Reproductive Health and Family Life Education: Implication for the School Social Workers

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Abstract

Poor knowledge about healthy reproductive health lifestyles and family life education contribute significantly to unhealthy sexual behaviors, unwanted pregnancies, sexually transmitted diseases, unsafe abortions and untimely death among the teenagers. Therefore, the youths in primary and secondary schools should have adequate knowledge about reproductive health and family life education and benefit from such issues. The paper discussed some important health issues in reproductive health such as family health issues, contraception, and teenage pregnancies. Furthermore, the objectives and assumptions of family life education which include acquiring knowledge about human development and behavior, understanding family mental patterns, becoming a parent and other family related matters were discussed. It went further to highlight the implications of reproductive health and family life education for the school social workers, which include: provision of adequate information on reproductive health, advocacy roles, community mobilization, health education, community outreach and counseling. It was concluded that, if the school social workers give adequate information or proper education to the youths in schools on how to attain positive reproductive health, many of them will be prevented from unhealthy sexual behaviours, sexually transmitted disease, teenage pregnancy, unsafe abortions and untimely deaths. It was recommended that the school social workers should help the numerous youths in schools by giving them proper health talks or education on various aspects of reproductive health and family life education that can prevent them from unhealthy sexual and reproductive behaviours.

Introduction

Health is a relative term which has various meaning to different people. To some people, health implies a state of wellbeing and to others; it implies absence of diseases or illness. Generally speaking, an ideal state of health implies that any disease or injury is a deviation from good health. Nicholas, (2008) affirmed that an ideal state can be restored by removing that disease and disability. Hence, health could be seen as a movement in a positive direction. It is a direction on a continuum. A movement toward positive end implies positive health whereas, a movement toward negative end implies illness, disability and disorders among others. In the same vein, Conrad, (2008) also confirmed that, health could be seen as being multidimensional. It encompasses all aspect of human living in terms of physical, biological, psychological, social, emotional and spiritual life. Simply put, World Health Organisation (1996) defined health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. WHO further explained that health is a source of everyday life, not of objective of living. Therefore, Porter and Perry, (2008) asserted that, health is a positive concept emphasizing social and personal resources as well as physical capacity.

Reproductive health care refers to the state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity, in all matters relating to the reproductive system and to its functions and processes. This implies that people are able to have a satisfying and safe sex life, that they have the capability to reproduce and the freedom to decide if, when and how often to do so, provided that these are not against the law. This implies further that women and men attain equal relationships in matter related to sexual relation and reproduction (Coleman and Testa2008).

In developing countries, especially in Africa, reproductive health has been a great concern to many stakeholders among who are- medical practitioners, social workers, health educators and guardian counselor because maternal mortality and morbidity are very high compared to developed word. In the same vein, Moronkola, Ojediran and Amosu (2006) reported that reproductive health knowledge, access to quality of care and maternal health services are poor in Africa. Significant health knowledge, belief and will power of women to access quality family planning services have become reproductive health problems in Africa, whereas, preventive and curative health care services are essential for improvement in the reproductive health of women.

Reproductive health occupies a central position in the identification of the health as well as the development of a given population. However, the events of reproductive health usually found in women who due to their biological function invariably bear the greatest burden of the shortcomings of reproductive health such as unsafe motherhood or unsafe abortion. Tremanye and Hawkins, (2001) observed that there is need to improve maternal and child health care services in developing countries, especially Nigeria because most deaths of women during pregnancy or delivery are preventable. In the revised National Health Policy of Nigeria (2004), these three current situations of the health status in the country were identified. Maternal morbidity rate (about one mother death in every one hundred deliveries) is one of the highest in the world. In the light of this, Moronkola et al (2006) further observed that one of the key national policies on reproductive health objective is to reduce maternal morbidity due to pregnancy and childbirth by 50%. They suggested that one of the strategic thrusts is the promotion of a healthy reproductive health life style by process of providing appropriate knowledge to bring about behavioral change and improve participation in the use of reproductive health services.

Landry, Singh and Darroch (2000) and Fabio (2013) observed that family planning is an important aspect of reproductive health which helps every one (women, children, men, families, nations and the whole world) to experience positive physical and mental health. Specifically, it protects women from unwanted pregnancies, thereby saving them from high risk pregnancies or unsafe abortions. Also, Aucus (2003) said if all women could avoid high risk pregnancies, the number of maternal deaths could fall by one quarter. In the same vein, Neil (2010) observed that other benefits accruing from family planning methods include prevention from cancers, sexually transmitted diseases and Human Immune-Deficiency Virus (HIV) Acquired Immune Deficiency Syndrome (AIDs). Review of literature also shows that the advantages of proper family planning are enormous because there is high fertility with underdevelopment in most African developing countries.

Rieksey, Holstege and Faber (2001) noted that reproductive health education has been controversial in spite of the lifelong impact of reproductive decisions. Some feel this education should be provided privately. Others point to diseases, unwanted pregnancies and the right to be educated about health issues, and believe the most reliable way to ensure it happens is through the school system. Even though reproductive health education remains debated, comprehensive

programmes are part of the public school curriculum (Sanders, 1994; Landry et al, 2000 and Martensoneyer 2000).

Arcus, (2003) reported that the history of reproductive health is long. It began in America as "morals education" in 1890s. About 23 years later, Chicago became the first city to introduce it into the public high schools. The United States public health service advocated for its inclusion in all public schools in 1940, but it was not until 1955 that the National Education Association and the American Medical Association agreed to publish informational pamphlets for teachers to use. During the 1960s, conservative groups began the fight to eliminate reproductive health education from the schools. But in 1986, the rising rates of AIDs and HIV prompted Surgeon General C. Everrett Koop to call for comprehensive AIDs and reproductive education beginning as early as third grade.

Bredfort (2001) earlier recorded that since the 1980s, reproductive health education has been taught in the public schools under the umbrella of "family life education". Human reproduction and contraception are taught but the curriculum includes discussion about risky behaviors and responsible decision making, mental health, relationships, teen pregnancy, parenting and issues of self-esteem. Jaromay (2008) and Roberto, (2008) in separate submissions observed that for the school children especially adolescents to cope with their developmental tasks and school problems successfully, they need adequate information about their reproductive health which the school social workers can provide. Hence the major trust of this paper centers upon how the school children (adolescents) can be helped by the school social workers to maintain positive reproductive health while in school and after leaving the school.

Adesokan (2009) observed that medical clinics that specialize in reproductive healthcare offer education for men and women that cover the range of health issues related to the human reproductive system. They teach the basics about pregnancy, sexually transmitted diseases (STDs) and urinary tract infections. They also provide information about cancers of the reproductive system, encourage cancer screening and explain how tests are done and what the results mean.

WHO (1995) affirmed that several issues in health needs to be addressed to be able to address or deal with reproductive health issues. These are: reduction in fertility rate, reduction in maternal mortality and morbidity, reduction in STD including HIV/AIDs and overall improvement in the quality of women. Premised on this, Adesokan (2009) reported that reproductive health has been promoted as a way to address a range of women health needs as well as improve the quality of services provided to current family planning users. It is widely believed that reproductive health knowledge helps to reduce ill health and premature deaths. In the same vein, Jaromay (2008) observed that reproductive health care is considered a worthy investment in its own right. Although, issues of reproductive health and sexuality involve men and women, women face more health risks than men. Further, Neil (2010) found out that about one-third of the total disease burden (ill health and premature deaths) that women face is linked to pregnancy, childbirth, abortion, HIV and other health disorders. It is imperative therefore, to note that women are more susceptible to STDs and HIV and can transmit these diseases to their unborn children.

Martensmeyer and Fine (2000) also observed that though reproductive health education is often associated only with birth control, it is important to note that it includes relationships and communication. Reproductive health educators meet with couples to teach them about family planning, their readiness to be parents, issues important to parenting and their contraceptive options. In like manner, Jaromey (2008) affirmed that educators work with teens to ensure they have accurate information and to discuss healthy relationships and safe dating. Reproductive health educators frequently help teens to become more aware of reproductive health

issues and to simply talk about difficult subjects.

Dudgeona and Inhorn (2004) said education about contraception begins with teaching about anatomy and physiology to provide an understanding of how each birth control method works. Therefore, educators should discuss the types of birth control and their effectiveness, as well as lifestyle issues that impact an individual's ability and willingness to use contraception. They further explained that because most modern contraceptive methods are designed for use by women and because most programmes assume that women are primarily responsible for family planning, women have been the primary subjects of contraceptive and family planning research. In the same vein, social science research associated with family planning has focused on predicting contraceptive use or non-use.

In another report, Ladry, Singh and Darroch (2000) affirmed that the ability to plan childbearing may be examined separately for its effects on a woman's health, the health of her children and the exercise of her economic, social and political rights. The women studies project conceptual framework (1993) also takes into account the larger context of social cultural, economic and other factors associated with the quality of women's lives as defined by women themselves. Also, Bredehoft (2001) asserted that understanding both the conceptual of gender and the roles of women are important contraception matters. While sex is a biological distinction, gender is defined as the socially constructed roles ascribed to males and females. This means that from birth, males and females are reared to occupy different social positions having different rights and obligations.

Roberto (2008) reported that countries are increasingly moving beyond family planning to a more encompassing view of the role of reproductive health in women's lives thus the framework includes use of other reproductive health services as another dimension that may affect contraceptive use and childbearing experience. Reproductive health services will vary by country but might include sexually transmitted disease (STD) diagnosis and treatment, general gynecological care, infertility counseling and treatment, maternal health services and abortion services among others. Tremanye and Hawkins (2001) also confirmed that reproductive health services can be obtained through the family planning programme or through a different programme such as an STD diagnosis and treatment center. The availability of general primary care for women or STD diagnosis and treatment may influence how a woman experiences family planning.

In the same vein, McNicoll, Bulatoo and Castreline (2000) found out that the use of contraception has a direct impact on a woman's childbearing experience, pregnancy and childbearing are pivotal concepts in the conceptual framework. They further asserted that along with the number of births or live children, a woman's fertility variables also may include her ability to space, delay or limit children, as well as her experience with infertility, child loss or planned or unplanned childlessness.

Dixon (1993) argued that preventing unwanted pregnancy is a top priority for reproductive health educators. According to the Centre for Disease Control and Prevention (2010), 41.9 out of every 1,000 teen aged 15 to 19 became pregnant in 2006, and about 2/3 were under the age of 18. Considering the social and economic costs of teen pregnancy – teenage moms are more likely to drop out of high school and be single parents; their children are more likely to drop out and have medical or behavioral problems. Bredehoft (2001) said all educators should focus on reducing the rate of teen pregnancy. Arcus, (2003) supported the aforesaid that Social workers as counselors, educators and community helper have a lot of responsibility to perform especially on the teenagers and teen pregnancy.

Family life education is that aspect of health education which prepares the child, adolescent or young adults to become responsible members of their society. Shira (2013) confirmed that it helps the individual to understand his development biologically, psychologically and socially to full maturity as a man or woman. It has to do with issues like the family's home environment, family relations, family budget and expenditure and so on. Laura, Froyen, Ryon, Andrian and Hope (2013) explained that sex education include human sexuality, adolescent problems, premarital sex and its consequences, menstruation, reproduction and relationships among others. They further said that the purpose of family life education is to strengthen and enrich individual and family wellbeing. The major objective of family life education therefore is for individuals to gain insight into one's self and others; to acquire knowledge human development and behavior in the family setting over life course.

Other objectives include: understanding marital and family patterns and processes, acquiring interpersonal skills for present and future family roles and to build strengths in individuals and families. It is assumed that, if these and other similar objectives are met through family life education, then families will be better able to deal with or prevent problems. In the same vein, families will be empowered to live their family lives in ways that are both personally satisfying and socially responsible for their family roles rather than to repair family dysfunction.

Laura, et al (2013) further asserted that there is an underlying assumption of family life education. It is relevant to individuals of all ages and to all families whatever their structure, stage of their life course, or special circumstances. These include issues such as getting married, becoming a parent, or the death of a parent. Other programmes are non-normative and include parenting children with special needs and prevention of elder abuse among others. Arcus (2003) reiterated that, all family members' needs family life education. The children need to be learned on: developing a sense of self, knowing what is right from wrong, learning about family roles and responsibilities, making and keeping friends, respecting similarities and differences in individuals and families and learning to make choices. Children of the same age or developmental stage are taught to the same things regardless of their particular family situations. Sexuality education is a controversial area in family life education especially at the primary school level. Many adults however believe that sexuality education is a family rather than a school responsibility. Advocates for the youths (1999) and Shira (2013) found out that, 93% of adults surveyed supported sexuality education for adolescents but fewer than half supported sexuality education in the elementary schools.

Family life education for adolescents, therefore, addresses two important kinds of needs. First, needs associated with changing physical, sexual, cognitive, social and emotional development. Second, their anticipatory or future family related needs to help prepare them for future adult responsibilities in marriage and parenting. Hennon and Arcus (2001) earlier affirmed that, important family life content for the adolescents includes: understanding oneself and others, building self-esteem, making choices about sexuality; forming, maintaining and ending relationships, taking responsibility for ones actions, understanding family roles and responsibilities and improving communication skills. Roberto (2008) raised one important issue that family life education is more complex. Premised on this assertion, adults must not only meet their own needs for family living but may also bear responsibility for the family socializations than to age or developmental level. That is, getting married or becoming parents is more important than the age at which these transitions occur. Premised on the aforesaid, it is imperative to note that, there is the need for all and sundry to have in-depth knowledge about family life education irrespective of age or gender.

In the same vein, Shira (2013) further affirmed that marriage education for adults has been a focus of family life education

since the earliest programmes in United States and Great Britain. Premarital couples are supposed to be given the opportunity to gain knowledge about family life and discuss critical issues and tasks of marriages, to acquire behavioral skills and problem-solving strategies to enhance their relationships, evaluate relationships including romanticism, untested assumptions and or unrealistic expectations. Furthermore, Roberto (2008) and Elizabeth (2008) in separate submissions said premarital programmes appear to be effective in meeting at least some of their goals, but they may be equally effective for all participants. Therefore, the social worker needs to work harder during counseling on marriage preparations for young adult couples. To remain healthy and maintain good reproductive health while in school, after leaving school and when getting married, the adolescent youths in upper primary and secondary schools need adequate education on family life and reproductive health. It is against this background that the major trust of this paper is cantered upon.

Implications of Reproductive Health and Family Life Education for the school Social Workers

Reproductive health and family life education have many useful implications for the school social workers, not only in Nigeria, but in other parts of the world. Such implications are:

i. Provision of adequate information on reproductive health

The concept of communication in reproductive health is to create awareness and impact on the lives of people. The success of any reproductive health service rests on communication process between the school social workers, individual students, family members and the community. On this premise, Schulr, Hashemi and Hassan (1996) and Laura et al (2013) in separate submissions postulated that it is imperative that the school social worker discharges his duty by educating and creating awareness about reproductive health among youth in schools which goes a long way to impact on the lives of people especially the in-school child. Also, Tremanye (2001) and Adesokan (2009) separately submitted that, Communication is a process and it can change overtime. It is a two way process of information exchange between two or more people in an attempt by one individual to persuade or change the behaviour of the other.

In this regard, Jaromay (2008) suggested that, the school social workers should provide adequate information on heterosexual behaviors to youths in secondary schools and give them health education or talks on personal hygiene, nutrition and antenatal care and other reproductive health matters. They should also advice them to avoid multiple sexual partners and its health implications. The school social worker should also motivate them through knowledge, idea or incentive which inspires them to achieve positive reproductive health while in school or after leaving school. While counseling the school children, the health care provider (school social worker) should give them adequate information which enables an informed decision about their health, for example counseling on HIV/AIDs (Ojedokun, 2004).

ii. Advocacy Role

An advocacy campaign is a set of targeted actions in support of a cause or issue. It is a set of actions taken by the school social worker to build consensus, gain support or create a favorable environment for introducing or changing specific strategies, programmes or policies. Adesina, (2004) defined advocacy as an active, directive role in which the social worker advocates for a client or for citizen's group. Therefore, the social worker should play advocacy role and provide leadership for collecting information for arguing the correctness of client's need and request for reproductive health services. The objective of social work advocacy role is not for ridicule or to censure a particular institution but to modify or change one or more of its

service policies. It is therefore, necessary to note that, the advocate is a partisan who is exclusively serving the interests of a client or a citizens' group. The school social workers must act as advocates to ensure that the rights of the school children are secured and that their needs are best served.

iii. Community Mobilization

The community is where the school social workers try to help the people to live healthily in their own environment. The community beliefs and practices influence health decisions about health. Community mobilization means to encourage, influence and arouse interest of the people to actively involve them in finding solutions to their problems. It is imperative therefore that, the social worker should mobilize the community to make informed decisions on reproductive health issues and family life matters. It suffice to say that the school social workers help in early identification of problems such as reproductive health needs, problems, solutions and utilization of family planning services. In the same vein, Mc Nicoll, Bulato and Casterline (2002) observed that, the mobilization role of the social worker extends further to embrace: identification of at-risk groups individuals by the community; adaptation of positive reproductive health behaviors in the community; greater flexibility in implementing reproductive health activities utilization of community social networks, such as women groups, village committees, religious leaders to promote reproductive health, collaboration and cooperation with other health workers in planning implementation and evaluation of reproductive health activities and programmes

iv. Health Education

Health education is a strategy of passing information across to the target audience with a view to influence a change in behavioral pattern. In view of this, health education on reproductive health and services is a strategy for reaching the individuals, groups, families, communities etc with health messages that will positively effect a change in their perception of reproductive health and family life. Ojedokun (2004) said Health education may be formal or informal, methods may include: talks, group discussions, lecture, role play, playlets, film-shows, dramas and demonstrations/return demonstrations. Means of communication during health education on reproductive health and family life include: verbal communication public address system, mass media, music printed materials and projectors. It is in this regard that Moronkola and Ojedokun (2002) wrote that some reproductive health issues requiring health education include: sexually transmitted diseases STDs including HIV/AIDs.

To help the school children develop positive attitude toward their reproductive health, the school social workers should give them adequate education or knowledge on antenatal care, natal and post-natal conditions, reproductive tract cancers, breast cancer, cervical cancer, prostate cancer and; unsafe abortion, family planning and prevention of mother-to-child transmission of HIV infections. Also, they should give them health education on reproductive health and family life which may include; diet and nutrition in pregnancy, immunization, personal hygiene, post-natal exercises, exclusive breastfeeding, anemia prevention in pregnancy, prevention of infection, andropausal and menopausal syndrome and infertility among others (Adesokan, 2004, Moronkola and Ojedokun, 2002). The school social workers also help in the development of specialized clinics and programmes for provide genetic counseling, abortion services, family planning services to people living with HIV/AIDs (PLWHIV).

v. Community Outreach and Counseling

Adesokan (2009) suggested that major clients for community outreach must include women both young and old and men with reproductive health problems for example sexual dysfunction, STDs and other sexual problems. Also, people who influence health related and reproductive health behavior are included in community

outreach – husbands, family, parent, mother and father in law among others. Community outreach also focus on clients to come to the clinics in their own natural situation and environment, therefore the social worker must see the clients as a part of a whole community. Philip, Placide, James, Philip, Alinson, Emmanuel, Selina and Patricia (2013) also postulated that there is the need to move into the community to learn how they could assist the people to find solution to their immediate needs and concern. Other issues that need community outreach include community attitudes, beliefs and taboos pertinent to child bearing; safe motherhood, prevention of maternal mortality, maternal and child health care, healthy pregnancy and child delivery and prevention of still birth from a particular geographical area.

It is imperative therefore, to note that counseling clients in reproductive health is a demanding role of the social worker. It involves face to face interaction in which the social workers give adequate information that enables the counselee make informed decision about his/her health. Effective counseling empowers and motivates a client. Also, counseling educates by providing specific information that states the facts objectively. Praise and encouragement involves speaking to a client using words that motivates and assures clients. It is imperative to note that praise and encouragement help build a client's confidence and reinforce desired behavior. In the same vein, Lekew, Reda, Tamene, Benedictand Deribe (2013) affirmed that, the client has rights in reproductive health services. Such rights include rights to: information, access, choice, safety, privacy, confidentiality, continuity and opinion. The social workers provide counseling services to special groups especially those that need family planning services and encourage voluntary acceptance, freedom of choice, informed decision and adoption of a family planning method. Philip et al (2013) further said, menopausal women, andropausal men, adolescent, people who have suffered one form of sexual violence or the other, are groups needing reproductive health care counseling. The role of the social worker therefore could not be overemphasized. Hence, they are essential tools in reproductive health and family life education.

Summary and Conclusion

Reproductive health and family life education is not for women alone, it affects both men and women alike. There is the need for proper dissemination of information on matters related to family planning, child spacing and child bearing including sexually transmitted diseases (STD) and HIV/AIDs. Efforts should also be geared towards reducing maternal morbidity and mortality as a result of childbearing. Child spacing, antenatal, postnatal care should also be encouraged. Premised on the foregoing, it is concluded that the social workers have enormous roles to play in reproductive health and family life education, especially in community counseling and health education. Also family planning should be encouraged to prevent maternal deaths and sexuality education should be intensified among young and old, male and female to prevent the spread of sexually transmitted diseases (STD) including HIV/AIDs. It can therefore be concluded that, if the school social workers give adequate information or proper education on how to attain positive reproductive health to the numerous youths in schools, many of them will be prevented from unhealthy sexual behaviors, infections, teenage pregnancy, unsafe abortions, and untimely deaths.

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