Community Health Nursing II

NSG321

University of Ibadan Distance Learning Centre
Open and Distance Learning Course Series Development

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Vice-Chancellor's Message

The Distance Learning Centre is building on a solid tradition of over two decades of service in the provision of External Studies Programme and now Distance Learning Education in Nigeria and beyond. The Distance Learning mode to which we are committed is providing access to many deserving Nigerians in having access to higher education especially those who by the nature of their engagement do not have the luxury of full time education. Recently, it is contributing in no small measure to providing places for teeming Nigerian youths who for one reason or the other could not get admission into the conventional universities.

These course materials have been written by writers specially trained in ODL course delivery. The writers have made great efforts to provide up to date information, knowledge and skills in the different disciplines and ensure that the materials are user-friendly.

In addition to provision of course materials in print and e-format, a lot of Information Technology input has also gone into the deployment of course materials. Most of them can be downloaded from the DLC website and are available in audio format which you can also download into your mobile phones, IPod, MP3 among other devices to allow you listen to the audio study sessions. Some of the study session materials have been scripted and are being broadcast on the university's Diamond Radio FM 101.1, while others have been delivered and captured in audio-visual format in a classroom environment for use by our students. Detailed information on availability and access is available on the website. We will continue in our efforts to provide and review course materials for our courses.

However, for you to take advantage of these formats, you will need to improve on your I.T. skills and develop requisite distance learning Culture. It is well known that, for efficient and effective provision of Distance learning education, availability of appropriate and relevant course materials is a *sine qua non*. So also, is the availability of multiple plat form for the convenience of our students. It is in fulfilment of this, that series of course materials are being written to enable our students study at their own pace and convenience.

It is our hope that you will put these course materials to the best use.

Prof. Abel Idowu Olayinka

Vice-Chancellor

Foreword

As part of its vision of providing education for "Liberty and Development" for Nigerians and the International Community, the University of Ibadan, Distance Learning Centre has recently embarked on a vigorous repositioning agenda which aimed at embracing a holistic and all encompassing approach to the delivery of its Open Distance Learning (ODL) programmes. Thus we are committed to global best practices in distance learning provision. Apart from providing an efficient administrative and academic support for our students, we are committed to providing educational resource materials for the use of our students. We are convinced that, without an up-to-date, learner-friendly and distance learning compliant course materials, there cannot be any basis to lay claim to being a provider of distance learning education. Indeed, availability of appropriate course materials in multiple formats is the hub of any distance learning provision worldwide.

In view of the above, we are vigorously pursuing as a matter of priority, the provision of credible, learner-friendly and interactive course materials for all our courses. We commissioned the authoring of, and review of course materials to teams of experts and their outputs were subjected to rigorous peer review to ensure standard. The approach not only emphasizes cognitive knowledge, but also skills and humane values which are at the core of education, even in an ICT age.

The development of the materials which is on-going also had input from experienced editors and illustrators who have ensured that they are accurate, current and learner-friendly. They are specially written with distance learners in mind. This is very important because, distance learning involves non-residential students who can often feel isolated from the community of learners.

It is important to note that, for a distance learner to excel there is the need to source and read relevant materials apart from this course material. Therefore, adequate supplementary reading materials as well as other information sources are suggested in the course materials.

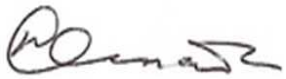
Apart from the responsibility for you to read this course material with others, you are also advised to seek assistance from your course facilitators especially academic advisors during your study even before the interactive session which is by design for revision. Your academic advisors will assist you using convenient technology including Google Hang Out, You Tube, Talk Fusion, etc. but you have to take advantage of these. It is also going to be of immense advantage if you complete assignments as at when due so as to have necessary feedbacks as a guide.

The implication of the above is that, a distance learner has a responsibility to develop requisite distance learning culture which includes diligent and disciplined self-study, seeking available administrative and academic support and acquisition of basic information technology skills. This is why you are encouraged to develop your computer skills by availing yourself the opportunity of training that the Centre's provide and put these into use.

In conclusion, it is envisaged that the course materials would also be useful for the regular students of tertiary institutions in Nigeria who are faced with a dearth of high quality textbooks. We are therefore, delighted to present these titles to both our distance learning students and the university's regular students. We are confident that the materials will be an invaluable resource to all.

We would like to thank all our authors, reviewers and production staff for the high quality of work.

Best wishes.



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Contents

About this course manual

Community Health Nursing II NSG321 has been produced by University of Ibadan Distance Learning Centre. All course manuals produced by University of Ibadan Distance Learning Centrer are structured in the same way, as outlined below.

How this course manual is structured

The course overview

The course overview gives you a general introduction to the course. Information contained in the course overview will help you determine:

- If the course is suitable for you.
- What you will already need to know.
- What you can expect from the course.
- How much time you will need to invest to complete the course.

The overview also provides guidance on:

- Study skills.
- Where to get help.
- Course assignments and assessments.
- Margin icons.

We strongly recommend that you read the overview *carefully* before starting your study.

The course content

The course is broken down into Study Sessions. Each Study Session comprises:

- An introduction to the Study Session content.
- Study Session outcomes.
- Core content of the Study Session with a variety of learning activities.
- A Study Session summary.

- Assignments and/or assessments, as applicable.
- Bibliography

Your comments

After completing Community Health Nursing II we would appreciate it if you would take a few moments to give us your feedback on any aspect of this course. Your feedback might include comments on:

- Course content and structure.
- Course reading materials and resources.
- Course assignments.
- Course assessments.
- Course duration.
- Course support (assigned tutors, technical help, etc.)

Your constructive feedback will help us to improve and enhance this course.

Course Overview

Welcome to Community Health Nursing II NSG 321

This course is designed to help students to develop research interest and skills in students with a view to preparing them for their professional responsibility. The course is aimed at guiding and assisting students to integrate the concepts of community health nursing into their primary professional roles.

The course seeks to equip nursing students with knowledge and skills of assessing and working with families and the communities wherein they live. Family theories that explain possible life cycles of the family with their attendant challenges are explored during the course. Attempt is also made at identifying vulnerable population within the family and communities with a view of identifying their needs and possible challenges. Community health nurses in collaboration with these groups of are empowered to skilfully proffer solutions to the identified challenges. Finally, some current issues affecting community health are explored.

Getting around this course manual

Margin icons

While working through this course manual you will notice the frequent use of margin icons. These icons serve to "signpost" a particular piece of text, a new task or change in activity; they have been included to help you to find your way around this course manual.

A complete icon set is shown below. We suggest that you familiarize yourself with the icons and their meaning before starting your study.

 Activity	 Assessment	 Assignment	 Case study
 Discussion	 Group Activity	 Help	 Outcomes
 Note	 Reflection	 Reading	 Study skills
 Summary	 Terminology	 Time	 Tip

Study Session 1

Family Health Nursing

Introduction

In this study session, we will discuss the concept of family both from traditional and WHO view points. We will also list and explain types of families. We will discuss functions of families as well as implications of community health nursing. Lastly, we will highlight family assessment tools and discuss a number of theories in nursing and social sciences that give insight into family dynamics and family processes.

Learning Outcomes

Outcomes

When you have studied this session, you should be able to:

1.1 define family from traditional view and as according to WHO
1.2 list and explain types and functions of the family and their implications to community health nursing
1.3 discuss implications of community health nursing
1.4 explain foundations for family health assessment in its various forms
1.5 discuss the concepts of basic tools used in family health assessment
1.6 explain the concept of family theories

Terminology

Family	A group consisting of parents and children living together in a household
World health organization (WHO)	A specialized agency of the United Nations that is concerned with international public health

1.1 Definitions of a Family

Traditional Definition: A "legal, lifelong, sexually exclusive marriage between one man and one woman with children, where the male is the primary provider and the ultimate authority".

Criticising traditional definition of the family:

1. Legal
2. Lifelong
3. Sexually exclusive between one man and one woman
4. Male being the primary provider and ultimate authority
5. Children involvement

Current trends- WHO's acceptable definition: A family is a self-identified group of two or more individuals whose association is characterized by special terms, who may or may not be related by bloodiness or law, but who function in a way that they consider themselves to be a family.

OR

A family refers to two or more individuals who depend on one another/ who choose to be involved in each others' lives and are therefore bound together by emotional ties and a sense of belonging (for emotional, physical and/or financial support).

1.2 Types of Families

Let's remind ourselves of the various definitions, roles, functions and values of families!

- Traditional/ nuclear family: a social unit composed of a father and a mother joined together in matrimony and their biological children/offspring (natural, adopted or both)
- Extended family: the above + extensions via biological ties or kinship (e.g. uncles, aunts, grandparents etc)
  - Family of origin (or orientation): the family into which an individual is born
  - Family of pro-creation: the family created for the purpose of raising children
  - Blended (bi-nuclear) family: the combination of two divorced families through remarriage.
- We now have single- parent families, step-parents families, same-gender families, families of need (voluntary family) and families consisting of friends.

Advancement in reproductive technology has given rise to:

- Surrogate motherhood (when a woman, for someone other than herself, carries a child conceived from an egg which was not her own) e.g. in gayism / lesbianism.

In the next 25 years (Staples, 1989):

- Sexual relations will precede marriage
- People will have a trial period of cohabitation before entering into marriage, and marriages will be delayed to late twenties/ thirties
- The divorce rate will continue to increase
- Remarriage will occur more slowly
- Couples will limit their families to 1 or 2 children
- Dual wage- earner family will be the norm in all households

1.2.1 Family Functions

Throughout history, a number of functions have been performed by the family. This refers to how families go about meeting the purposes of the broader society.

Family functions are basically divided into 2:

- **Instrumental functions**: those that pertain to activities of daily living.
- **Expressive functions:** those that have to do with the affective dimension of the family.

The functions include:

1. **Socialization and Social Placement**: the parents are the major agents of socialization which involves inculcating the norms and values for the many family roles that are required of the family members. The family is responsible for transforming the infant into a social being who can assume adult social roles. Although this role is shared with many institutions outside the family e.g. the school, churches, mosques, health and human service agencies.

2. **Reproductive Function**: the continuity of both the family and the society continues to be ensured through this function. Though thwarted, by the various emerging trends discussed about earlier, this function is being achieved through adoption, artificial insemination, or other technological means that may or may not include a second parent.

3. **Economic Function**: achievement of economic survival is now done through many means as against what operated in the past (children were expected to contribute towards this, fathers were expected to bring in money while the mother stays at home to take care of the children etc)

1.2.2 Family Structure

This refers to the characteristics and demographics (e.g. age, sex, number) of individual members who make up family units. More specifically, it defines the roles, responsibilities and the positions of family members. There is no "typical" model of family structure. The family structure changes and modifies over time. The same individual may participate in a number of family life experiences over time.

ITQ

Question

What is the difference between family functions and family roles?

Feedback

Family roles are responsibilities performed by individual members of the family with a view of achieving family goals WHILE Family functions are responsibilities performed by the family as a unit with a view of achieving the goal of the community wherein such a family lives.

1.3 Implication for Community Health Nursing

A family is who they say they are i.e. do not try to re-constitute or re-define for them (keep your socio-cultural opinion to yourself). Community health nurses working with families should communicate and include all family members in health care planning.

Views the family from 3 perspectives:

As a Context: In this context, the emphasis of care is the individual bearing in mind that he or she is a part of a larger system, the family. Mostly used in other specialty areas of nursing e.g. how has the clients' diagnosis of insulin-dependent diabetes affected the family?

As a Client: This is when the family is seen as a whole, rather than the individuals. The family is viewed as a set of interacting parts and emphasizes assessment of the dynamics among these parts rather than the individual parts. it looks at the family as a interactional system e.g. how is the family reacting to the mother's recent diagnosis of liver cancer?

As a Component of Society: the family is seen as one of the many institutions of the society along with health, education, religious and financial institutions to receive, exchange or give services.

1.4 Family Assessment

The identification of one or more family to utilize is not an end in itself but a means to an end. It is to help the CHN assess the family for strengths, weaknesses, potential and actual threats. The following are to be assessed:

1.4.1 The Family Environment

It's the physical, psychological and social dimensions of the environment within which the family lives. This is expedient because all these have their contributory impacts on the family.

1.4.2 Physical Environment

This includes the dwelling and the conditions both inside and outside. Size, number of rooms, orderliness, condition of the yard, furnishings, plumbing, heat, health and safety hazards e.g. presence or absence of smoke detectors and fire extinguishers, emergency exits etc; ability to purchase basic services e.g. refuse collection, security, electricity etc. Other physical aspects of the environment to be assessed include neighborhood, air and water quality. Information about the neighborhood can be obtained through windshield survey and by asking questions from the family members: how easily accessible are schools, churches, mosques, hospitals, stores, public transportation; types of homes occupying the environment, crime rate, air, water and noise pollution, quality of sanitation etc.

Each of these areas should be addressed based on the identified need of the family. In addition, the family members should be asked about their knowledge and perceptions to some of these issues because this to a large extent influences both the way the family functions within that environment and the degree to which the family will respond to nursing interventions.

1.4.3 Psychological Environment

The significant aspects of this include developmental stages, family dynamics and emotional strengths. Also to be assessed is the communication patterns- verbal and non- verbal, both within and outside the family, family roles and coping strategies in use.

1.4.4 Social Environment

This includes religion, race, culture, social class, economic status and external resources such as school and health resources (how does the family manage health and illnesses).

1.4.5 Family Strengths

This includes ability to provide for physical, emotional, and spiritual needs of the family, sensitivity to the needs of other family members, effective communication pattern, ability to provide support, security and encouragement, ability to initiate and maintain growth- producing relationships within and outside of the family, capacity to create and maintain constructive and responsible community relationships in the neighborhood, ability to grow with and through children, ability for self- help and the ability to accept help when appropriate, ability to perform family roles flexibly, respect for the individuality of each family member, ability to use a crisis or seemingly injurious experiences as a means of growth and a concern for family unity and loyalty

Though attainable, it is unlikely that any family will have all these qualities. However, the degree to which they manifest these behaviors gives the nurses clues to how well the family is managing its life. The stronger the family is, the lesser the intervention and vice- versa.

1.5 Family Assessment Tools

1.5.1 Genogram

This is a tangible and graphical picture outlining family's patterns over a period of like three generations. It records family information e.g. significant life events, cultural and religious identification, occupations, place of residence.

1.5.2 Family Health Tree

The genogram + genetic and familial diseases, obesity, anorexia nervosa, mental illness, infectious diseases, family risk factors (cancers, DM, hypertension) and strengths (longevity, specific diseases' resistance, regular general health check etc)

1.5.3 Ecomap

This is a visual depiction of the family members contact with the larger systems through a graphic description of its relationship and interactions with its immediate external environment. It helps to explore the available connections and resources identifying the ones to be made and explored as well.

Tip

Other tools include observation of the family and their environment and the family interview.

The whole family should be engaged in completing the assessment tools so that family member's involvement in their own health care is ensured right from the beginning. It should also be noted that "visual gestalt", conveyed through the use of these tools provides information more simply and usefully than writing in words. They act as constant reminders for nurses to "think the family".

Family Diagnosis

There are two major systems of nursing diagnosis based on actual and potential threats identified during family assessment.

1. The Omaha System of problem identification. It has four levels: the domain, the problem, the modifiers and the signs and symptoms.
2. The North American Nursing Diagnosis Association (NANDA) community diagnostic labels.

1.6 The Family Theories

A number of theories in nursing and social sciences give insight into family dynamics and family processes.

1.6.1 Nursing Theories

Neuman's System Model; King's Open Systems Model; Roy's Adaptation Model and Roger's Life Process Model

Neuman's System Model

Has family system approach as its foundation. Opines that
(a) The way that family members express themselves influences the whole and creates the basic structure of the family.
(b) All transactions take place within this structure and are directed toward keeping the structure stable as it moves between stability (wellness) and instability (illness).
The major goal of the nurse using this theory is to help stabilize the family system within its environment.

Roy's Adaptation Model

Roy believes that the family can be a unit of analysis and the adaptive system that is assessed. Enhancement or modification of the focal stimuli (factors precipitating an adapting response), contextual stimuli (all other factors that contribute to the behavior), and residual stimuli (factors that may affect behavior for which effects are not validated) promotes adaptation of the family system.
The nurse using this theory assesses the family coping skills and the environmental context within which the family faces the stressor and uses this data to facilitate a positive adaptation to the changes engendered by the crisis.

Roger's Life Process Model

Rogers describes the family as an "irreducible family energy field". She believes that individuals within the family generates "energy" and the energy generated by family dynamics influences all

members i.e. family members can learn from one another in ways that are unique and beneficial to the family members.

King's Open System Model

Imogene King views the family as both a context and as a client. She believes that nurses are partners in health care with families and respects clients/ family's decisions. The theory opines that family nursing consists of helping individuals to reach goals through improved interaction and communication.

She opines that mutual goal setting requires decision making between the nurse and the family- as individuals or as a whole. She assumes that the client has the right to self- determination. It frees the nurse to provide education, instructional support, resourcing, and referrals that are truly going to make a big difference to the clients'/family's lives.

Note

It is one that encourages active clients' participation by empowering them to make informed decisions regarding their individual lives and the health of the entire family.

The nurse simply develops a healthy relationship with the family, identifies actual/ potential problems, and provides adequate information and mutually set realistic goals for short- term or long- term resolution of the identified problems.

1.6.2 Social Science Theories

Examples of these are Developmental theory, General Systems Theory, Structural- Functional Conceptual Framework.

These theories are important to understand because they give direction to nursing care of families.

Developmental Theory

It is also known as the Life Cycle Approach. It purports that families evolve through typical developmental stages and experience growth and development much in the same way as individuals. Each stage is characterized by specific issues and tasks. The ways in which the tasks are resolved help determine the family's capability for handling the challenges of the next stage. Developmental tasks are works that must be completed at each stage of development before movement to the next stage is possible.

This approach is useful in that it helps the nurse in planning the health care that is family oriented and appropriate to the family's stage of development. The degree to which developmental tasks are successfully resolved by the family affects the functional and dysfunctional aspects of family life.

Tip

Anxiety is generated when developmental tasks are resolved poorly and this anxiety may be carried from one generation to another. Unpredictable life events such as childlessness, untimely death, divorce, severe illness, war and the like, all create stress for the family.

Adoption is another aspect of family development having certain phases, tasks and emotional issues that must be addressed. Birth parents, adoptive parents, and adoptees each have their own developmental tasks. However, this model has limited value because it purports a two-parent nuclear family and begins with marriage. It maintains that the nuclear family is the norm and that most young adults marry in their early twenties before developing a career of their own and child- rearing activities.

Note

- Birth parents: must make a decision to give up the child; prepare for the adoption; relinquish the child for adoption; resume their lives afterwards and mourn the loss of the child; may later decide to search for the child or make themselves available to be found by the child; or finally accept the loss with peace.

- Adoptive parents: first make a decision to adopt and go through the process of adoption; receive the child and accept the new member into the family; deal with adoptive issues throughout life – link up with biological parents or not.

- Adoptee: separation from biological parents; bond with adoptive parents; decides whether to seek out their biological parents or not; disclosure of adoptive status to family of procreation or not etc

The major strength of this approach is that it provides a basis for forecasting what a family will be experiencing at any period in the family life cycle.

Structural- Functional Conceptual Framework

Family structure refers to family organization, arrangement of family units and the relationship of family units to one another. There are 3 main dimensions of family structure: internal family structure (family composition, gender, rank, and order); external family structure (extended family and larger systems); and contextual family structure (ethnicity, race, social class, religion and environment).

This theory looks at the arrangement of members within the families, relationships between the members, and the roles and relationships of the individual members to the whole family. Emphasis is placed on how the societal structure supports the basic functions of the families, or vice versa.

This approach describes the family as open to outside influences, yet at the same time the family maintains its boundaries.

Nurses refer to this model when they talk about the structure, forms or type of family, such as single- parent families, step families, nuclear families, or extended families. It is a useful framework for assessing families and health.

Illness of a family member results in alteration of the family structure and function e.g. if a single mother is ill, she ma y not be able to carry out her various roles, so grandparents or siblings may have to assume childcare responsibilities. Family assessment will include determining if changes resulting from health issues influence the family's ability to carry out its functions. Family power structures and communication patterns are affected by the illness of a parent.

General System Theory

Systems depend on both positive and negative feedback to maintain a state of homeostasis/ steady state. The theory is also called cybernetics. The theory is useful in family assessment because it emphasizes the interdependence of the family parts and asserts that whatever affects the family as a whole affects each of its parts.
The theory also explains the way a member relates with other members of the family and with the **society**

ITQ

Question

Define developmental theory

Feedback

Developmental theory states that families evolve through typical developmental stages and experience growth and development much in the same way as individuals.

Study Session Summary

Summary

In this Study Session, we were able to discuss the concept of family as viewed within the contemporary definitions. Tools for assessing the family physical, social and psychological environments and making subsequent family diagnoses were reviewed. Various theories adaptable and useful for providing adequate care to families by community health nurses were also explored.

Assessment

Assignment

1. According to WHO, define the term family.
2. What would you describe as an "ideal" family structure?
3. Identify the various domains to be assessed by the community health nurses during family visits.
4. Identify the major difference between the genogram and family health tree
5. Which family assessment tool would be appropriate in explaining the General system theory?

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Study Session 2

Family with Special Needs

Introduction

In this study session, we will explain the idea of child abuse and child neglect. We will also describe the risk factors for community health nurse as well as the types of child abuse. Finally, we will discuss the various types of implications of child abuse/child neglect to community health nurses.

Learning Outcomes

Outcomes

When you have studied this session, you should be able to:

2.1 differentiate between child abuse and child neglect with definitions
2.2 list and explain risk factors associated with child abuse and neglect
2.3 list and explain types of child abuse
2.4 discuss the implications of child abuse/ neglect to the community health nurse

Terminology

Child abuse	Is when a parent or caregiver, whether through action or failing to act, causes injury, death, emotional harm or risk of serious harm to a child
Child neglect	A type of maltreatment related to the failure to provide needed, age-appropriate care

2.1 The Concept of Child Abuse

Child abuse is defined as a physical or mental injury, sexual abuse or exploitation, negligent treatment, or maltreatment of a child by somebody who is responsible for the child's health and welfare.

Note

Types of abuses in the family

Domestic violence (a spectrum of violence within the family)

Spousal/ partner abuse (physical, emotional, or sexual abuse perpetrated by either husband or wife against the marriage partner; also called "marital rape").

Wife abuse(physical, emotional, or sexual abuse perpetrated by husband against his wife)

Women battering (women in relationships in which battering is on-going)

Elder abuse (physical abuse, neglect, intimidation, cruel punishment, financial abuse, abandonment, isolation, or other treatment of an elder, resulting in physical harm or mental suffering).

There are basically 4 types: physical abuse, emotional abuse, sexual abuse, and neglect. Each year, approximately 160,000 children are severely abused, 3 million are abused and/or neglected, and 1,000-2,000 die as a result of the assault by their caretaker. Under- fives are the mostly abused followed by under – one. Children are often referred to as innocent. They are vulnerable by the virtue of their age, size, sex, basic dependence on adults and lack of power.

Definitions of what constitutes child abuse differ by culture, socio-economic groups and neighbourhoods. This is largely because children are regarded to as their parent's properties and so the community has been so reluctant to interfere in matters concerning child rearing.

2.1.1 Nursing Assessment

The Community health nurse who works with the family or individuals is in a position to recognize abuses and to advocate for the child. Advocacy is difficult, if the nurse cannot maintain the objectivity necessary for obtaining a history. This is because history taking is an important aspect of advocacy.

Also, differentiating between child abuse and child discipline may pose a challenge too. Any suspicious finding warrants a thorough history and a complete physical assessment to provide for child's safety.

2..2 Child Neglect

This is when the family fails to provide for child's basic needs of food, clothing, shelter, supervision, education, emotional affection and stimulation, and health care. It is the most frequently reported form of child maltreatment. A thorough history taking and assessment is critical as well.

Depending on the particular manifestation of neglect, the community health nurse should assess what type of education and support the family might need to improve the care of the child. If the family does not have enough resources to provide for basic needs, the nurse can offer referral to social service agencies that can assist.

It is also necessary to explore the parents' childhood upbringing because if they too were neglected then, it may just be natural to parent in the way they know. An important nursing intervention is to teach specific skills for increased positive parent- child interactions, improving problem- solving abilities, enhancing personal hygiene and nutritional skills.

Family therapy may be another useful adjunct if the family is amenable.

Neglect may be a precursor to other types of abuse, might exist in tandem with other types of abuses or as a singular form of abuse. Though neglect is less externally traumatic than other forms of child abuse, the long- term sequelae and potential for adult dysfunction are serious.

Points to be considered by the nurse

- Is clothing too large, too small, or inappropriate for child's developmental stage?
- Is the child dressing himself, herself without any adult's supervision?
- Do the parents have unrealistic expectations of the child's ability to cope with environmental realities e.g. cold weather?
- Is either parent abusing substances and thus depleting the family income?

2.3 Risk Factors for Child Abuse

- Unplanned/ unwanted pregnancy
- Teenage pregnancy
- Single parenthood
- Closely spaced children
- Substance abuse
- Social isolation
- Poor support system
- Limited knowledge of child development
- Previous report to child protective services
- Previous history of child abuse
- Partner violence
- Children with disability/ developmental challenges

2.4 Types of Child Abuse

2.4.1 Physical Abuse

Obvious signs are seen like bruises (normal childhood bruising is common over bony prominences whereas bruising of soft tissues- lower back, buttocks, abdomen, under the armpit or shoulders where the child/ baby was grabbed, multiple sites at different stages of healing- is suggestive of abuse); burns- cigarette burns, hot iron, curling comb, immersion of arms and legs in hot water; fractures, abdominal injuries- though may not have external signs

2.4.2 Sexual Abuse

This may or may not involve force or coercion depending on the age of the child.

2.4.3 Emotional Abuse

These are verbal or behavioural actions diminishing the self worth or self esteem of the child. It includes name calling, put- downs, isolating, stigmatizing, humiliating or ignoring the child. Community health nurses should help to explore which is applicable and assist parents to make a conscious effort to resolve this.

2.5 Implications for the Community Health Nurse

2.5.1 Primary Prevention

This includes:

- Community mitigation laws/ policies against violence
- Public health education
- Strong community sanctions
- Decreased vulnerability to violence/ abuse through decent dressing, security consciousness within and outside the home
- Health education- child health education, adolescent education, self defence skills etc.
- Family cohesion
- Assessment of risk factors already explored.

2.5.2 Secondary Prevention

It entails early identification/ prompt management. This includes:

- Family recreation periods to ventilate abusive risk factors
- Effective communication with abusive families
- Early identification of signs and symptoms of abuse
- Identification of stressors

- Removal of client away from stressor or eliminating the stressor etc

Tertiary Prevention

It is a rehabilitation and prevention of recurrence. It includes:

- Referral to appropriate community agencies
- Role modelling
- Support groups
- Public policies etc.

ITQ

Question

Differentiate between physical abuse and emotional abuse

Feedback

Emotional Abuse includes verbal or behavioural actions diminishing the self worth or self esteem of the child. It also includes name calling, put-downs, isolating, stigmatizing, humiliating or ignoring the child **WHILE** Physical Abuse includes obvious signs like bruises, burns-cigarette burns, hot iron, curling comb, immersion of arms and legs in hot water; fractures, abdominal injuries- though may not have external signs.

Study Session Summary

Summary

In this Study Session, we explained the idea of child abuse and child neglect identifying their similarities and striking the differences. We also discussed the risk factors for community health nurses as well as the types of child abuse alongside various types of implications of child abuse/child neglect to community health nurses. Lastly, community health nurses were identified as being able to provide primary, secondary and tertiary intervention to better the potential impacts of child abuse/ neglect.

Assessment

Assignment

1. Differentiate between Child abuse and child neglect.
2. Identify any risk factors associated with child abuse and neglect
3. Highlight and explain the types of abuse in children
4. Describe the various ways the community health nurse can help identify early and prevent child abuse/ neglect in our society?

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Study Session 3

Women Empowerment

Introduction

This study session discusses the concept of women empowerment. Levels as well as benefits of women empowerment will be explored too. Finally, barriers of women empowerment will be examined.

Learning Outcomes

Outcomes

When you have studied this session, you should be able to:

3.1 define term women empowerment
3.2 explain levels of empowerment
3.3 discuss benefits of women empowerment
3.4 explains barriers to women empowerment

Terminology

Empowerment	A management practice of sharing information, rewards, and power with employees so that they can take initiative and make decisions to solve problems and improve service and performance. To give power or authority to; authorize, especially by legal or official means
Women empowerment	The creation of an environment for women where they can make decisions of their own for their personal benefits as well as for the society

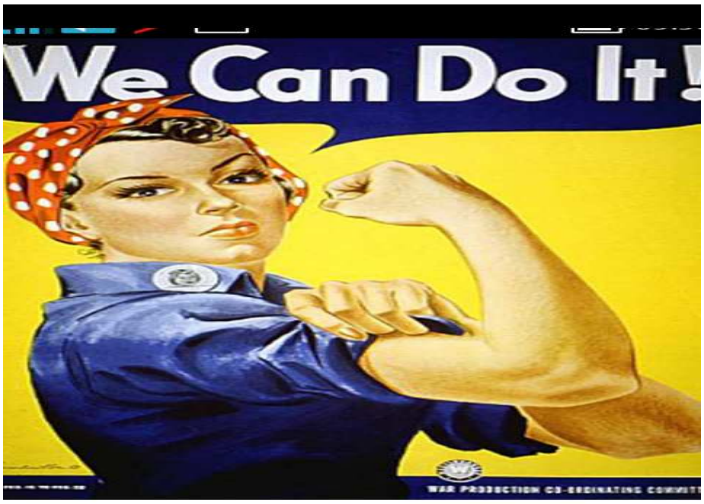
3.1 Women Empowerment

Empowerment is a word used to refer to the act of strengthening the political, social, economics, emotional and educational aspect of an individual to help them in combating the problem around him or her. **Women empowerment** deals with strengthening the right of women in nation. This is not about lack of power; there is power but the ability to exercise the power is lacking.

Despite many international agreements affirming human rights, women are still much more likely to be poorer and more illiterate

than the men. They usually have less access than men to medical care property ownership, credit training and employment.

The ability of women to control their own fertility is absolutely fundamental to women empowerment and equality, when a woman can plan her family, she can plan the rest of her life. When she is healthy, she can be more productive and when her reproductive rights, including right to decide the number, timing, spacing of her children; and ability to make decision regarding reproduction free of discrimination, coercion and violence are promoted and protected, she has freedom to participate more fully and equally in the society.



3.1.1 Understanding Gender Equality

Gender equality implies a society in which women and men enjoy the same opportunity, outcomes, right and obligations in all sphere of life. Equality between men and women exist when both sexes are able to share equally in the distribution of power and influence, have equal opportunities for financial independence through work or through setting up business, enjoy equal access to education and opportunity to develop personal ambition. A critical aspect of promoting gender equality is the empowerment of women, with a focus on identifying and redressing power imbalances and giving women more autonomy to manage their own lives.

3.1.2 Platform for Women Empowerment

To achieve equality, the platform for action emphasizes the need for women to work together and in partnership with men towards the common goal of gender equity worldwide. Although the Beijing Declaration and Platform for action is a standalone document, it builds upon consensus and progress made at earlier United Nations conferences/summits particularly the conference on

women in Nairobi in 1985 which developed the Nairobi forward in looking for strategies for the advancement of women.

The Beijing platform focuses on 12 critical areas of concern that must be addressed to achieve gender equality and women's empowerment.

- Women and poverty
- Education and training of women
- Women and health
- Violence against women
- Women and armed conflict
- Women and the economy
- Women in power and decision making
- Institutional mechanisms for the advancement of women
- Human right of women
- Women and the media

3.1.3 Dimensions of Empowerment

Reproductive Health

Women are more vulnerable than men to reproductive health problem. These problems include maternal mortality and morbidity. Failure to provide information and services to help women protect their reproductive health contributes a gender-based discrimination and a violation of women's right.

Economic Aspect

More women live in poverty than men. This is due to the fact that women are not allowed to go out and fend for themselves; or they are not paid properly for the services they render. Women should be paid in their work place and not being discriminated in the economic sphere

Educational Aspect

About 2/3rd of the illiterate adults in the world are women. Higher women education is associated with both, however infant mortality and lower fertility as well as higher opportunity for the education of their children.

Political Aspect

Social and legal institutions still do not guarantee women equality in human rights; that is right to vote and be voted for. Women are rarely found in high places of authority where decisions are made regarding the constitution of the country. Therefore, they are exposed to so many violent attacks and oppression. There should be laws against domestic violence of women; they should be allowed to take actions when cases are brought up.

Stewardship of National Resources

There should be provision of security, water, food father that oversee the family's health and diet because women tend to put up immediate practice whenever they learn about nutrition and preserving the environment and material resources.

3.1.4 Principles of Women Empowerment

According to the United Nations, the principles of women empowerment are as follows:

Establish High Level of Corporate Leadership for Gender Equality (Principle I)

- Leadership Promotes Gender Equality.
- Affirm high level support and direct top level policy for gender equality and human right
- Establish company-wide goals and targets for gender equality and include progress as a factor in managers' performance reviews.
- Engage internal and external shareholders in the development of company policies programs and implementation plans that advances equality.

Treat all Women and Men Fairly at Work - Respect and Support Human Rights and Non-Discrimination (Principle II)

- Inclusion And Non-discrimination
- Pay equal remuneration, including benefit, for work of equal values and strive to pay a living wages to all women and men
- Ensure that work place policies and practice are free from gender based discrimination.
- Offer flexible work options, leave and re-entry opportunities to positions of equal pays and status.

Ensure the Health, Safety and Well- Being of all Women and Men Workers (Principle III)

- Health, safety and freedom from violence.
- Taking into account differential impacts on women and men, provides safe working conditions and protection from exposure to hazardous materials and discloses potentials risks.
- Strive to offer health insurance or other needed services including for survivors of domestic violence and ensure equal access for all employees.
- Train security staff and managers to recognize signs of violence against trafficking, labour and sex exploitation.

Promote Education, Training and Professional Development for Women (Principle IV)

- Education and training
- Ensure equal access to all company supported education and training programme, including literacy, vocational classes and information technology.
- Provide equal opportunities for formal and informed networking.
- Offer opportunities to promote the business case for women empowerment and positive impact of inclusion for men as well as women.

Implement Enterprises Development; Supply Chain and Marketing Practice that Empower Women (Principle V)

- Enterprises Development Supply Chain And Marketing Practices.
- Expand business relationships with women owned enterprises including a small business and women entrepreneurs.
- Support gender sensitive solutions to credit and lending burners.
- Respect the dignity of women in all marketing and other company materials.

Promote Equality through Community Initiations and Advocacy (Principle VI)

- Community Leadership And Engagement
- Lead by example - showcase company commitment to gender equally and women's empowerment
- Use philanthropy and grants programs to support company commitment to inclusion, equality and human right.

Measure and Publicly Report Progress to Achieve Gender Equality (Principle VII)

- Transparency, Measuring and Reporting.
- Incorporate gender markers into ongoing reporting obligations.
- Make public the company policies and implementation plan to promote gender equality.
- Establish bench mark that facilitates inclusion of women to all levels.

3.2 Levels of Empowerment

Generally, empowerment occurs at three levels:

3.2.1 The Individual Level

This deals with individual women's abilities to take control over their lives, their perceptions about their own value and abilities to identify a goal and work towards this goal.

3.2.2 The Group Level

It deals with the collective action and sense of agency that women experience together.

3.2.3 The Society Level

This deals with the permissiveness of the political and social climate, the societal norms and the public discourse on what is possible and impossible for women to do, and how women should behave.

3.3 Benefits of Women Empowerment

3.3.1 Economic

When women are empowered to do more, there is possibility of economic growth and reduction in global poverty since women represent most of the world's poor population. A study found that of a fortune 500 companies, those with more women board directions had significantly higher financial returns and increase economic output of d nation.

3.3.2 Political

When women are informed in decision making, their decisions are more family-friendly, this is due to their human nature. Big Magrete Thatcher of the United Kingdom and Dora Akunyili of Nigeria who brought about a radical change in the fight against fake drugs are women who were involved in politics.

3.3.3 Educational Benefit

Women and mothers are usually the first teacher that a child encounters at home. When women are educated same is passed/ impacted onto the children. More so, statistics have shown that women are first leads that are now moving to the fore front of many disciplines (medicine, nursing, engineering etc).

3.3.4 Reproductive Health

This will help women make informed decisions on issues like family planning and child spacing. This will also reduce the rate of maternal and child mortality and morbidity.

3.3.5 Entrepreneurship

This will help women create jobs and reduce the army of unemployed youth in the society. This helps women to become decision makers since decisions are needed in the management of the businesses.

3.3.6 The Family

As postulated by staples 1989 that in 15years time, the family will be a dual wage earner. This is a situation whereby the woman is also involved in fending for the family. This has gone a long way to help the family financially.

3.4 Barriers to Women Empowerment

Many of the barriers to women's empowerment and equity lie in-grained in cultural norms. Many women feel these pressures while others have become accustomed to being treated inferior to men. Even if men legislated NGOs etc are aware of the benefits women empowerment and participation can have, many are scared of disrupting the status quo and continue to let societal norms to get in the way of development. Research shows that the increasing access to the internet can also result in an increased exploitation of women. Types of victimization include cyber stalking harassment, online pornography and flaming.

Note

Recent studies also show that women face more barriers in the workplace than men do. Gender related barriers involve sexual harassment. Unfair hiring practices, career progression and unequal pay where women are paid less than men for performing the same job. Such barriers make it difficult for women to advance their workplace or receive fair compensation for the work they provide.

3.4.1 Implications to Community Health Nursing

1. In order to understand empowerment, citizens who are devalued must be seen as
2. oppressed and marginalized by society, not simply as clients to be served. Sources of oppression range from poverty and abuse to social isolation and lack of access to valued resources.
3. Service systems must give up their control over people who are currently devalued. This means eliminating the power relationships which exist between professionals and citizens by ensuring collaboration and by supporting consumer controlled initiatives.
4. For a power transfer to occur, citizens must be the ones to identify the problems and solutions to personal and community issues and must have direct access to funding that normally only goes to service agencies.
5. While power cannot be given to people by professionals, concerned professionals can work to eliminate the systematic barriers that have been created which oppress, control, and disempower vulnerable citizens.
6. Listening to the concerns, stories, feelings, experiences, and hopes of people who feel powerless is the basis for broadening people's awareness of their oppression. The language of professionalism, which encourages dependency and control, needs to be replaced by dialogue, which supports mutuality and reciprocity.
7. Build upon the strengths and capacities of citizens and avoid a focus on deficits. This is critical for building self-esteem, which is both an outcome and part of the empowerment process.
8. Participation in community life at three levels is critical for the empowerment of individuals: working on issues which affect their own lives; connecting with others who have had similar experiences; and being involved in a range of community groups and activities.
9. Encourage and support citizens to make ongoing contributions to their communities through access to valued social roles such as employee, volunteer, mentor, advocate, or friend.
10. Citizens who are consumers of services should have control over the resources and personal supports they need to live with dignity.
11. It is possible to learn important strategies about prevention from studying the process of empowerment; for example, as people become more empowered, they rely less on formal service systems and more on informal support networks.

These learnings can be used as important principles for proactively empowering potentially vulnerable individuals and groups.

The empowerment of women has become one of the most important concerns of 21st century not only at national level but also at the international level. Efforts by the government are on to ensure gender equality but government initiatives alone would not be to achieve this goal. Society must take initiative to create a climate in which there is no gender discrimination and women have full opportunities of self-decision making and participating in the social political and economic life of the country with a sense of equality.

Finally, to empower the female sounds as though we are dismissing or ignoring males but the truth is both genders desperately need to be equally empowered.

When you educate a boy you educate an individual but when you educate a girl you educate a nation. Education is a human right and an essential tool for achieving the goal of equality development and peace.

ITQ

Question

What are the three levels of empowerment?

Feedback

They are:

a. The Individual Level: This deals with individual women's abilities to take control over their lives, their perceptions about their own value and abilities to identify a goal and work towards this goal.
b. The Group Level: It deals with the collective action and sense of agency that women experience together.

c. The Society Level: This deals with the permissiveness of the political and social climate, the societal norms and the public discourse on what is possible and impossible for women to do, and how women should behave.

Study Session Summary

Summary

This Study Session discussed the concept of women empowerment. Levels as well as benefits of women empowerment will be explored too. Finally, barriers of women empowerment were examined.

Assessment

Assignment

1. Define women empowerment
2. States the benefits of women empowerment
3. Discuss the various levels of empowerment
4. What are the barriers to women empowerment?

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Study Session 4

Communicable and Infectious Diseases

Introduction

In this study session, we will juxtapose communicable and infectious diseases. We will also described characteristic features of carriers state. Principles underlying the control of communicable diseases will also be discussed.

Learning Outcomes

Outcomes

When you have studied this session, you should be able to:

4.1 define the following terms:

a. communicable disease

b. infectious disease

4.2 describe the characteristic features of carrier state

4.3 explain the principles underlying the control of communicable disease

Terminology

Communicable diseases	Are infectious diseases transmissible (as from person to person) by direct contact with an affected individual or the individual's discharges or by indirect means (as by a vector)—compare contagious disease.
Infectious diseases	Are disorders caused by organisms — such as bacteria, viruses, fungi or parasite

4.1 Communicable and Infectious Diseases

Infective Agent/Agent of Infection: Infectious diseases are caused by different types of organisms ranging from viruses, bacteria, fungi, protozoa, helminths.

Viruses: measles, small pox, common cold, influenza, poliomyelitis, infective hepatitis.

Bacteria: tuberculosis, pneumonia, streptococci sore throat, typhoid, bacterial dysentery, leprosy.

Protozoa: Malaria, trypanosomiasis

Helminths: Schizotosomiasis, hookworm, tapeworm, filiariasis, ascariasis (round worm).

Reservoir of Infection/Source of Infection: This is the natural habitat of infective agent i.e where they live and multiply depending on the host for survival. The reservoir may be man, animal or non-living thing.

Man: The reservoir in man, the organisms are specifically adapted to man e.g measles, small pox, typhoid, meningococcal meningitis, gonorrhoea, syphilis, HIV/AIDS. This human reservoir includes the active cases (sick people) and the carriers.

A carrier is a person who harbours infective agent without showing the signs of the disease but his capable of transmitting the agent to other people. There are 3 types of carrier states: Convalescent carrier, Healthy carrier, Incubatory or precocious carrier

Convalescent Carrier: This is a person who continues to harbour the infective agent after recovering from the illness e.g typhoid, gonorrhoea etc. they may excrete the agent for only a short period or may become a chronic carrier. A chronic carrier continues to excrete the organism continuously or intermittently over a period of years.

Healthy Carrier: A healthy carrier is a person who remains well throughout the infection.

Incubatory or Precocious Carrier: the infected person excretes the pathogen during the incubatory period before the onset of the symptoms.

Therefore, the carrier state plays an important role in the epidemiology of certain infectious diseases like poliomyelitis, meningococcal meningitis, typhoid, candidiasis, amoebic dysentery or amoebiasis.

4.2 Characteristic Features of Carrier State

- The number of people in the carrier state is more than the sick people in the society.
- The carriers and the contact do not know that he is sick or infected. Hence, the contacts do not take precaution to avoid infection.
- The carriers are not debilitated and can continue to make contact everywhere they go.

- A convalescent carrier continues to excrete the organism to become a chronic carrier, continuously or intermittently over a period of years to a free zone.

4.2.1 Reservoir of Animal

Reservoir of animal is called **zoonosis.** Zoonosis is applied to those infectious diseases of vertebrate animals that are transmissible to man under natural conditions.

- Where man uses the animal for food (teanisis) e.g beef/pork, birdflu.
- Where there is a vector transmitting the infection from animal to man e.g plague (flea), viral encephalitis (mosquito).
- Where the animal bites man e.g Rabies (dog).
- Where the animal contaminates man's environment including his food e.g salmonellosis.

4.2.2 Reservoir in Non-Living Things

The agents are fully adapted to living free in nature. They are saprophytes. Example living free in soil, they can withstand any adverse environment changes. They are usually vegetative and spore forming e.g Tuberculosis. Others are clostridia organisms and they are 3: clostridium tetani (tetanus), clostridium welchi (gas gangrene), clostridium botulinum (botulism).

Mode of Transmission

It is the bridge that connects the infective agent to the susceptible host. Once an infectious agent leaves a reservoir, it must get transmitted to a new host if it is to multiply and cause diseases. The route by which an infectious agent is spread is the mode of transmission. It is important to identify the different mode of spread, because prevention and control differ depending on the type.

We have different modes of transmission. They include:

Agency of Non-Living Things

This is called vehicle and this can be achieved through:

a. Contamination of hands, food, water and soil.
b. Inhalation and this is airborne infection which can occur in poor ventilation, overcrowding in sleeping areas and public areas.

Agency of Living Things

This are referred to as vectors. There are 2 types:

Mechanical Vector: This type of vector serves as "taxi"

Biological Vector: It involves a life cycle of the agent in the vector e.g mosquitoes and blackfly i.e the agent must go through secondary multiplication inside the vector before it is transmissible to man. The agent undergoes developmental processes within the vector and multiplies inside the vector. When the insect bites, it can be the host susceptible.

Contact

This contact may be either direct or indirectly and this can occur where there is overcrowding i.e direct. It is very common in the urban area than rural area.

a) **Direct**: it refers to the transfer of an infectious agent from an infected host to a new host, without the need for intermediates such as air, food, water or other animals. Direct modes occur in two ways.

i) **Person to Person**: the infectious disease is spread through direct contact between people touching, biting, kissing, sexual intercourse, or direct projection of respiratory droplets into another person's nose or mouth during coughing, sneezing or talking. e.g HIV infection.

ii**) Trans Placental Transmission**: this refers to the transmission of an infectious agent from mother to foetus through the placenta. e.g. toxoplasmosis, syphilis which can cause congenital malformation.

b**) Indirect:** is when infectious agents are transmitted to new hosts through intermediates such as air, food, water, objects or substances in the environment, or other animals. Indirect transmission has three subtypes:

i) **Airborne Transmission**: the infectious agent may be transmitted in dried secretions from the respiratory tract, which can remain suspended in the air for some time. For example, the infectious agent causing tuberculosis can enter a new host through air borne transmission.

ii) **Vehicle Borne Transmission**: a vehicle is any non-living substance or object that can be contaminated by an infectious agent, which then transmits it to a new host. Contamination refers to the presence of an infectious agent in or on the vehicle.

iii) **Vector Borne Transmission**: a vector is an organism, usually an anthropoid which transmits an infectious disease to a new host. Arthropod which act as vehicles include: houseflies, mosquitoes, lice, and ticks.

Susceptible host

There are various things in the body that protects an individual from infection. An example is the protective organs which serves

as a protective mechanism of the host and includes the skin and mucous membrane. The skin helps to prevent the entrance of micro-organisms while the mucous membrane in the nose helps trap micro-organism and duct by the action of cilia and mucous so that it does not go further into the respiratory organ.

Smokers are prone to infection because they have destroyed their mucous membrane and cilia present. There is also antibacterial fluid in the body e.g. saliva, gastric juice which serves as protective mechanism that prevent micro-organisms from entering the body.

Situations that can make the host susceptible to infections

- Age: especially in the young and elderly
- Malnutrition
- Fatigue
- Trauma
- Pregnancy
- Lifestyle of the host including knowledge of good diet, knowledge of hygiene, knowledge of disease control. All these will help protect against infection.

Combating Communicable Diseases

Combating communicable disease begins with prevention then control. There are 5 levels of preventive medicine:

- Health education
- Specific protection
- Early detection and prompt treatment of disease.
- Disability limitation
- Rehabilitation

Health Education

This is a slow undramatic form of preventive medicine aimed at changing the attitude and behavioural pattern often remain unchanged in spite of technical and social advances. This most often have lasting effect and is a long term measure. This health education must be related specifically to individual communicable diseases.

Specific Protection

It depends on the aetiology of the disease and mode of transmission. Examples of specific protection include immunization and vaccination. Also, the use of prophylactic drugs like antimalarial, mosquito nets, mosquito proof on the windows and doors, mosquito repellent and mosquito coils can be protective.

Early Detection and Prompt Treatment of Disease

This is linked with curative services i.e. there must be infrastructures. Detective clinics such as chest clinics for x-rays for

detecting tuberculosis, pregnant women have antenatal for detecting abnormalities in pregnancy to ensure that mother and baby are in good health and after delivery, cancer clinics to detect cancers. Any problem identified is treated promptly and to back this up, the hospital must have improved laboratory and facilities. All these will improve the chances of early detection of diseases and hence prevent further diseases. Also there must be skilled manpower of health care professional which will be involved in this early detection of diseases.

Disability Limitation

After clients have been cured, disability could develop such as in poliomyelitis. It involves preventing and reducing risks of complications and deformity. e.g. preventing foot drop in a patient with poliomyelitis.

Rehabilitation

This is restoring function to a high level as much as possible and enabling patient to live as near normal as possible within the limit of the handicap, preventing relapse and complications.

Control of Communicable Diseases

This can be achieved by:

Notification of existence of infection or disease

This is usually done by legal empowerment. It must be done at the local, state, national and international levels for specific diseases. Examples of international notifiable diseases are cholera, yellow fever.

Tracing Source of Infection

This can be in man, animal.

Blocking the Route of Transmission

Such as air-borne, food-borne, water-borne etc.

Protecting the Susceptible Host

This can be achieved by immunization, prophylactic drugs.

4.3 Principles Underlying the Control of Communicable Diseases

There are five ways of controlling infection by breaking the cycle:

A. Direct Action against Agent of Infection by Dealing with the Reservoir and Source of Infection

- Active treatment of ill patient
- Treatment of carriers of infection

- Isolation
- Availability of modern health facilities readily accessible to the people who will utilize them, the facilities and the operators must be culturally acceptable to the people. The people involved in the planning state of the control of infection, the facilities should be vast with good laboratories, trained personnel and availability of potent drugs.
- Effective health education
- There should be complete elimination of the agent of infections to avoid transmission, if they are vectors destroy them or eliminate them e.g mosquito (malaria)
- Notification of health authorities (LG-STATE-FEDERAL)

B. Preventing the Means of Transmission (Vector) from Getting to the Infective Agent

- By destroying the vector
- By good refuse disposal e.g if housefly is a vector
- By good sewage disposal through building of good toilets and discouraging defecation of faeces in the bush.
- Discouraging the use of fresh faeces as fertilizers to plant vegetables.
- Refuse must be well covered.

C. Direct Action against Means of Transmission (the Vehicle)

- **Water:** by purification of water
- **Milk:** pasteurization and storage of milk in a good environment
- **Hands:** wash hands after going to the toilet, after cleaning the toilet, before preparation of foods and before eating. Also, ensure the nails are cut short.
- **Flies:** protect your environment from flies by destroying houseflies. All food establishment and houses must be screened with net. Foods on the table and pot of foods should be covered.
- **Soil:** do not use fresh faeces to plant vegetables especially fruits e.g carrot, cucumber.

D. Direct Action against Means of Transmission (the Vector)

- Kill with insecticides
- Attempt to put a barrier between the susceptible host and the means of transmission by using mosquito nets and covering of doors and windows with nets.
- Wearing of a long sleeve shirt and trousers to prevent bites of flies if a farmer.

4.3.5 Making the Susceptible Host Less Susceptible

- Immunization

- Use of prophylactic drugs to prevent the attack of diseases e.g. Daraprim to prevent malaria
- Health education to prevent occurrence of the disease: the community health worker should give health education on the following as the case may be:
- Clean water supply
- Actions to prevent pollution of clean water
- Importance of food hygiene
- Danger of food wadding through stagnant water
- Filtration of waters (using clean white cloth)
- Importance of netting windows and doors
- Importance of personal hygiene
- Maintenance of good environmental sanitation
- Importance of giving immunization- children and women of child bearing age
- Importance of early treatment of common minor ailments.
- Mobilize the community to build toilets, sink wells, Zone Rivers, clear weeds and dispose empty containers.

ITQ

Question

Which other name can you call zoonosis and what does it mean?

Feedback

Zoonosis is also called reservoir of animal**.** Zoonosis is applied to those infectious diseases of vertebrate animals that are transmissible to man under natural conditions.

Study Session Summary

Summary

In this Study Session, we were able to explain communicable and infectious diseases. We also described characteristic features of carrier's state. Principles underlying the control of communicable diseases were also discussed.

Assessment

1. What is a communicable disease?
2. List the characteristic features of carrier state
3. Explain the principles underlying the control of communicable diseases

Assignment

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Study Session 5

HIV/AIDS

Introduction

In this study session, we will state what HIV/AIDs stand for, we will examine current issues about HIV in Nigeria and define HIV and AIDs. We will also discuss the modes of transmission of HIV. Finally, we will describe the signs and symptoms of HIV and other non- medical management.

Learning Outcomes

Outcomes

When you have studied this session, you should be able to:

5.1 define HIV and AIDS

5.2 list and explain the current issues about HIV in Nigeria

5.3 analyse HIV's mode of transmission

5.4 describe HIV signs and symptoms

Terminology

Human immunodeficiency (HIV)	A virus that attacks the immune system, the body's natural defence system
Acquired immunodeficiency syndrome (AIDs)	A disease in which there is a severe loss of the body's cellular immunity, greatly lowering the resistance to infection and malignancy

5.1 Definition of Concepts

- HIV Stands for Human Immunodeficiency Virus. It is a group of viruses known as retroviruses. This gets into the body and invades the cells of the body immune system.
- AIDS stands for acquired immunodeficiency syndrome. It is caused by HIV and occurs when the virus has destroyed so much of the body defences that immune cell counts fall to critical levels or certain life threatening infections or cancerous cells develop.

5.2 Current Issues about HIV/AIDs in Nigeria

Nigeria is the most populous country in Africa with the population of over 160million.In Nigeria an estimated of 3.6% of the population is living with HIV and AIDS. Several factors have contributed to the spread of HIV in Nigeria and these include:

1. Sexual networking practices such as polygamy.
2. High incidence of untreated sexually transmitted infections.
3. Low condom use.
4. Poverty.
5. Poor health status.
6. Stigmatization and denial of HIV infection among vulnerable groups
7. Another important factor is the issue of diverse ethnicity, religion, languages and culture which has posed a major challenge to HIV prevention programmes.

Note

Globally, 85% of HIV transmission is through heterosexual intercourse.

In United States, approximately one-third of new diagnoses appear to be related to heterosexual transmission.

Infections in women are increasing.

Worldwide, 42% of people living with HIV are women and in US, approximately 25% of new diagnoses are women and the number increases daily.

HIV infection in children has declined and this is due to early diagnosis and treatment of mothers.

The first case of HIV/AIDS in Nigeria was in 1985 and since then there has been an increase in the epidemic of the disease. For instance an estimation of 5.1%-5.4% of the population have been affected with HIV/AIDS by 1999(Pen chard et al, 2002) and by 2006, 6.1 million of 140 million population is living with HIV/AIDS. The number of people with the disease has steadily been increasing and little wonders its inclusion in the MDGs. After the first case in 1985, it was reported in 1986 and by 1987 the Nigeria health sector established the National AIDS Advisory Committee, which was shortly followed by establishment of National Expert Advisory Committee on AIDS (NEACA). Prevalence of HIV/AIDS in Nigeria has been on the increase since 1986.It increased from 1.6-5.8% in the period between 1991 and 2001. In 2005, there was reduction of about 4.4%. Estimated number of affected person in 2006 was 2.99 million with female constituting about 58% (Ileuma S.A,2009).

Approximately 220,000 people died from AIDS in Nigeria in 2009, this has brought about a decline in life expectancy. In 2010 the overall life expectancy was only 52 years because of the rapid

spread of HIV in Nigeria both the governmental and non-governmental organizations are putting strategies in place to combat the deadly disease e.g. PEPFER (President emergency plan for AIDS relief), Global Bank and World bank are the two main funders of HIV programs in Nigeria; NACA; SACA; LACA; NELA; ARFH just to mention a few.

5.3 Mode of Transmission of HIV

There are four routes of HIV transmission in Nigeria though the first three routes serve as the main route of transmission:

5.3.1 Heterosexual Sex

Factors contributing to this include lack of information about sexual health and HIV; Low levels of condom use and High levels of sexually transmitted diseases.

5.3.2 Blood Transfusion

HIV transmission through unsafe blood accounts for the second largest source of HIV infection in Nigeria.

5.3.3 Use of Sharp (Infected) Objects

- A number of small scale studies indicated sharing of sharp instruments including
- hypodermic needles
- use of unsterilized tattoo grooming equipment and blades (e.g. razor blades)

5.3.4 Mother – to – Child Transmissions

Each year around 57,000 babies in Nigeria are born with HIV.

5.3.5 Organ Transplant

Although this is rare, but a recent incident in Taiwan occurred when the HIV test result for the donor was mistakenly thought to have been negative (false negative).

5.4 HIV Signs and Symptoms

- Many people with HIV do not know they are infected
- Early HIV symptoms also include fever, headache, tiredness, and enlarged lymph nodes in the neck.
- AIDS is the later stage of HIV infection, when the body begins losing its ability to fight infections.

The infections that happen with AIDS are called opportunistic infections: they include

1. Pneumonia caused by pneumocystis
2. brain infection with toxoplasmosis
3. widespread infection with a bacteria called MAC (mycobacter)
4. A weakened immune system can also lead to other unusual conditions;
5. Lymphoma; a form of cancer of the lymphoid tissue) in the brain, reddish, or purple spots that develop on the skin or in the mouth.

5.5 Non-Medical Management

The basic principles of good medical practice apply to the provision of care for infected individuals and support for their families and friends. Patients infected with HIV are faced with numerous challenges at all stages of the diseases because AIDS is highly a publicised disease for which there is no cure. A diagnosis of HIV infection often has a devastating impact on the individual, family and friends. It places great emotional stress on the nurses themselves. The fear of stigma is associated with AIDS therefore social isolation can occur.

According to WHO/ICN joint declaration on AIDS, the nursing responsibility is to people who require nursing care and that in providing care he/she promotes an environment in which the values, customs and spiritual beliefs of individuals are respected.

Owing to the widening range of disease manifestations and to the psychological aspects of the infection, broad professional nursing skills, counselling are needed to provide optimal nursing care wherever it might be needed.

5.5.1 HIV Medication

The drugs are called highly active antiretroviral therapy and they have substantially reduced HIV related complications and death.

5.5.2 HIV Prevention

The only way to prevent infection from the virus is to avoid behaviour that put you at risk; Decreasing risk related to sexual inter course i.e. the Use of condom and Avoiding multiple sex partner. It also includes decreasing risk of prenatal transmission, decreasing risk at workplace, exposure to contaminated fluid needle stick injury and sharing needles

5.5.3 Implications for Health Care Workers

The implications will be considered under the following levels of nursing interventions:

Primary (prevention of HIV/AIDS and promotion of health)

- Abstinence
- Being faithful/fidelity
- Condom use
- Sex education
- Public enlightenment and awareness
- Proper disposal of sharps in the hospital
- Proper screening of blood before transfusion
- Universal safety precautions
- Proper sterilization of surgical instruments
- Caesarean section for infected mothers

Secondary (early identification by screening and prompt management)

- Early antenatal screening to prevent mother to child transmission
- Post- exposure prophylaxis for health workers who have being exposed to infected blood or blood products
- Voluntary Confidential Counselling and Testing (VCCT) should be done for the populace
- Anti retroviral drugs should be commenced as stipulated for those qualified
- Treatment of opportunistic infections
- Regular medical check up

Tertiary (rehabilitation and living healthy with HIV/AIDS)

- Introduce them to People Living with HIV/AIDS (PLWHA) group
- Psychotherapy
- Advice on healthy living example rest, adequate diet, exercise etc and avoiding risky behaviours like smoking, alcoholism, self medications, etc
- Carry the family along in the long term management

The biggest historical and commonest barrier to therapeutic nurse-patient communication was “distancing” oneself from the patient, associated with lack of involvement. Back in the 1970’s, nurses were taught and advised to distance themselves from patients, so as to concentrate on the tasks in hand without feelings getting in their way. Unfortunately, this impression or ideology still exits till date.

The problem of distancing/isolation leads into the problem of avoiding disclosure as the nurse worries that exploring an area might do more harm than good. Medicine has been seriously criticized for this patriarchal approach of knowing what is best for

the patient and telling only what the doctor thinks the patient should know. A frequent complaint of patients is that they rarely see a nurse during their hospitalization, unless she brings medicine or carries out a procedure.

Note

Distancing oneself from clients present with insufficient exploration of possible correlates to the existing problems; a situation which might do more harm than good. Health practitioners have been criticized for the patriarchal approach of "sieving" information and informing client with is "perceived "as appropriate.

The constant parade of hospital personnel in and out of the ward with their often short, professional and superficial visits referred to as "people, people everywhere and not one to care", connotes ineffective communication. This is because the nurse is "seen as just one more, and this could be confusing and exhausting for patients who might not be able to differentiate the particular contributions of individuals".

It was observed that doctors found it difficult to communicate about a serious disease with poor prognosis to a patient, but did not hesitate when the news was good. In this case, it was the nurse who collaborated with the doctor to decide how the patient (and family) should be informed. But we must remember that the patient is the only person able to decide where a conversation should be directed, and question(s) must be answered honestly, rather than avoided.

Nurses should remember that HIV/AIDs is of public health concern and Nigeria accounts for 10% of the global HIV/AIDS burden. Life expectancy in Nigeria moved from 54 years for women and 53 years for men in 1991 to 48 years for women and 46 years for men in 2009. Nigeria has a long way to go in tackling this devastating epidemic. Community and public health nurses are therefore in the best position to educate, advice and counsel the populace on the prevention of contacting this disease

ITQ

Question

How can organ transplant be a mode of HIV transmission?

Feedback

Organ transplant can be a mode of HIV transmission when the HIV test result for the donor is mistakenly thought to have been negative (false negative).

Study Session Summary

Summary

In this Study Session, we stated what HIV and AIDs stand for, that is human immunodeficiency virus and acquired immunodeficiency syndrome. We examined current issues about HIV in Nigeria. We also discussed the modes of transmission of HIV. Finally, we described the signs and symptoms of HIV and the various non-medical managements.

Assessment

Assignment

1. Identify the various modes of transmission for H.I.V/ AIDs
2. Discuss the current issues about HIV in Nigeria
3. What do HIV and AIDS stand for?
4. Discuss HIV signs and symptoms

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Study Session 6

Teenage Pregnancy

Introduction

This study session will discuss the concept of teenage pregnancy defining a teen as an individual between the ages of thirteen and nineteen, and pregnancy as a physiological state between the periods of conception to birth when a woman carries a developing foetus in her uterus. Impact and causes of teenage pregnancy will also be discussed. Finally, roles of community health nurses in teenage pregnancy will be emphasised.

Learning Outcomes

Outcomes

When you have studied this session, you should be able to:

6.1 define following terms:

a. a teen

b. pregnancy

c. teenage pregnancy

6.2 discuss the impact of teenage pregnancy

6.3 explain the causes of teenage pregnancy

4.4 examine roles of a community health nurse in teenage pregnancy

Terminology

Teenage	Relating to or characteristic of people between 13 and 19 years old
Pregnancy	The condition or period of being pregnant or the state of carrying a developing embryo or foetus within the female body
Teenage pregnancy	A teenage girl, usually within the ages of 13-19, becoming pregnant. A girl who has not reached legal adulthood, which varies across the world, who becomes pregnant

6.1 Definition of Teenage Pregnancy

Who is a teen? A teen is an individual between the ages of thirteen and nineteen while Pregnancy is a physiological state between the periods of conception to birth when a woman carries a developing foetus in her uterus. It can also be defined as a state of being pregnant. Teenage pregnancy is therefore defined as a teenage girl, usually within the ages of 13 to 19 becoming pregnant. This refers to girls who have not reached legal adulthood which varies across the world who become pregnant.

Teenage pregnancy is pregnancy in human females under the age of 20 at the time that the pregnancy ends. A pregnancy can take place after the start of the puberty before first menstrual period, but usually occurs after the onset of periods. In well-nourished girls, menarche usually takes place around the age of 12 or 13.Pregnant teenagers face many of the same obstetrics issues as other women. There are, however, additional medical concerns for mothers aged below 15 years. For mothers aged 15–19, the risks are associated more with socioeconomic factors than with the biological effects of age. Risks of low birth weight, premature labour, anaemia , and pre-eclampsia are connected to the biological age itself, as it was observed in teen births even after controlling for other risk factors (such as utilization of antenatal care etc.).

In developed countries, teenage pregnancies are often associated with social issues, including lower educational levels, higher rates of poverty, and other poorer life outcomes in children of teenage mothers. Teenage pregnancy in developed countries is usually outside of marriage, and carries a social stigma in many communities and cultures. By contrast, teenage parents in developing countries are often married, and their pregnancies welcomed by family and society. However, in these societies, early pregnancy may combine with malnutrition and poor health care to cause medical problems.

Teenage pregnancies appear to be preventable by comprehensive sex education and access to birth control methods. Abstinence-only sex education does not appear to be effective.

6.2 Impact of Teenage Pregnancy

Several studies have examined the socioeconomic, medical, and psychological impact of pregnancy and parenthood in teens. Life outcomes for teenage mothers and their children vary; other factors, such as poverty or social support, may be more important than the age of the mother at the birth. Many solutions to counteract the more negative findings have been proposed. Teenage parents who

can rely on family and community support, social services and child-care support are more likely to continue their education and get higher paying jobs as they progress with their education.

6.2.1 On the Mother

Being a young mother in an industrialized country can affect one's education. Teen mothers are more likely to drop out of high school. However, recent studies have found that many of these mothers had already dropped out of school before becoming pregnant, but those in schools at the time of their pregnancy were as likely to graduate as their peers.

Young motherhood in an industrialized country can affect employment and social class. Less than one third of teenage mothers receive any form of child support, vastly increasing the likelihood of turning to the government for assistance. The correlation between earlier childbearing and failure to complete high school reduces career opportunities for many young women.[One study found that, in 1988, 60% of teenage mothers were impoverished at the time of giving birth. Additional research found that nearly50% of all adolescent mothers sought social assistance within the first five years of their child's life.

Note

Teenage women who are pregnant or mothers are seven times more likely to commit suicide than other teenagers. Women who became mothers in their teens — freed from child-raising duties by their late 20s and early 30s to pursue employment while poorer women who waited to become moms were still stuck at home watching their young children — wound up paying more in taxes than they had collected in welfare.

According to the National Campaign to Prevent Teen Pregnancy, nearly 1 in 4 teen mothers will experience another pregnancy within two years of having their first. Pregnancy and giving birth significantly increases the chance that these mothers will become high school drop-outs and as many as half have to go on welfare. Many teen parents do not have the intellectual or emotional maturity that is needed to provide for another life. Often, these pregnancies are hidden for months resulting in a lack of adequate prenatal care and dangerous outcomes for the babies. Factors that determine which mothers are more likely to have a closely spaced repeat birth include marriage and education: the likelihood decreases with the level of education of the young woman – or her parents – and increases if she gets married.

6.2.2 On the Child

Early motherhood can affect the psychosocial development of the infant. The children of teen mothers are more likely to be born prematurely with a low birth weight, predisposing them to many other lifelong conditions. Children of teen mothers are at higher

risk of intellectual, language, and socio-emotional delays. Developmental disabilities and behavioural issues are increased in children born to teen mothers. One study suggested that adolescent mothers are less likely to stimulate their infant through affectionate behaviours such as touch, smiling, and verbal communication, or to be sensitive and accepting toward his or her needs.

Another found that those who had more social support were less likely to show anger toward their children or to rely upon punishment.

Poor academic performance in the children of teenage mothers has also been noted, with many of them being more likely than average to fail to graduate from secondary school, beheld back a grade level, or score lower on standardized tests. Daughters born to adolescent parents are more likely to become teen mothers themselves. A son born to a teenage mother is three times more likely to serve time in prison.

6.2.3 Other Family Members

Teen pregnancy and motherhood can influence younger siblings. One study found that the younger sisters of teen mothers were less likely to emphasize the importance of education and employment and more likely to accept human sexual behaviour, parenting, and marriage at younger ages; younger brothers, too, were found to be more tolerant of non-marital and early births, in addition to being more susceptible to high-risk behaviours. If the younger sisters of teenage parents babysit the children, they have an increased risk of getting pregnant themselves. Once an older daughter has a child, parents often become more accepting as time goes by. The probability of the younger sister having a teenage pregnancy went from one in five to two in five if the elder sister had a baby as a teenager.

6.2.4 On the Community

Teenage pregnancy affects the society in many ways especially in the form of greater public expenses. Some examples of these expenses are foster care, social welfare programs and health expenses. Pregnant teenagers do not have a life built up to support a baby, so they often need the help of those around them. This help comes in the form of informal community support, such as babysitting or hand-me-down baby essentials.

Others include;

- Contributes to the already high number of young kids having babies.
- Decreases the chances of finishing secondary school and going on to the University, thus, one more under-educated

person not contributing to the advancement of the community.

- Starts or continues a cycle of young people having kids young which is hard to break. Hence, a community with an increasing number of teenage mothers.
- Forces young people to find jobs/forces the community to take care of their responsibility of the community thereby reducing the per- capital income.
- The potential that the child won't have active parent in their life which leads to behavioural problems later in life and in school thereby increasing the number of h hoodlums in the community.
- Teenage pregnancies are considered as a high risk pregnancy, which means they are more likely to have medical complications as they have they have not finished growing thereby leading to an increase in the mortality rate of the community.

6.3 Causes of Teenage Pregnancy

These include;

6.3.1 Early Marriage

In some societies, early marriage and traditional gender roles are important factors in the rate of teenage pregnancy. For example, in some sub-Saharan African countries, early pregnancy is often seen as a blessing because it is proof of the young woman's fertility. The average marriage age differs by country and countries where teenage marriages are common experience higher levels of teenage pregnancies. In the Indian subcontinent, early marriage and pregnancy is more common in traditional rural communities than cities.

6.3.2 Lack of Sex Education

The lack of education on safe sex, whether it is from parents, schools, or otherwise, is a cause of teenage pregnancy. Many teenagers are not taught about methods of birth control and how to deal with peers who pressure them into having sex before they are ready. Many pregnant teenagers do not have any cognition of the central facts of sexuality.

In societies where adolescent marriage is less common, such as many developed countries, young age at first intercourse and lack of use of contraceptive methods (or their inconsistent and/or incorrect use; the use of a method with a high failure rate is also a problem) may be factors in teen pregnancy. Most teenage pregnancies in the developed world appear to be unplanned. In an attempt to reverse the increasing numbers of teenage pregnancies,

governments in many Western countries have instituted sex education programs, the main objective of which is to reduce such pregnancies and STDs. Countries with low levels of teenagers giving birth accept sexual relationships among teenagers and provide comprehensive and balanced information about sexuality.

6.3.3 Adolescent Sexual Behavior-Alcohol and Drugs

Note

Adolescent Sexuality. In most countries, most men experience sexual intercourse for the first time before their 20th birthdays. Men in Western developed countries have sex for the first time sooner than in undeveloped and culturally conservative countries such as Sub-Saharan Africa and much of Asia. The increased sexual activity among adolescents is manifested in increased teenage pregnancies and an increase in sexually transmitted diseases.

Inhibition-reducing drugs and alcohol may possibly encourage unintended sexual activity. If so, it is unknown if the drugs themselves directly influence teenagers to engage in riskier behaviour, or whether teenagers who engage in drug use are more likely to engage in sex. Correlation does not imply causation. The drugs with the strongest evidence linking them to teenage pregnancy are alcohol, cannabis, "ecstasy" and other substituted amphetamines. The drugs with the least evidence to support a link to early pregnancy are opioids , such as heroin, morphine, and oxycodone, of which a well-known effect is the significant reduction of libido –it appears that teenage opioid users have significantly reduced rates of conception compared to their non-using, and alcohol , "ecstasy" , cannabis, and amphetamine using peers.

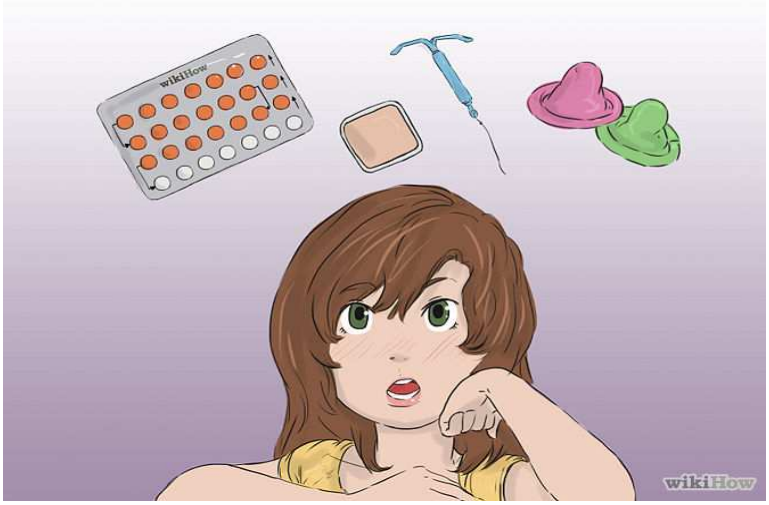
6.3.4 Lack of Contraception

Adolescents may lack knowledge of, or access to, conventional methods of preventing pregnancy, as they may be too embarrassed or frightened to seek such information. Contraception for teenagers presents a huge challenge for the clinician. In 1998, the government of the United Kingdom set a target to halve the under-18 pregnancy rate by 2010.The Teenage Pregnancy Strategy (TPS) was established to achieve this. The pregnancy rate in this group, although falling, rose slightly in 2007, to 41.7 per 1000 women. Young women often think of contraception either as 'the pill' or condoms and have little knowledge about other methods. They are heavily influenced by negative, second-hand stories about methods of contraception from their friends and the media. Prejudices are extremely difficult to overcome.

Over concern about side-effects, for example weight gain and acne, often affect choice. Missing up to three pills a month is common, and in this age group the figure is likely to be higher. Restarting

after the pill-free week, having to hide pills, drug interactions and difficulty getting repeat prescriptions can all lead to method failure.

Some women gave three main reasons for not using contraceptives: trouble obtaining birth control (the most frequent reason), lack of intention to have sex, and the misconception that they "could not get pregnant.



Among teens in the UK seeking an abortion, a study found that the rate of contraceptive use was roughly the same for teens as for older women. In other cases, contraception is used, but proves to be inadequate. Inexperienced adolescents may use condoms incorrectly, forget to take oral contraceptives, or fail to use the contraceptives they had previously chosen. Contraceptive failure rates are higher for teenagers, particularly poor ones, than for older users. Long-acting contraceptives such as intrauterine devices, subcutaneous contraceptive implants , and contraceptive injections (such as Depo-Provera and Combined injectable contraceptive), which prevent pregnancy for months or years at a time, are more effective in women who have trouble remembering to take pills or using barrier methods consistently. According to The Encyclopaedia of Women's Health, published in 2004, there has been an increased effort to provide contraception to adolescents via family planning services and school-based health, such as HIV prevention education.

6.3.5 Age Discrepancy in Relationships

According to the Family Research Council, a conservative lobbying organization, studies in the US indicate that age discrepancy between the teenage girls and the men who impregnate them is an important contributing factor. Teenage girls in relationships with older boys, and in particular with adult men, are more likely to become pregnant than teenage girls in relationships with boys their own age. They are also more likely to carry the baby to term rather than have an abortion.

6.3.6 Sexual Abuse

Studies from South Africa have found that 11–20% of pregnancies in teenagers are a direct result of rape, while about 60% of teenage mothers had unwanted sexual experiences preceding their pregnancy. Before age 15, a majority of first-intercourse experiences among females are reported to be non-voluntary; the Guttmacher Institute found that 60% of girls who had sex before age 15 were coerced by males who on average were six years their senior. One in five teenage fathers admitted to forcing girls to have sex with them. Multiple studies have indicated a strong link between early childhood sexual abuse and subsequent teenage pregnancy in industrialized countries. Up to 70% of women who gave birth in their teens were molested as young girls; by contrast, 25% of women who did not give birth as teens were molested.

In some countries, sexual intercourse between a minor and an adult is not considered consensual under the law because a minor is believed to lack the maturity and competence to make an informed decision to engage in fully consensual sex with an adult. In those countries, sex with a minor is therefore considered statutory rape.

In most European countries, by contrast, once an adolescent has reached the age of consent, he or she can legally have sexual relations with adults because it is held that in general (although certain limitations may still apply), reaching the age of consent enables a juvenile to consent to sex with any partner who has also reached that age. Therefore, the definition of statutory rape is limited to sex with a person under the minimum age of consent. What constitutes statutory rape ultimately differs by jurisdiction.

6.3.7 Socio-Economic Factors

Teenage pregnancy has been defined predominantly within the research field and among social agencies as a social problem. Poverty is associated with increased rates of teenage pregnancy. Economically poor countries such as Niger and Bangladesh have far more teenage mothers compared with economically rich countries such as Switzerland and Japan. A young poverty-stricken girl clutches her child

There is little evidence to support the common belief that teenage mothers become pregnant to get benefits, welfare, and council housing. Most knew little about housing or financial aid before they got pregnant and what they thought they knew often turned out to be wrong.

6.3.8 Low Self-Esteem /Desperation

Some teenagers in their pursuit of being accepted by their peers and also due to their desperation venture into activities that are detrimental to their health by getting involved in some illicit acts such as premarital sex, alcohol abuse etc. Most times they have the feeling that others are doing it so they can also do it and not doing it makes teenagers feel inferior to others. These kinds of teenagers most time lack the adequate knowledge about use of contraceptives.

6.4 Role of the Community Health Nurse

The role of the Community health nurse is explained under the primary, secondary and tertiary prevention.

6.4.1 Primary Prevention

This aims at postponing first sexual intercourse. Its focus is to educate and empower teens.

We can utilize primary preventions by;

- Educating the teens on risks and consequences of sex.
- Empower teenagers to prevent pregnancy by making contraceptives and emergency contraception easily available.
- Access to information is crucial for young people who want to prevent pregnancy.
- Parental involvement in prevention programs may reduce teenage pregnancy.

Parents, schools, religious institutions (Agents of socialization) also have an important role to play in the primary prevention of teenage pregnancies.

6.4.2 Secondary Prevention

This is at encouraging teens to use contraceptives consistently and to detect pregnancy early through pregnancy test .It also involves providing services for early detection of teen pregnancy, early prenatal care and support to prepare teen for becoming a parent.

6.4.3 Tertiary Prevention

This is to counsel teens about available options including keeping the baby, adoption and abortion. It also involves starting programmes that prevent future unwanted pregnancies among teens and help parenting teens give the best care to their child. Strategies include parenting classes, services to help teens complete their education, well child care, nutrition and immunization services; and provision of social support groups to the teenage mother.

What stands out is the fact that pregnancy is a choice for only a very few. For most sexually active teenagers, a lack of knowledge and communication skills ensure that the odds are stacked against them. For the first time, however, national targets to reduce teenage pregnancy have resources attached to them.

Note

Change is achievable only by giving consistent messages to young people. Developing SRE policies in schools and providing sexual health services that young people feel confident to use are vital, as is ensuring teenage parents are fully supported to give themselves the best chance in life.

Teenage parents and their children are among the most vulnerable members of society and this has now been formally recognised by public health strategy. Rather than labelling young people, we have been given a chance to work with them to tackle the causes of teenage pregnancy and to ensure that they can at least make informed choices about when to become parents.

ITQ

Question

How can a mother suffer teenage pregnancy?

Feedback

As a teenage mother, the following could be the impacts of teenage pregnancy:

a. Being a young mother in an industrialized country can affect one's education. Teen mothers are more likely to drop out of high school.
b. Young motherhood in an industrialized country can affect employment and social class
c. Teenage women who are pregnant or mothers are seven times more likely to commit suicide than other teenagers
d. According to the National Campaign to Prevent Teen Pregnancy, nearly 1 in 4 teen mothers will experience another pregnancy within two years of having their first

Study Session Summary

Summary

In this Study Session, we discussed the concept of teenage pregnancy defining a teen as an individual between the ages of thirteen and nineteen, and pregnancy as a physiological state between the periods of conception to birth when a woman carries a developing fetus in her uterus. Impact and causes of teenage pregnancy was also discussed. Finally, roles of community health nurses in preventing teenage pregnancy was emphasised and

examined.

Assessment

Assignment

1. Who is a teen?
2. Discuss fully the impact of teenage pregnancy
3. What are the causes of teenage pregnancy?
4. Examine the role of a community health nurse in preventing teenage pregnancy

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