PAC) is considered an essential component of emergency obstetrical care services because it is one of the leading causes of maternal mortality and morbidity.

The World Health Organization defines abortion as —the termination of pregnancy from whatever cause before the fetus is capable of extra uterine life.

5.5.1 FACTS AND FIGURES RELATED TO MATERNAL MORTALITY DUE TO UNSAFE ABORTION

Of the 40 to 60 million abortions performed annually worldwide, an estimated 20 million are deemed unsafe, and 95% of these occur in developing countries. The World Health Organization (WHO) estimates that at least 80,000 women die annually as a result of unsafe abortion, accounting for almost 13% of the maternal deaths worldwide, and in some countries up to 60%. Unlike many pregnancy-related problems and other accidents and illnesses, deaths and injuries due to unsafe abortion are entirely preventable. They are caused by punitive laws, narrowly defined health policies, and failure to provide adequate health and family planning services.

5.5.2 DISTINCTION BETWEEN SAFE AND UNSAFE ABORTION

Safe abortion is a procedure and technique performed by trained health-care providers with proper equipment, correct methods, and sanitary standards.

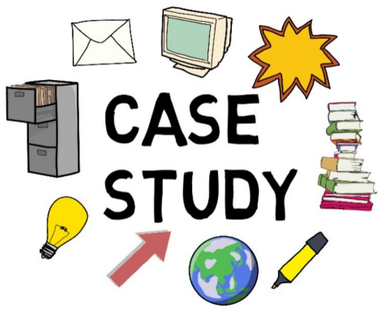
Unsafe abortion is a procedure performed either by persons lacking necessary skills or in an environment lacking minimal medical standards or both. Sepsis conditions are a frequent complication of unsafe abortion involving unsterilized instrumentation and procedure (WHO, 2003).

Post-abortal care refers to the package of care needed to provide quality services following spontaneous abortion and unsafe abortion. Post-abortal care services should include both medical and preventive care.

Medical methods, also known as non-surgical methods, make use of pharmacological drugs to treat conditions of post-abortion.

Surgical methods make use of trans-cervical procedures, such as MVA, dilatation and curettage (D&C), and dilatation and evacuation (D&E).

5.6



1. Tola is 16 and has just concluded her WAEC exam. Her boyfriend, Joseph, a university undergraduate student has promised to assist her in gaining admission into the same university, he has a few other girlfriends. Tola has been having sex with Ben for some time. and he usually pulls out before he cums. She confided in a friend that she is feeling “funny”. Upon telling Ben about feeling unwell and may be pregnant, he slaps her face and accuses her of seeing other guys as he had been careful.

a. What do you think is happening here?

b. What advice will you give Tola and Joseph?

2. A friend chats you up and tells you she is not using any contraception because she tried taking the oral contraceptive pill, but it made her feel unwell. She doesn’t want to suggest condoms to her boyfriend because she is worried that he will think that she has been unfaithful and end their relationship.

a. What advice would you give her?

b. How can you help?

MODULE 6

STI'S, AIDS & YOUTH VULNERABILITY

OBJECTIVES

At the end of this module, you should be able to:

- Discuss myths and misconceptions about HIV and AIDS
- Define the terms HIV and AIDS
- Discuss the Management &Treatment of HIV & AIDS
- Identify three ways of preventing HIV.

Step 1

Ask the participants to explain what they understand by STI.

Step 2

Let them list the different types of STIs they know. Write answers on the flip chart and probe further if participants do not mention HIV.

"AIDS CANNOT BE CURED BUT CAN BE PREVENTED. ARE YOU PLAYING YOUR PART?"

6.1 DEFINITION OF TERMS

HIV is the Human Immunodeficiency Virus. It is a virus that infects human beings and causes a lowering of the body's` immune system" This makes it impossible for the body to fight certain infections.

H – Human because the AIDS virus only lives in human beings and not in animals, insects, water, or air.

I – Immuno-deficiency, the AIDS virus causes the body soldiers that act as the body defense immune system ineffective in protecting the body from diseases.

V – Virus, is a microscopic organism that we cannot see with our eyes but which is very harmful to our body.

AIDS is a condition that results when a person's immune system has been lowered (due to infection with HIV) so that the body can no longer fight other diseases such as malaria, tuberculosis, skin infections, and so on.

A - Acquired means that one gets the disease from somewhere else and not from birth.

I - Immune means that one is protected and has body soldiers with the ability to fight illness and stay healthy.

D - Deficiency which simply means that one is lacking something.

S - Syndrome, a group of illnesses that happen together. People with AIDS get many of the same types of infection and diseases such as cough, diarrhea, skin infection, etc

6.2 MODE OF TRANSMISSION

There are three (3) basic modes of HIV transmission from an infected person to another.

a. Sexual intercourse
b. Infected blood and blood products
c. Infected mother to her child

HIV can be transmitted by:

- Having unprotected sexual intercourse (vaginal, oral or anal) with an infected person.
- Sharing of sharp or pointed skin-piercing instruments, e.g. razor blade, hair clippers, piercing needles, scarification knives with an infected person or transfusion of infected blood or blood products. (Note: the fundamental issue here is the exchange of infected blood).
- From infected mother to her baby during pregnancy, delivery and after delivery (during breastfeeding).

How HIV is NOT transmitted

HIV cannot be transmitted through regular social contacts like:

a. Touching
b. Holding or shaking of hands
c. Sharing plates, cups, dresses, bathroom, and swimming pool,
d. Dancing or through Sneezing and Mosquitoes or insect bite
e. Caring for a PLWHA and

6.2.1 SOCIO-CULTURAL FACTORS INFLUENCING THE TRANSMISSION OF HIV

Widowhood rite

Usage of un-sterilized instruments for male circumcision and female genital cuttings

Group sex

6.2.2 GENDER AND HIV TRANSMISSION

Gender is an essential factor that affects the possibility of an individual becoming infected with HIV.

Women are more vulnerable to sexual infection with HIV for the following reasons:

Biological factors

- In unprotected heterosexual intercourse, women are twice as likely as men to acquire HIV from an infected partner.
- The large surface of the vaginal wall exposed during intercourse increases the likelihood of transmission of the virus.
- Microscopic lesions that can occur during intercourse are said to be entry points for the virus.
- Young women/ girls are more at risk because they have not reached maturity; the lining

of the vagina is fragile and more likely to be bruised during intercourse.

- More quantities of the virus are present in sperm than in vaginal fluids.

SOCIOECONOMIC FACTORS

- Less access to education and economic opportunity results in women being more dependent on men in their relationships, hence they cannot always control when, with whom, and in what circumstances they have sex.
- In many societies, women lack knowledge and access to information about HIV/AIDS.
- Many women who have no means of support exchange sex for material favours and survival.

SOCIO-CULTURAL FACTORS

- Some societies do not expect women and girls to make decisions about sex or even to discuss sexuality. They are therefore unable to request or insist that their partners use a condom.
- If women refuse sex or request condom use, men often suspect infidelity. Therefore, women often risk abuse if they refuse sex or request that their partners use a condom. - In societies where violence against women is permitted, they can be forced to have sex with their partners.
- Women are expected to have relations with or to marry older men, who are more sexually experienced and more likely to be infected. Men are, however seeking younger partners to avoid infection and in the belief that sex with a virgin cures AIDS and other diseases.
- In many societies, men can have multiple sexual partners and take risks such as patronizing commercial sex workers.
- In Nigeria, same-sex relationships are not accepted, and this leads to stigmatization of men who have sex with men; making them more likely to hide their sexual behavior, and less likely to access HIV services.

6.3 PSYCHOACTIVE SUBSTANCE USE AND HIV TRANSMISSION SUBSTANCE

Any psychoactive material which, when consumed, affects the way people feel, think, see, taste, smell, hear, play or behave. The substance could be a medicine, industrial product, or even a biological degradation product as in the case of fermented sewage. A psychoactive substance may not necessarily be a drug, e.g., petrol, gum.

Drug: Any substance with the potential to prevent or cure disease or enhance physical or mental welfare or any chemical agent that alters the biochemical or physiological processes of tissues or organs.

Drug abuse: The use of any substance under international control outside therapeutic indications, in excessive doses, or over an unjustified period.

COMMONLY ABUSED PSYCHOACTIVE SUBSTANCES

- Alcohol Tobacco
- Cannabis (Indian Hemp)
- Stimulants (Chinese capsule, coffee
- Pawpaw leaves
- Solvents, e.g. glue, petrol
- Heroin
- Tranquilisers
- Amphetamines
- Cocaine

6.3.1 FACTORS PREDISPOSING TO PSYCHOACTIVE SUBSTANCE USE

These factors can be sub-divided into 3 – Individual, Family and Societal Factors

Individual factors

i. Defective personality, including chronic inadequacy

ii. Low self-esteem

Family

i. Parents use a psychoactive substance

ii. Distant relationship between parents and children or other family members

iii. Parental deprivation, e.g. separation, divorce, death of parents

Society (including school, neighborhood)

i. Peer pressure

ii. Advertisement / media influence

iii. Societal values that permit/ encourage the use of psychoactive substances

iv. Availability of substances in society

v. Economic factors

6.3.2 Effects of psycho-active substance abuse

Psycho-active substance abuse has effects that go beyond the individual to impact negatively on his family and society at large.

Some effects of psychoactive substance use include:

- Loss of sense of responsibility
- Family disruption
- Lack of achievement of goals
- School dropout
- Promiscuity
- Road traffic accidents
- Increased crime rates
- Abnormal behaviour, e.g. madness.
- Sleep disturbances etc.
- Poverty

6.3.3 EFFECTS OF PSYCHO-ACTIVE SUBSTANCE ABUSE ON HIV TRANSMISSION

Group work

Let participants discuss how psycho-active substance abuse could influence HIV transmission

- Allow five (5) minutes for the discussion.
- Recall and ask a representative to speak.
- Request others to comment.
- Clarify and expand points as follows

The use of these substances depresses judgment making the individual do things he/she would not ordinarily do if he was not under the influence of these drugs.

These could include:

Getting involved in high-risk sexual behaviour such as having sexual intercourse with someone he/she has just met, not using a condom when having sexual intercourse.

6.3.4 PREVENTION OF PSYCHO-ACTIVE SUBSTANCE ABUSE

Predisposing issues to substance use are:

- Educating adolescents and young people on the dangers of substance abuse
- Legislation to prohibit production, sale, advertisement of these substances
- Social and religious groups to get involved in the prevention of substance use
- Improving relationships between parents and their children
- Early diagnosis and treatment of individuals who are addicted to these drugs
- Provision of facilities for counselling adolescents and youth on the dangers of drug use,
- Rehabilitation of addicts
- Regulation of cultivation of tobacco and cannabis.
- Providing those who grow these crops with alternate sources of income, e.g. they can grow other crops
- Enforcement of laws against substance use, e.g. the law banning smoking in public places

Summary

Drug abuse is the use of any substance under international control outside therapeutic indications, in excessive doses, or over an unjustified period. Common substances abused include tobacco, alcohol, cannabis, etc. Drug abuse also enhances the spread of HIV/AIDS by depressing judgment and making the addict engage in high-risk sexual behavior. Government and individuals should address the problems of psychoactive substance use in Nigeria.

6.4 PREVENTION OF HIV INFECTION

A. Abstinence from all forms of sexual intercourse

B. Being faithful to one uninfected sexual partner (mutual fidelity, “zero grazing”)

C. Consistent and correct use of a condom

6.4.1. PREVENTION OF TRANSMISSION THROUGH BLOOD AND BLOOD PRODUCT

- Avoid sharing of sharp, skin-piercing instruments (like razors, clippers, etc.) with an infected person
- Avoid transfusions with HIV infected blood. To achieve this, ensure that blood samples are screened for HIV. Persons donating organs for transplantation should be screened for HIV

6.4.2 PREVENTION OF TRANSMISSION FROM MOTHER TO CHILD

- During pregnancy; recommend the use of ART (antiretroviral therapy)
- During childbirth, a cesarean section may be done
- ART could also be given to a child delivered by an HIV positive mother who did not have HIV prevention care during pregnancy.

6.5 MANAGEMENT OF HIV

Introduction

It is essential to know that there is no treatment or cure for HIV&AIDS as of now. In the session on HIV prevention, we have discussed the place of using drugs to prevent the transmission of HIV from infected mother to the child (pMTCT). In this section of the manual, additional information on the management of HIV&AIDS is provided as a critical message.

Key Messages

• PLWHA should be encouraged to improve health-seeking behavior, hygiene, good nutrition and as much as possible stay healthy at all times, i.e. positive living

- Prompt treatment of opportunistic infections
- ART for those whose viral load has advanced to the level requiring it under medical supervision
- Psycho-social support and care.

At present, there is no known cure for AIDS. However, HIV and AIDS could be managed through healthy living, use of anti-retroviral drugs, and treatment of opportunistic infections, care and support.

6.6 HIV TESTING SERVICES (HTS)

Key Information

HIV Counselling and Testing (HTS) is a process by which an individual undergoes counselling, enabling him/her to make an informed decision about being tested for HIV.

Counselling is defined as an interaction between two or more people in which one person assists another person(s) to make an informed decision". A person who is assisting another is referred to as a counsellor, while a counselee (client) is the person(s) who is being helped."

NOTE: counselling is not giving advice instead; it is providing the counselee with the necessary information to make an informed decision about the issue presented.

HIV testing is the gateway to HIV prevention, treatment, care and other support services. People's knowledge of their HIV status through HIV testing services (HTS) is crucial to the success of the HIV response.

The goals of HIV testing services are to:

- Identify people with HIV through the provision of quality services for individuals couples and families;
- Effectively link individuals and families to appropriate HIV treatment, care and support, as well as HIV prevention services, based upon their status; and support the scale-up of high impact interventions to reduce HIV transmission and HIV-related morbidity and mortality, that is, anti-retroviral therapy (ART), voluntary medical male circumcision (VMMC), prevention of mother-to-child transmission (PMTCT), pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP)

6.6.1 IMPORTANCE OF HIV TESTING (HTS)

- It allows the client(s) to be better informed about the issue.
- It enables an individual to take a voluntary and informed decision.
- It allows for better interaction between a counsellor (provider) and the client(s).
- It allows clients to ask questions and receive answers that will correct misconceptions, rumors, and myths.
- It enables a client(s) to be assisted by a counsellor to understand his or her needs and feelings about a situation, and to plan for the future.
- It enables one to know if one has the virus or not.
- Knowing the result will help one to make changes to one's way of life that will help preserve health.
- It helps to prevent and control the spread of HIV.

6.6.2 THE PROCESS OF HTS

There are four necessary steps in the HTS process:

a. Pre-test counselling: This prepares the client for the test. Personal risk assessment is conducted at this point.

b. Testing for HIV: This involves a blood test for the presence of antibodies to HIV. The result of the test could be negative, positive, or indeterminate.

c. Post-test counselling: This helps the person to understand and cope with the test result. NOTE: the test result can only be disclosed during post-test counselling.

d. Ongoing/support counselling: This is provided after post-test counselling. Depending on the situation of the client, there may be a need for psycho-social, medical, and emotional support. This may require additional sessions with the counsellor, which may also lead to a referral to other service providers.

6.7 COUNSELING

Qualities of a Good Counselor

- Must be knowledgeable about HIV&AIDS and adolescent reproductive health issues.
- Must be able to give accurate information.
- Must not be judgmental.
- Must know his/her limitations.
- Must be friendly.
- Must have good communication skills.
- Must be readily accessible to clients.
- Must be self-disciplined.
- Must be observant.
- Must maintain confidentiality

6.8 HIV/STI RISK ASSESSMENT

Ask each participant to conduct an STI/HIV risk assessment of herself/himself by administering the questionnaire on themselves and ticking Yes or No.

STI/HIV risk assessment questions	YES	NO
Do I have a sexual partner?		
Has my current partner had more than one sexual partner?		
Do I have more than one sexual partner?		
Do I dislike using a condom when having sex?		
Do I share needles, syringes, or sharp instruments?		
Have I ever had unprotected sexual intercourse?		
Do I have sex to gain money, food, employment drugs, or to pass examinations?		
Do I indulge in alcohol?		
Do I indulge in substance abuse?		
Have I participated in cult/oath-taking activities where blood mixing/ licking/ drinking was involved?		

Allow 5 minutes for the exercise.

- Recall the participants to discuss the exercise.
- Stress that one's sexual lifestyle will determine if one is at risk or not. This simple test will help each participant to find out if s/he is at risk or not.
- Stress the implications of any Yes answer.

Explain that the more Yes answers, the higher the risk

6.9 CARE AND SUPPORT FOR PLWHA AND PABA

Introduce the topic by explaining that living with HIV or AIDS is a complicated process. Unfortunately, PLWHA is often stigmatized, which further aggravates their condition. We need to understand that these categories of people are in every respect human and have rights like any other person. Therefore, we need to care for, support and never discriminate against them as a result of their HIV.

Definition of Terms

1. PLWHA refers to "a person living with HIV (who has tested positive to the virus) or has progressed to AIDS". Explain that HIV and AIDS may cause some health problems beginning at the time of seroconversion, and terminating with AIDS and possibly death.
2. PABA - "a person affected by AIDS (PABA) is one who has a relation, friend or close associate living with the virus or AIDS.

6.9.1 CARE AND SUPPORT NEEDS OF PLWHA AND PABA

The care and support needs of PLWHA and PABA can be broadly categorized into 4:

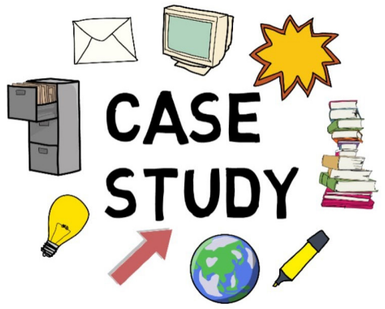
1. Physical Needs
   a. Doing household chores
   b. Eating an appropriate diet
   c. Maintaining proper hygiene

2. Psycho-Social Needs
   a. Acceptance and respect
   b. Love
   c. Companionship

3. Financial Needs
   a. Money for daily subsistence needs
   b. Money to meet medical needs

4. Medical Needs
   a. Treatment and management of opportunistic infections.
   b. Anti-retroviral drug.

6.10



Janet is a pretty young lady who loves life and enjoys having fun every Friday night when she closes from work. She was introduced to Diran at a night club and they set up an appointment to meet at the spot every Friday night. They enjoyed each other's company and when they are not meeting, they exchange nude pictures and engage in sex chats. On a fateful, day Diran introduced Janet to Tramadol and told her it would make her enjoy their nights out better. Janet loved the experience and couldn't wait till the next meeting.

They engaged in sex at the club toilet and then spend the night at Diran's house.

About 2 months after, Janet decided to join an HIV counseling and testing outreach holding in her community and found out that she was HIV positive.

REFLECTION:

1. What should Janet and Diran have done differently?
2. Who was at fault?

YOUTH AMPLIFY TRAING MANUAL

MODULE 7

POLICIES AND LAWS ON ADOLESCENT AND YOUTH SRHR IN NIGERIA

OBJECTIVES

At the end of the module, participants should have a better understanding of;

- Existing legal and policy documents or frameworks on SRHR in Nigeria
- How do these policies and laws affect young people?
- The effect of policies and laws on young people
- The new legislation in place and how they are set to affect the public.
- How inclusive are these policies for Persons with Disabilities (PWDs)

OBJECTIVES

“By investing in the right policies and programmes for adolescents to realize their potential and human rights to health, education and full participation in society we can unleash the vast human potential of this ‘SDG Generation to transform our world

Step 1

Ask participants if they are aware of a law/policy guiding youth and adolescent health.

Step 2

Let them state what they know about the laws and write it on a flip chart

7.1 HISTORY OF SRHR IN NIGERIA

Before the 21st Century discussions on reproductive and sexual health rights had been a 'taboo' in traditional African societies. While the right to health has been internationally recognized, reproductive health rights gained formal acceptance only in 1993, and the need for people especially women to have access to quality reproductive health services such as medical care, family planning, safe pregnancy, delivery, and prevention of sexually transmitted infections, such as HIV/AIDS is increasingly gaining recognition in Africa at large and Nigeria in particular.

Laws and policies are the legal and official framework that guides the implementation and uptake of SRH services to influence positive behavioral change. In Nigeria, reproductive health rights have a powerful moral resonance; they have not been enacted into law by the national or state assemblies. Secondly, laws intended to ensure adequate information and quality of care in reproductive health services have little weight where there is no government commitment to training health workers to respect reproductive rights. Similarly, laws ensuring access to reproductive health care services, such as safe abortion, can only be implemented where there is an investment in facilities that are equipped and authorized to perform these procedures.

Nonetheless, formal laws and policies are critical indicators of the government's commitment to promoting reproductive rights. This chapter will examine the policies and laws on Adolescent and youth SRHR in Nigeria and how these rights can be realized.

7.2 BACKGROUND

The International Conference on Population and Development (ICPD) held in Cairo in 1994 marked the recognition of a new paradigm in addressing human reproductive and health. For the first time, there was a clear focus on the needs of individuals, on the empowerment of women, and the appearance of a growing discourse on the relationship between human rights and health, linking new ideas of health to the struggle for social justice and respect for human dignity.

According to the International Conference on Population and Development (ICPD), reproductive rights embrace certain human rights that are already recognised in national laws, international laws and international human rights documents, and other consensus documents.

These rights are women's right to have control and decide responsibly on matters related to their sexuality, which include sexual and reproductive health, free of coercion, discrimination and violence; the fundamental right [of all women] to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.

Nigeria ranks amongst countries with the highest rate of maternal mortality and morbidity, and in spite of the global recognition of the right to health as a human right, Nigeria is yet to embrace the concept as there is no specific legislation on the right to health in Nigeria. Healthcare provisions are contained in Chapter II of the Constitution of FRN, which embodies the economic and social policies of the country. Also, Section 17 (3) (c) provides that the state shall direct its policy towards ensuring that there are adequate medical and health services for all persons. However, the provisions of Chapter II have been excluded from adjudication by the courts; thus, no right of action can ensue from the breach of the provisions of the said chapter by the government.

Chapter IV of the 1999 Constitution FRN which provides for fundamental human rights makes no provisions for the right to health in spite of the fact that the right to life is only meaningful to a person who is healthy and the right to freedom of movement has no value for a person who is rendered immobile by a preventable disease.

Over the years, a human rights-based approach to reproductive health has evolved which emphasizes the health rights, to have children by choice, and to have a safe and satisfying sex life. It is now recognized that women and men have the right to attain the fullest enjoyment of sexual health throughout their life cycle. Rights are defined as 'legitimate claims' which involve three intersecting dimensions: social, legal, and personal. Social rights consist of claims that are legitimized variously by religion, ideology, traditions, culture, and social norms. Legal rights are defined in international and national laws. The personal dimension concerns how individuals perceive their rights, based on their experience, knowledge, and multiple influences from the social dimensions. Reproductive rights are entitlements to social conditions and services that make reproduction a truly mutual effort between men and women in an atmosphere devoid of coercion, fear, or stigmatization.

International human rights law provides well established conceptual frameworks for sexual and reproductive health (SRH) rights. Still, these frameworks are almost far from being relevant to the policy debate on SRH in Nigeria. The gap between legal human rights and the truth in Nigeria is enormous, particularly for poor women, men, girls, and boys.

7.3 REPRODUCTIVE HEALTH AS A HUMAN RIGHTS ISSUE

The World Health Organization defines health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.

According to the WHO Constitution, the enjoyment of the highest attainable standard of health is one of the fundamental human rights of every human being, including PWDs without distinction. The World Health Organization further defines sexual health as a state of physical, emotional, mental and social well-being in relation to sexuality. It is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

This definition suggests that people with adequate reproductive health have satisfying and safer sexual lives, and can make a choice as to whether, when and how they would like to have children. Reproductive Health is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes.

Reproductive health, therefore, implies that people can have a satisfying and safe sex life and that they can reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are: the rights of men and women to be informed, have access to safe, effective, affordable and acceptable methods of family planning including methods for regulation of fertility, which are not against the law; and the right of access to appropriate health care services to enable women to have a safe pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

7.4 CHALLENGES IN ACCESSING REPRODUCTIVE HEALTH SERVICES

The impediments to making SRH rights a reality in Nigeria are multiple and mutually reinforcing, encompassing socio-cultural and gender norms, resource and capacity constraints, and unfavorable legal environments. These have much influence on not only the masses but including the policymakers and the law enforcement agents. Despite efforts by the Nigerian government, advocacy by civil society organizations, and substantial financial allocations by international donor agencies, laws and policy regulations on reproductive health issues are ineffective and in dire need of reform.

With the presence of national policies on population and reproductive health, family planning programs continue to suffer severe setbacks due to people's socio-cultural inclinations. Abortion laws are too restrictive with possible reforms seeming a long way off.

Attempt to reform Nigeria's restrictive abortion law, in 2007, was opposed by women's groups and anti-abortion groups. Two bills submitted to the Nigerian national assembly—one designed to fully implement the terms of the International Convention for the Elimination of all Forms of Discrimination Against Women (CEDAW) and the other to establish an Institute of Reproductive Health in the country—were rejected because anti-abortion protesters (including women) accused the bills' sponsors of attempting to legalize abortion.

In these two situations, it was evident that policymakers were guided by moral and religious considerations rather than by evidence-based approaches. Further, there are statutory, cultural and religious factors militating against women's reproductive health rights, and they have been a significant cause of women's continued oppression. Issues in reproductive rights from the point of view of gender equality are also significant challenges young persons face in accessing SRHR.

From the above, especially the introduction it is safe to say Nigeria doesn't have many policies on Reproductive Health, just bit in pieces everywhere and specific matters determine the law that applies. However, the National Reproductive Health Policy approved in 2010 appears to be the most comprehensive. Even though there is room for improvement, but taking cognizance of the fact that reproductive health and its contents are somewhat sensitive in these parts of the world, we can say there is a significant improvement as to policy on reproductive health.

Here is a summary of sections from the National Reproductive Health Policy 2010 that most apply to Reproductive, Maternal, Newborn, Child, and Adolescent Health which serves as the framework SRHR in Nigeria.

The National Reproductive Health Policy was approved in 2010 by the Federal Government of Nigeria to ensure availability and access to full sexual and reproductive health information and quality services. The policy does this by seeking to address the critical issues it identifies which includes: low funding, inadequate human resources, poor integration of maternal and family planning services, the high cost of commodities at service delivery points, limited efforts at family planning demand creation, high unmet need for family planning, inadequately equipped facilities, and lack of linkages between adolescent reproductive health (ARH) services and the regular health service delivery system, poor coordination of ARH at state levels together with quality issues in STI/HIV/AIDS services, and limited activities in the areas of reproductive cancers, andropause, and menopause.

The policy outlines vital underlying values and strategic priorities for the Reproductive Health (RH) Policy:

- A right-based approach to the highest attainable standard of health
- Ensuring equitable sexual and reproductive health in a
- Gender-sensitive manner
- Cultural sensitivity and targeting changes in harmful cultural practices
- Participatory and consultative in meeting people's needs
- Evidence-based-research for development, implementation, and service delivery Strategic Priorities
- Healthy pregnancy and childbearing through improving antenatal, delivery, postpartum and newborn care.
- Healthy sexual development and sexuality through the promotion of sexual health, provision of appropriate sexual and reproductive health information and friendly services to young people, and combating sexual coercion and other reproductive rights violation.
- Infection-free sex and reproduction through combating reproductive tract infections, including HIV and other sexually transmitted infections (STIs), and high-quality management of post-abortion complications and gynecological morbidities.
- Achieving desired and intended fertility, including prevention of mistimed and unwanted pregnancies through the provision of high-quality services for family planning, including infertility services

7.5 INCLUSION POLICIES FOR PERSONS WITH DISABILITIES (PWDS)

Based on the World Report on Disability (2011), approximately 25 million Nigerians live with one form of disability or the other with an estimated 13 million of this population being women and girls. Persons with disabilities have the same sexual, and reproductive health (SRH) needs as other people.

They need the minimum package of reproductive health services available to everyone else. Still, their unique circumstances create barriers to access, such as communication barriers, ignorance of service providers, societal attitude, and inadequate capacity of service providers to manage clients with disabilities.

These factors combine to deny persons with disabilities essential reproductive health services. Nigeria's national health policies and plans do not normally mainstream issues of disability or make provisions for persons with disabilities, they may only mention or include PWD among the target groups. For example, the current National

Reproductive Health Policy and Strategy, the National Strategic Health Development Plan, the National Strategic Plan on HIV/AIDS, and a host of other national documents do not spell out concrete interventions for addressing the concerns of persons with disabilities. However, what is required is neither "hard science" nor a unique health program for them. What is needed is for existing services to be adapted to accommodate persons with disabilities and to provide information about services in a manner that they can comprehend and utilize.

Women and girls with disabilities (WGWDs) are significantly affected, because generally, they are poor, live in remote rural areas without any economic power, and experience multiple forms of discrimination, first as women then as WGWDs. They have often been denied the right to establish relationships and to decide whether, when, and with whom to have a family. Many have been subjected to forced abortions or forced marriages. They are more likely to experience physical, emotional, and sexual abuse and other forms of gender-based violence. They are more likely to become infected with HIV and other sexually transmitted infections (STIs).

Young Persons with Disabilities (PWDs) are particularly vulnerable to marginalization and discrimination, making the link between sexual and reproductive health and their disability strong. They are often excluded from economic empowerment initiatives because of their disability resulting in poorer health outcomes, lower education achievements, less economic participation, and higher rates of poverty than people without disabilities.

Young PWDs experience triple discrimination; both from their disability, poverty, and their gender. In Nigeria, SRHRs are perceived to be a mere feminist utopic aspiration, which should not be accorded any attention, however, should the topic be given any attention at all, it is usually focused only on the needs of able-bodied women excluding the concerns of WWDs.

WWDs also have SRHRs and needs arising therefrom that entitle them to equal opportunities and equal protection of both international and municipal laws.

Violations of the SRHRs of WWDs have been condoned in developed and developing nations like Nigeria as they are still viewed, erroneously, as people who cannot take part in sexual and reproductive activities. However, the truth is that WWDs are equally sexually active, and capable and able to conceive and bring a pregnancy to term. Many disabilities do not prevent an active sexual and reproductive life, especially for WWDs.

7. 5.1 SRH-RELATED EXCERPTS FROM THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES (CRPD)

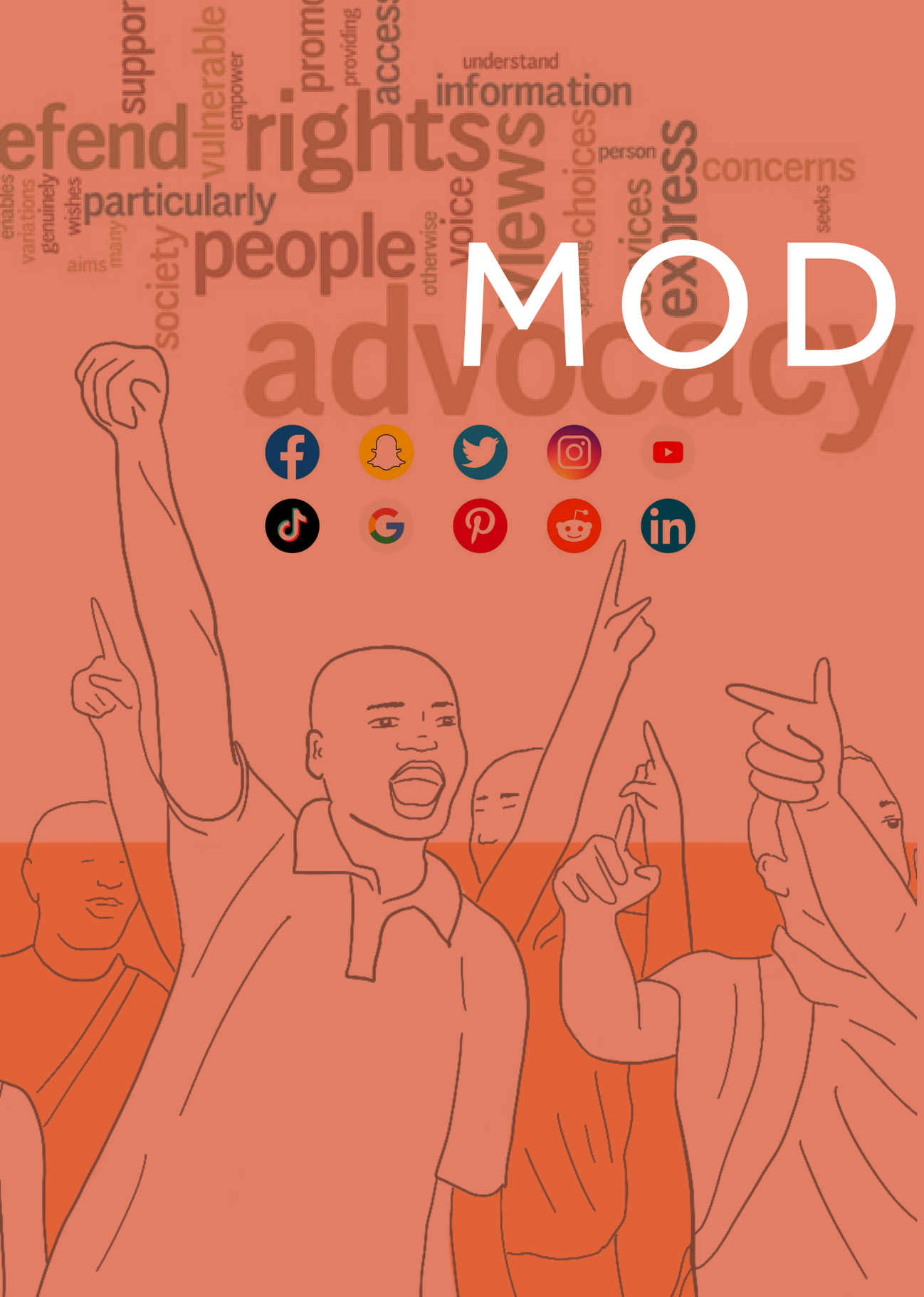
The Nigerian Government ratified the UN-Convention on the Rights of Persons with Disabilities on 24th September 2010; hence we are duty-bound to ensure that all laws, policies, and programs in the country comply with this convention and its provisions. Aside from being a signatory to the Convention, Chapter Four of the 1999 Constitution of the Federal Republic of Nigeria, puts the government in the position to protect the rights of all Nigerian citizens. Top among these rights is the "Right to Life", which can only be guaranteed when all our population is guaranteed "access to quality health services."

On paper, the Nigerian Government says it is committed to providing Comprehensive and Integrated Sexual and Reproductive Health Services for all Nigerians. In practice, however, these deliverables have continually faced considerable challenges as we remain far from attaining comprehensiveness and proper integration in the provision of Sexual and Reproductive Health especially for our Women and Girls with Disabilities (WGWDs).

These challenges and setbacks have not only stemmed from limited resources and required manpower in the health sector, but a bigger socio-economic and cultural barrier posed by the Nigerian community in the form of; societal lack of knowledge and understanding of disability issues and disability rights, underestimated data capture of disabled persons in Nigeria; increased public stigmatization and denial of human rights, i.e. freedom of association, movement, right to private and family life, freedom from discrimination & victimization, and right to a fair hearing of Persons With Disabilities (PWDs) especially for our Women and Girls with Disabilities.

Conclusively, Sexual and reproductive health rights (SRHR's) are human rights and as such, are central to the realization of human rights for all persons including women with disabilities, especially the rights to life, health, freedom from torture and ill-treatment, privacy, education, and non-discrimination, among others. The United Nations and other human rights bodies consistently have emphasized that states' obligations to guarantee.

SRHRs requires not only ensuring women have access to comprehensive reproductive health information and services but also taking affirmative measures to improve reproductive health outcomes and to ensure that women have the opportunity to make fully informed decisions about their sexuality and reproduction, free from violence, discrimination, and coercion.



MODULE 8

ADVOCACY AND PUBLIC EDUCATION

OBJECTIVES

At the end of the module, you should be able to:

- Identify the different stakeholders in the community.
- Understand how to deploy storytelling in passing messages across.
- Understand how social media can be used as a tool in increasing awareness and utilisation of SRH services

- To learn through experience.
- To talk confidently and openly about their thoughts and feelings.
- To effectively make the right decisions.

8.1 NATURAL AND SOCIAL ATTRIBUTES TO LOOK OUT FOR WHEN SELECTING POTENTIAL PEER EDUCATORS.

An ideal peer educator is a young person who:

i. Is liked by peers

ii. Has a wide social network.

iii. Is trustworthy, credible, and one whom other young persons naturally turn to for advice.

iv. Has respect for other people.

v. Is innovative in the sense that s/he could bring new ideas and practices into their peer groups.

vi. Has the ability to communicate effectively and be assertive.

vii. Has the ability to work in groups or as a team leader.

viii. Has an interest in the topic of the project or the intervention

8.1.2 QUALITIES OF A GOOD PEER EDUCATOR

These are the skills and attributes that must be developed through peer education training for a person to function as a good peer educator.

i. Must be knowledgeable about the subject matter.

ii. Must be friendly and approachable.

iii. Must be able to communicate well with peers.

iv. Must be able to speak in front of groups.

v. Must be non-judgmental of peers who come from different groups or backgrounds or who hold different views.

vi. Must be concerned about the welfare of peers.

vii. Must be able to model appropriate behavior.

8.1.3 ROLES OF PEER EDUCATORS

The role of peer educators includes the following:

i. Provide information to their peers either individually or in a small group.

ii. Conduct community awareness activities.

iii. Assist in counseling their peers on Adolescent Sexuality and Reproductive Health (ASRH) issues and HIV prevention.

iv. Organise community programs that can bring about behavioral changes.

v. Refer young people to identified linkages within the community.

vi. Act as a role model for his/her peers.

8.2 SOCIAL BEHAVIOUR CHANGE COMMUNICATION (SBCC)

Social Behaviour Change Communication (SBCC) is an integral component of a comprehensive SRHR program. Considering, STIs prevention, care, and support, BCC has several different but effective interrelated roles. To improve skills and sense of self-efficacy, this SBCC program will focus on teaching and reinforcing new skills and behaviors, such as condom use, negotiating safer sex, and safe injecting practices. It will contribute to the development of a sense of confidence in making and acting on decisions. Our strategy in increasing knowledge will ensure people are given the basic facts about SRHR in a language or visual medium or any other medium that they can understand and relate to.

One of the roles of SBCC on this project is to stimulate conversation of healthcare-seeking behaviors for SRH knowledge-seeking and utilization of available services. To prevent self-medication and underlying factors from risk behaviors, risk settings, environments and cultural practices related to sex and sexuality, and marginalized practices (such as drug use) that create these conditions.

We are also promoting essential attitude change. Our SBCC will lead to appropriate attitudinal changes, for example, perceived personal risk of STIs like HIV, belief in the right to and responsibility for safe practices and health-supporting services, compassionate and non-judgmental provision of services, greater open-mindedness concerning gender roles, and increasing the fundamental rights of those vulnerable to and affected by HIV and AIDS. Communication about HIV prevention and AIDS mitigation should address stigma and discrimination and attempt to influence social responses to them.

By creating a demand for information and services, our SBCC will spur individuals and communities to demand information on SRH and appropriate services. Our SBCC will lead to policymakers and opinion leaders toward practical approaches to SRHR by promoting services for prevention, care, and support. Our BCC will promote services for STIs, intravenous drug users (IDUs), support groups for PLHA; clinical care for opportunistic infections; and social and economic support

8.3 WHAT IS ADVOCACY?

Advocacy means taking action to create desired change. Advocates organize themselves to take steps in tackling issues they feel strongly about that cause inequality in society. Advocacy has been described as “speaking truth to power” as it helps people speak out about things that affect them negatively. Advocacy comes in the form of many activity types; from research to create solutions, to building coalitions of like-minded people, to public campaigns in raising awareness, to the use of digital and traditional media, and more to create change. Advocacy can be used to create change anywhere in the world on any issue of social inequality.

Research of the facts about the issue, the problems it causes, and possible solutions – is vital to be able to persuade people to your way of thinking. It’s said that good advocacy speaks to “hearts, minds, and hands” by making people care about the issue, understand the facts and know what they can do to help. By reminding people about an existing problem and showing them how they can address the problem, public education is one of the most critical steps in advocacy as it helps create awareness on the issues we intend to solve. For instance, by creating awareness around adolescent sexual and reproductive health access, we awaken the youth in our community, the need to take charge of their sexual and reproductive health.

Advocacy can be done by a wide range of techniques including campaigning, social media campaigns, demonstrations, launching petitions, and mobilizing others to take action. Advocates work to find ways to organize evidence, attention, and action to create positive change.

Peer Educators are trained to incorporate storytelling into their advocacy and public education because of its many benefits. Storytelling is a human art form that teaches about the human experience. As such, subjects, even like math and science, are not outside the world of human experience or the art of storytelling. They are woven into the fabric of our lives in ways of which we may not be aware.

Listening to a story instead of watching a video allows us to connect with people more. Stories have a way of helping people use their imagination more fully. This creative process encourages free thinking and the formation of innovative ideas.

A channel is a way through which a message is disseminated. It is essential to know which channels can most effectively reach particular target populations. Identifying the range of

available channels should be part of every Public Education and Advocacy campaign. Messages can be delivered through mass media—for example, television or radio spots; articles in periodicals; or material in brochures, posters, flip charts, picture codes or comics—or in-person, by health workers, peer educators, counselors, or other trained personnel.

Digital and Traditional Medias are channels which are being considered. These channels can be explored alongside other means of delivery, such as musical or dramatic performances and community events. Messages can also be reinforced with "gimmicks" such as key chains or stickers. It is essential to think about how particular channels can help achieve specific goals. Each medium has its advantages and disadvantages, so that each may be best suited to one particular circumstance. For example, research has shown that mass media can raise awareness of specific facts because the mass media are assumed to carry a specific authority and reliability.

"We are, as a species, addicted to story. Even when the body goes to sleep, the mind stays up all night, telling itself stories." -

Jonathan Gottschall,

The Storytelling Animal

ATTRIBUTES OF STORYTELLING

Interactive: Storytelling involves a two-way interaction between a storyteller and one or more listeners. The responses of the listeners influence the telling of the story. In fact, storytelling emerges from the interaction and cooperative, coordinated efforts of teller and audience. The interactive nature of storytelling breaks down any barrier between the speaker and the listeners.

Storytelling uses words: Storytelling uses language. Either in written or spoken format, storytelling uses a language that is easy to understand for the listeners. In some settings, Pidgin English will be the more appropriate language for effective communication.

Storytelling uses action: Other than words, storytelling uses gesticulations, body language, and non-verbal communication to illustrate the concepts and ideas being shared.

Storytelling presents a story: Storytelling always involves a narrative. It covers the components of a story which involves character, setting, plot, conflict, and resolution. These components keep the story running smoothly.

Storytelling engages the imagination of the listeners: Storytelling engages the imagination of the listeners. The listeners enjoy the illusion that they are witnessing the character or events described in the story.

STORYTELLING TECHNIQUES

Digital Storytelling Technique: This involves the art of storytelling that leverages technology and digital tools to engage listeners. Digital Storytelling is a short form of digital media production that allows people to share their stories using non-physical media parts.

Examples include Micro Movies (Skits), podcasts, photography, videos, blogposts etc. Digital storytelling enhances the experience for both the author and audience and allows for greater interactivity. Usually, it also has a wide audience.

2. Traditional Media Technique: Involves the use of an established or customary practice of sharing knowledge, interpreting experiences, or passing on the collective through the techniques of oral narration, written word, or illustrations. Usually, most traditional stories feature a beginning, middle, and end. Examples include physical meetings, community events, TED talks, etc.

HOW TO TELL A GOOD STORY

There are multiple ways to tell a great story. However, here are four ways of telling a great story:

1. Be real: True stories or well-told fictional stories connect with listeners or readers. It is important to be real with your stories in order to effectively connect with people and get them to take action.
2. Know what you are trying to convey: Telling a great story requires that you know the content you are sharing very well in order to improve the understanding of the listeners.
3. Engage your listeners: The best stories engage others. Whether you write, talk or make a video, create a method that engages other people. Some listeners also would like to share their own stories or experiences.
4. Review: When you have constructed your story, take some time to review your story and how to deliver it. Ask other people for their opinion of your piece.

8.4

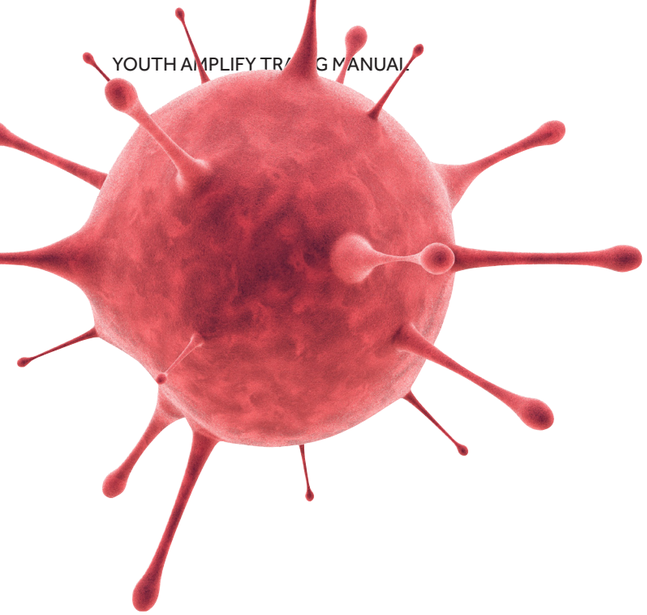
Bunmi a 300 level student of the University of Instagram has stayed out of school for a month because she had recently discovered that she may be pregnant despite her boyfriend practicing withdrawal method has been depressed and stayed out of school for 2 weeks to avoid the stigma associated with her getting pregnant. She came across an Instagram page called Youthchoose which gave her access to adequate SRH information and where the service provision centres are located. She decides to visit the centre and was given all the necessary information and provided with a contraception method to prevent such experiences in the future.

REFLECTION:

1. What can you say about the situation Bunmi found herself in?
2. What do you think Bunmi could have done differently?

MODULE 9

COVID-19 AND SRH



9.1 WHAT IS COVID-19?

The coronavirus disease (COVID-19) is caused by a new strain of coronavirus (SARS-CoV-2) that has not been previously identified in humans. First reported to the World Health Organisation (WHO) on the 31st of December, 2019 in Wuhan, China.

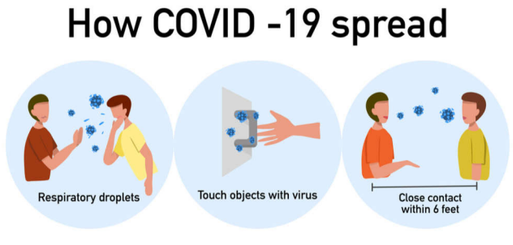
Most people infected with the COVID-19 virus will experience mild to moderate respiratory illness and recover without requiring special treatment. Older people and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness. COVID-19 can also cause severe illness and even death. - WHO

9.1.1 HOW IS IT SPREAD?

• Direct Transmission: When an uninfected person comes in contact with droplets of saliva or discharge when an infected person coughs, sneeze, speak, sing or breathe heavily, this is more likely to happen when people are in direct or close contact (less than 1 meter apart) with an infected person.

Touching infected surfaces: The virus can also spread after infected people sneeze, cough on, touch surfaces, or objects, such as tables, doorknobs, and handrails. Other people may become infected by touching these contaminated surfaces, then touching their eyes, noses, or mouths without having cleaned their hands first.

• Aerosol transmission: this can occur in specific settings, particularly in indoor, crowded, and inadequately ventilated spaces, where an infected person(s) spend long periods with others, such as restaurants, choir practices, fitness classes,



nightclubs, offices, and/or places of worship.

9.1.2 Symptoms of COVID-19
• Cough

• Fever

• Shivering /shaking (chills)

• Body pain

• Headache

• Sore throat

• The recent loss of taste or smell

• Difficulty in breathing/shortness of breath

• Diarrhoea/abdominal pain

• Runny nose/catarrh

• Fatigue (tiredness)

9.1.3 HOW TO PREVENT THE SPREAD?

• Keep at least a 1-meter distance from other people whether they have symptoms or not.

• Wear a mask, especially at gathering s and when you can't physically distance.

• Avoid crowded places and events, poorly ventilated indoor locations, and prolonged contact with others.

• Avoid touching surfaces, especially in public settings. Clean surfaces regularly with standard disinfectants.

• Frequently clean your hands with soap and water, or an alcohol-based hand rub/sanitizer.

• Always cover your coughs and sneezes with a bent elbow or tissue, and throw used tissues into a closed bin. Then wash your hands or use a hand sanitizer.

9.2 COVID-19 AND SRHR

The novel coronavirus disease (COVID-19) outbreak was first declared in China in December 2019, and WHO declared the pandemic on 11 March 2020. A fast-rising number of confirmed cases has been observed in all continents. As of January 20201, a total of over 92 million cases and 2 million deaths have been recorded globally, and over a thousand cases and 1,500 deaths in Nigeria. Countries have suffered a great crisis and chaos in responding to the virus and to prevent its transmission and deaths. Sexual and reproductive health (SRH) and rights is a significant public health issue during the epidemics. There has only been limited scientific evidence to identify the impact of the disease on SRH, including clinical presentation and outcomes of the infection during pregnancy, or for persons with STI/HIV-related immunosuppression

9.2.1 COVID-19 IMPACT ON ACCESS TO SRH SERVICES

Beyond the clinical scope of SRH, more worthy of attention is the impact of COVID-19 at the health system level and disruptions or interruptions in the regular provision of SRH services, such as pre-and postnatal checks, safe abortion, contraception, HIV/AIDS, and sexually transmitted infections.

In response to this, countries including Nigeria had to quickly mobilize resources for the diagnosis and treatment of COVID-19 patients and instituting public health measures to contain the spread of the infection. This potentially resulted in

disruption in the delivery of other health services including SRH related services.

The enforcement of a lockdown to flatten the curve and spread of the virus has resulted in the closure of schools and limited access to health services. Girls and young women have experienced barriers in accessing essential sexual and reproductive health information and services and with more devastating impact on adolescent and youth in hard to reach areas and with little or no access to digital technology as a source of SRH information and service despite the increased report of cases of gender-based violence, child marriage, teenage pregnancy, and rape.

There is an urgent need to enforce every adolescent and youth's sexual health rights and provide means to ensure unhindered access to sexual health information and services irrespective of the location.

The government should ensure continued access to sexual and reproductive health services in times of crisis which means keeping the clinics open and using digital health as an alternative to face-to-face visits/ appointments.

Sexual and Reproductive Health messages should be made available through alternative means such as radio, television programs, daily mail messages, newspapers, social media, billboards, fliers and included in COVID-19 messages.

There is a need for collaborations between the government and the private sector to work together in ensuring continuity in the supply of contraceptives and essential medicine for persons living with HIV.

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PRE-TEST/POST-TEST

S/N	QUESTIONS	TRUE	FALSE
1	SRHR champions must be very well informed about SRHR issues so that they can share accurate information with other young people		
2	Every man and woman was once an adolescent.		
3	Gender inequality is a harmful gender norm.		
4	Harmful gender norms can undermine healthy relationships and can affect young people's reproductive and sexual health.		
5	Contraception is when a couple plan the number of children they want and when they want to have them.		
6	Family planning is the use of a method or more than one method to prevent a woman from becoming pregnant.		
7	SRH Champion should help young people with referrals to health and other support services.		
8	SRH Champion addresses young people's SRHR challenges and advocate for improved SRHR of young people in their communities.		
9	SRHR champions do not necessarily have to be well informed about SRHR issues to share accurate information with other young people.		
10	A lack of formal education reduces the access of young people to sexual health and rights information.		
11	Only males must be educated about their sexual and reproductive health and rights		
12	Service providers should be trained on how to deliver SRH services professionally without cultural or religious bias.		
13	Laws regarding SRHR should be reviewed and updated to reflect the right terms and definitions of sexual offenses		
14	Sex and Gender mean the same.		
15	Youth-friendly services should be accessible to ALL adolescents and young people.		
16	Birth control causes weight gain.		

PRE-TEST/POST-TEST

S/N	QUESTIONS	TRUE	FALSE
17	Condom is the only reliable contraceptive method.		
18	Family planning is meant for women who have had at least 2 children.		
19	You CANNOT get pregnant with withdrawal method.		
20	Friends can engage in unprotected sex.		
21	Sexually transmitted infections (STI) can cause infertility.		
22	You CANNOT get pregnant if you have unprotected sex with a single partner.		
23	HIV can ONLY be transmitted through sexual intercourse.		
24	AIDS can be cured.		
25	Women's and girls' SRH rights MUST be respected, protected, and honored.		
26	Having multiple sexual partners increases a person's risk of having an STI.		
27	Appropriate sexual and reproductive health information and health services can help youth to make healthy choices		
28	Norms about young people and sex can affect interactions between youth and health care providers.		
29	Positive beliefs about contraception can increase the likelihood of use.		
30	Young women are generally more vulnerable than adults to unsafe abortion and abortion-related complications		
31	Young people should have the opportunity to be involved in all decision making that affects their lives.		
32	Sexual rights of young people can be advocated for through media		
33	Young person's parents should speak on their behalf about issues concerning their health.		

NOTE

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