Comprehensive
Reproductive Health and Family Planning
Training Curriculum

MODULE 16: REPRODUCTIVE HEALTH SERVICES FOR ADOLESCENTS

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NOTES TO THE TRAINER

PURPOSE

This training manual is part of the Comprehensive Reproductive Health and Family Planning Training Curriculum for service providers. It is designed to prepare participants to provide quality reproductive health services to adolescents. It is to be used to train physicians, nurses, counselors, and midwives. Parts of the module may be adapted for use with community-based workers or auxiliary workers.

All of the modules in the curriculum are designed to actively involve participants in the learning process. Sessions include simulation skills practice; discussions; case studies; role plays; and using objective knowledge, attitude, and skills checklists.

DESIGN

The comprehensive training curriculum consists of 16 modules:

1. Introduction/Overview
2. Infection Prevention
3. Counseling
4. Combined Oral Contraceptives and Progestin-only Pills
5. Emergency Contraceptive Pills
6. DMPA Injectable Contraceptives
7. Intrauterine Devices
8. Breastfeeding and Lactational Amenorrhea Method
9. Condoms and Spermicides
10. Voluntary Surgical Contraception
11. MVA for Treatment of Incomplete Abortion
12. Reproductive Tract Infections
13. Postpartum/Postabortion Contraception
14. Training of Trainers
15. Quality of Care
16. Reproductive Health Services for Adolescents

Included in each module is a set of knowledge assessment questions, Competency-Based Training (CBT) skills checklists, trainer resources, participant materials, training evaluation tools, and a bibliography.

PARTICIPANT SELECTION

This module is meant for mid-level providers of family planning services (nurses, nurse midwives, nurse assistants, physicians, counselors, and others) who already have some skills and training in reproductive health but need training on how to provide youth-friendly services. Clinic and program managers also need to have a clear idea of the goals, challenges, and resource requirements of a youth-friendly program so that they will be supportive and appreciative of provider efforts. For this reason, inclusion of a member of management staff, either in the training itself or in a separate sensitization, is highly

desirable. All clinic staff, including the receptionist and other auxiliary personnel, should be sensitized to the needs of adolescent clients who come to the facility for reproductive health services. This can be accomplished by giving a short course to these staff using Unit 4, Communicating with the Adolescent Client, *Specific Objective 1*.

USING THE MODULES

- The modules provide flexibility in planning, conducting, and evaluating the training course.
- The curriculum allows trainers to formulate their own training schedule based on results from the training needs assessments.
- The modules can be adapted for different cultures by reviewing case studies and using only the ones that are appropriate. Additional case studies can be devised based on local statistics, cultural practices, social traditions, and local health issues.
- The modules can be used independently of each other.
- The modules can also be lengthened or shortened depending on the level of training and expertise of the participants.
- In order to foster changes in behavior, learning experiences have to be in the areas of knowledge, attitudes, and skills. In each module, general and specific objectives are presented in terms of achievable changes in these three areas.
- Training references and resource materials for trainers and participants are identified.
- This module is divided into two volumes, the *Trainer's Manual* and the *Participant's Manual*.
- The *Trainer's Manual* contains the "Training Guide" and the "Appendix."
    - ♦ The "Training Guide" presents the information in two columns.
        - – The first column, "Content," contains the necessary technical information.
        - – The second column, "Training/Learning Methods," contains the training methodology (lecture, role-play, discussion, etc.) to be used and the time required to complete each activity.
    - ♦ The "Appendix" contains:
        - – "Transparencies."
        - – "Trainer's Tools" including answer keys to case studies, learning exercises, the pre- and post-tests, and Competency-Based Training (CBT) skills checklists.
        - – "List of Acronyms."

- The *Participant's Manual* contains:

  - "Participant Handouts" for group exercises, case studies, and pre- and post-tests, as well as a participant evaluation form. Any handouts that are to be used in class are found in this section.

  - "Content" drawn from the *Trainer's Manual* that can be used as reference material by the participant. The material should be photocopied and available by the time training begins. The materials may be given out at the end of each specific learning objective or all together at the end of the course.

GUIDE TO SYMBOLS

References to participant handouts, transparencies, and trainer's tools occur as both text and symbols in the "training/learning methods" section. The symbols have number designations that refer to specific objectives and the sequence within the specific objectives. Handouts, transparencies, and trainer's tools are arranged in chronological order and correspond to the numbered symbols in the "training/learning methods" section.

Participant Handout

Transparency

Trainer's Tool

INFORMED CHOICE

Informed choice is allowing a client to freely make a thought-out decision about family planning based on accurate, useful information. Counseling provides information to help the client make informed choices.

"Informed" means that:

- **Clients have the clear, accurate, and specific information that they need to make their own reproductive health choices.**

- **Clients understand their own needs.** They have thought about their own situation, and with the help of service providers, they decide on appropriate treatment, procedures, or methods of family planning according to their own needs.

"Choice" means that:

- **Clients have a range of family planning methods to choose from.**

- **Clients have a choice whether and how they want to be treated.**

- **Clients make their own decisions.** Clients always select from the available procedures and methods for which they are medically eligible.

Adapted from: Hatcher, R.A., W. Rinehart, R. Blackburn, and J.S. Geller. 1997. *The essentials of contraceptive technology*. Baltimore, MD: Johns Hopkins School of Public Health, Population Information Program.

CLIENT RIGHTS DURING FACILITY ASSESSMENT

In order to present a consistent philosophy of client rights, the following information should be shared with participants in preparation for their clinical assessment experiences. The rights of the client to privacy and confidentiality should be considered at all times during a clinical assessment. When a client is undergoing a physical examination, it should be carried out in an environment in which her/his right to bodily privacy is respected. When receiving counseling, undergoing a physical examination, or receiving surgical contraceptive services, the client should be informed about the role of each individual inside the room (e.g. service provider, individuals undergoing training, supervisors, instructors, researchers, etc.).

The client's permission must be obtained before having a participant observe any services. The client should understand that s/he has the right to refuse being observed or interviewed by a participant. Furthermore, a client's care should not be rescheduled or denied if s/he does not permit a participant to be present.

It can be difficult to maintain strict client confidentiality in a training situation when specific cases are used in learning exercises such as case studies and clinical conferences. Such discussions always should take place in a private area, out of hearing of other staff and clients, and should be conducted without reference to the client by name.

Source: Sullivan, R., R. Magarick, G. Bergthold, A. Blouse, and N. McIntosh. 1995. *Clinical training skills for reproductive health professionals.* Baltimore: JHPIEGO Corporation.

DO'S AND DON'TS OF TRAINING

The following "do's and don'ts" should ALWAYS be kept in mind by the trainer during any learning session.

DO'S

- **Do** maintain good eye contact
- **Do** prepare in advance
- **Do** involve participants
- **Do** use visual aids
- **Do** speak clearly
- **Do** speak loud enough
- **Do** encourage questions
- **Do** recap at the end of each session
- **Do** bridge one topic to the next
- **Do** encourage participation
- **Do** write clearly and boldly
- **Do** summarize
- **Do** use logical sequencing of topics
- **Do** use good time management
- **Do** K.I.S. (Keep It Simple)
- **Do** give feedback
- **Do** position visuals so everyone can see them
- **Do** avoid distracting mannerisms and distractions in the room
- **Do** be aware of the participants' body language
- **Do** keep the group focused on the task
- **Do** provide clear instructions
- **Do** check to see if your instructions are understood
- **Do** evaluate as you go
- **Do** be patient

DON'TS

- **Don't** talk to the flip chart
- **Don't** block the visual aids
- **Don't** stand in one spot — move around the room
- **Don't** ignore the participants' comments and feedback (verbal and non-verbal)
- **Don't** read from the curriculum
- **Don't** shout at the participants

INTRODUCTION

RESOURCE REQUIREMENTS:

- Markers
- Flipchart
- Polaroid camera (if doing the optional exercise)
- Tape
- Pens/pencils

TIME REQUIRED: 1 hour, 45 minutes

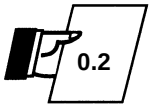
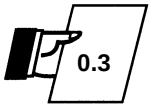
WORK FOR TRAINERS TO DO IN ADVANCE:

- Prepare Participant Handouts 0.1, 0.2, 0.3, 0.4, and 0.5.

Introduction

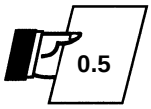
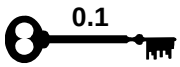
CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
Introducing Trainers and Participants	**INTRODUCTION OF PARTICIPANTS (20 MIN.)** The trainer(s) should: • Greet participants (Px) and introduce yourself. • Ask all Px to give their names. • Divide Px into pairs. • Ask Px to spend 10 minutes interviewing each other (5 minutes for each interview). Include the trainers in the exercise and pair them with Px. Px may ask any questions that will help them be able to introduce their partner to the rest of the group. • At the end of 10 minutes, ask each Px to introduce their partner to the rest of the group.
DEFINE PARTICIPANTS' EXPECTATIONS OF THE COURSE 1. What do you hope to accomplish during this course? 2. Do you anticipate any difficulties during the course? 3. While you attend this training, what will you be missing at home? For example, do you have a young baby or a sick family member? 4. While you attend the training, what will you be missing at work? Is there someone to cover your position, or will certain work not be completed? 5. How do you think this training will help	**EXPECTATIONS (30 MIN.)** The trainer should: • Ask the group to pair off, so that they have a different partner for this exercise. • Distribute *Px Handout 0.1: Defining Participants' Expectations* to each Px.  • Ask each pair to spend 10 minutes interviewing each other like a journalist to answer the five questions.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
you at work?	• Have each person present her/his partner's expectations to the group. • Make note of all of the expectations so that you can refer to them throughout the course. **GALLERY OF EXPERTS (OPTIONAL)** **Note:** *The "Gallery of Experts" should be used as an alternative, not as an addition, to the interview conducted in the "Introduction of Participants" and the "Expectations" exercise.* The trainer(s) should: • Give each Px a sheet of flipchart. • Ask her/him to write down: – Her/his name. – Her/his profession and place of work. – Her/his greatest skill when it comes to adolescent reproductive health. – What s/he wants to learn about adolescent reproductive health. – In the future, the one thing s/he would like people to say about her/his work with adolescents. – What her/his biggest concern was when s/he was an adolescent. • With a polaroid camera, take a photo of each Px. • Have the Px attach her/his photo to her/his sheet of flipchart.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
	• When Px are done, tape the pieces of flipchart around the room creating a gallery of experts. • Have each Px go around the room and read her/his flipchart to the larger group.
SUGGESTIONS FOR EFFECTIVE PARTICIPATION **DO:** • Listen. • Ask a question when you have one. • Feel free to share an illustration or example. • Request an example to clarify a point. • Search for ways in which you can apply a general principle or idea to your work. • Think of ways you can pass on ideas to your subordinates and co-workers. • Be skeptical–don't automatically accept everything you hear. • Participate in the discussion. • Respect the opinion of others. **DON'T:** • Try to develop an extreme problem just to prove the trainer doesn't have all the answers. (The trainer doesn't.) • Close your mind by saying, "This is all fine in theory, but..." • Assume that all topics covered will be	**TRAINER PRESENTATION (10 MIN.)** The trainer should: • Ask Px for suggestions for effective participation. • Give Px additional suggestions. • Ask a Px to record the suggestions of the group. • Distribute *Px Handout 0.2: Suggestions for Effective Feedback*.  **REVIEW OF TRAINING OBJECTIVES AND SCHEDULE (5 MIN.)** The trainer should: • Review the unit training objectives and specific learning objectives for each unit with Px. • Distribute *Px Handout 0.3: Training Schedule*. 

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
equally relevant to your needs. • Take extensive notes; the handouts will satisfy most of your needs. • Sleep during class time. • Discuss personal problems. • Dominate the discussion. • Interrupt. **WHERE ARE WE?** Starting each day with "Where Are We?" is our opportunity to review the previous days' material, especially the key points of each session. Each day one participant will be assigned to conduct the exercise. This person should take some time to write down the key points from the day before. The participant who is assigned should briefly present these key points and then ask participants for any additions. **REFLECTIONS** After a full day of activities, we need to take time to look over what we have done and examine what it means to us individually. The "Reflections" activity is an opportunity for the trainers and Px to share feedback on the training activities and to identify areas that need reinforcement or further discussion. Therefore, each day, selected Px (housekeeping team) will solicit feedback from the other Px during breaks or lunch and then at the end of the day will meet with the trainers to discuss how the day of	**TRAINER PRESENTATION (10 MIN.)** The trainer should: • Explain that "Where Are We?" requires the active cooperation of the Px, so be certain to make their role clear. • Explain that the exercise "Where Are We?" will be a regular feature at the beginning of each day during the training session. • This activity should be used to review previous days' material, especially the key points of each session. • Problems identified during the "Where Are We?" session should be resolved before continuing with the day's work (whenever possible), since unresolved issues may hinder the learning process. • Distribute *Px Handout 0.4: Where Are We and Reflections*. 

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
training went. For the first session of "Reflections," the housekeeping team should ask other Px the following questions and share responses with the trainers: • What did I like about today and why? • What did I not like about today and why? • What did I learn and experience today that I will be able to use? The housekeeping team is free to vary the exercise to make it more interesting and less repetitive.	• Explain that the "Reflections" activity will be performed at the end of the day's activities. • Be sure to close each day's activities with a session of "Reflections" on the day. • Make a note of the Px and trainers' feedback. • Attempt to address ideas and concerns during the discussion and during the following days' lesson plans. **Housekeeping Teams** • Organize the Px into groups. • Explain that each day these groups will be responsible for certain activities related to the training. The groups will be responsible for conducting both the "Reflections" and "Where Are We" exercises. They should also be responsible for getting Px to return on time after breaks and for conducting energizing exercises after breaks or lunch. Other responsibilities may be included, such as providing feedback to the trainers at the end of the day. **PRE-TEST (30 MIN.)** The trainer should: • Explain to Px that a test will be given before and after the training. • Explain that the purpose of the test is to evaluate the training. The test before training helps the trainer focus the training on the right topics. The test after training is a reflection on how

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
	good the training was based on whether the Px improved their knowledge of the subject matter. • Distribute the pre-test (*Px Handout 0.5)*.  • Allow Px 30 minutes to complete the pre-test. • Using the *Answer Key (Trainer's Tool 0.1)*, review Px answers so that you know what areas were the most difficult for Px. Be sure to focus on these areas during training. 

UNIT 1:
NATURE OF ADOLESCENCE

INTRODUCTION:

Adolescence refers to the period of a young person's life between the ages of 10 and 19. During this transition to adulthood, adolescents develop biologically and psychologically and move towards independence. Because adolescents encounter health risks and often exhibit risk-taking and experimental behavior, counselors and care providers need to understand the stages of adolescence and to be able to help adolescents attain a desired state of general and reproductive health. It is also important for service providers to acknowledge the reproductive rights of adolescents as a key foundation for service provision.

UNIT TRAINING OBJECTIVE:

To help providers understand the importance of adolescent reproductive health, the stages of adolescent development, the desired state of general and reproductive health, and the reproductive rights of adolescents.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Explain the rationale for undergoing special training on adolescent reproductive health.
2. Identify biological and psychosocial changes that occur during adolescence.
3. Discuss desirable health status for adolescents.
4. Identify the reproductive rights of adolescents.

TRAINING/LEARNING METHODOLOGY:

- Trainer presentation
- Group work
- Discussion
- Brainstorming

MAJOR REFERENCES AND TRAINING MATERIALS:

- Family Care International. 2000. *Sexual and reproductive health.* New York: Family Care International.
- IPPF. 1991. *Rights of the client*. London: IPPF.
- James-Traore, T.A. 2000 (draft). *Developmentally-based interventions and strategies: a tool for promoting health and reducing risk among adolescents.* Washington, DC: FOCUS on Young Adults/Pathfinder International.
- Reproductive Health Materials Partnership. n.d. *Your sexual and reproductive health rights.* Johannesburg: Reproductive Health Materials Partnership.
- Vereau, D. 1998. *Improving interpersonal communications skills for counseling adolescents on sexual and reproductive health.* Lima, Peru: Pathfinder International.
- WHO/UNFPA/UNICEF. 1999. Programming for adolescent health and development. *WHO Technical Report Series.* 886.

RESOURCE REQUIREMENTS:

- Markers
- Flipchart
- Overhead projector
- Screen

EVALUATION METHODS:

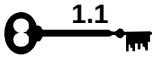
- Pre- and post-test
- Reflections
- Where Are We?
- Participant reaction form

TIME REQUIRED: 2 hour, 45 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

- Prepare Transparencies: 1.1, 1.2, and 1.3
- Prepare Participant Handout 1.1.

Specific Objective #1: Explain the rationale for undergoing a special training for adolescent reproductive health

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
BARRIERS TO INFORMATION AND SERVICES FOR YOUTH • Lack of services: little access to family planning or services for treatment or prevention of STI/HIV • Lack of access to condoms • Provider, parent, teacher, and community attitudes about youth and sexuality • False beliefs that young people are not sexually active and that information will increase sexual activity • Lack of messages targeted to youth • Lack of providers trained to deal with youth • Policies, legislation, and protocols that restrict adolescents from accessing services and information	**SENSITIZATION EXERCISE: ADOLESCENT CLIENT'S EXPERIENCE (20 MIN.)** The trainer should: • Introduce the exercise by explaining that adolescents often face many barriers when trying to access ARH services and information. The following story represents a typical experience of an adolescent trying to access services. • Read the story found on *Trainer's Tool 1.1: Barriers to Information and Services for Youth*.  • The story should be told in three segments, reflecting three different visits to the local clinic. The segments show several obstacles at each visit that would not be necessary if quality services existed. • While telling the story, hold up the sign with the word "MOTIVATION" written in large bold letters. • Each time the client in the story experiences an obstacle to her seeking/receiving ARH services, tear a piece of the MOTIVATION sign, indicating that the client has lost some motivation to practice good RH. • At the end of the first visit, discard the first and largest sign, which should be mostly torn up by the end of that visit.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
	• Continue the story for the second visit with the second, smaller sign and use the smallest sign for the third visit. • Ask Px to identify obstacles that adolescents face when trying to access services. Supplement answers using the content on the left-hand side of the page.
WHY SHOULD THERE BE SPECIAL TRAINING FOR ADOLESCENT REPRODUCTIVE HEALTH CARE PROVISION? **Adolescents are different from adults.** • They have different needs because of their physical and psychological stages. • They have different cognitive abilities and skills, which requires different counseling approaches and more time. • They tend to be less well-informed and require more information. • Conflicts between cultural or parental expectations and adolescents' emerging values present serious challenges for young people. **Adolescence is a critical age for risk-taking.** • Adolescents are moving toward independence and tend to experiment and test limits, including practicing risky behaviors. • Using substances or drugs for the first time typically occurs during adolescence.	**BRAINSTORMING (10 MIN.)** The trainer should: • Ask Px to brainstorm why there should be a special training for adolescent reproductive health. • Fill in missing information from the content section on the left-hand side of the page.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Sexual experiences (not always voluntary) usually begin during adolescence. • Consequences of risky behaviors can have serious and long-term effects. **Adolescence is an opportune time for professional interventions.** • Adolescents are undergoing educational and guidance experiences in school, at home, and through religious institutions; health education can be part of these efforts. • Life-long health habits are established in adolescence. • Interventions can help adolescents make good decisions and take responsibility for their actions, often preventing serious negative consequences in the future. • There are many effective channels for reaching adolescents: schools, religious institutions, youth organizations, community and recreational activities, parental communication, peer education, the media, and health service facilities. **Special training allows providers to be more responsive to the needs of adolescents.** • Well-trained providers are able to better serve adolescents and deliver adolescent services in a more efficient and effective manner.	

Specific Objective #2: Identify biological and psychosocial changes that occur during adolescence

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
STAGES OF ADOLESCENT DEVELOPMENT **Early Adolescence (10-13)** • Onset of puberty and rapid growth • Impulsive, experimental behavior • Beginning to think abstractly • Adolescent's sphere of influence extends beyond her/his own family • Increasing concern with image and acceptance by peers **Middle Adolescence (14-16)** • Continues physical growth and development • Starts to challenge rules and test limits • Develops more analytical skills; greater awareness of behavioral consequences • Strongly influenced by peers, especially on image and social behavior • Increasing interest in sex; special relationships begin with opposite sex • Greater willingness to assess own beliefs and consider others **Late Adolescence (17-19)** • Reaches physical and sexual maturity	**TRAINER PRESENTATION (15 MIN.)** The trainer should: • Use *Transparency 1.1: Stages of Adolescent Development* to briefly explain the stages of adolescence (early, middle, late), stressing that timing varies according to culture and individual development.  ? Ask Px, how can culture and opportunities affect timing and attainment of adolescent characteristics? **GROUP WORK (30 MIN.)** The trainer should: • Divide Px into 2 groups: – Group 1: physical and sexual changes during adolescence. – Group 2: psychological and emotional changes during adolescence. • Ask both groups to discuss changes assigned to them and to list major changes on a flipchart.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Improved problem-solving abilities • Developing greater self-identification • Peer influence lessens • Reintegration into family • Intimate relationships more important than group relationships • Increased ability to make adult choices and assume adult responsibilities • Movement into vocational life phase	• Fill in any missing points through a brief review of the subject using *Transparency 1.2: Changes During Adolescence.* 

Specific Objective #3: Discuss desirable health status for adolescents

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
DESIRABLE ADOLESCENT HEALTH STATUS Young people between the ages of 10-19 who have survived the vulnerable period of childhood are generally healthy. The challenge for reproductive health care providers is to help young people achieve a desired state of reproductive health, which, according to the Cairo International Conference on Population and Development, "is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters related to the reproductive health system and to its functions and processes." Desirable health status includes: • Adequate height and weight for age. • Good nutrition. • Up-to-date with immunizations. • Free of disease and illness. • Emotional support from family/friends. • Ability to avoid substance abuse. • Ability to make an informed decision on sexual activity (whether to engage in sexual activity, with whom, when, what type, and how to protect oneself from pregnancy and STI/HIV) that is free of coercion. • Good self-image both in terms of physical appearance and personal character.	**DISCUSSION (20 MIN.)** The trainer should: • Write the Cairo ICPD statement found in the content section on the left-hand side of the page on the flipchart. • Ask Px to explain what the statement means. • Lead a discussion on the characteristics of a positive and healthy adolescent. ? Ask Px, how can adolescent health be improved in your community? • Fill in missing information from the content section on the left-hand side of the page.

Specific Objective #4: Identify the reproductive rights of adolescents

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
REPRODUCTIVE RIGHTS OF THE ADOLESCENT CLIENT A right is something that an individual or a population can legally and justly claim. For instance, individuals can claim equality within a population or such civil liberties as the right to vote. Reproductive rights are those rights specific to personal decision-making and behavior in the reproductive sphere, including access to reproductive health information, guidance from a trained professional, and RH services. In addition to rights established within individual countries, major international conventions have articulated reproductive rights, including those that are specific to adolescents. These policies provide the basis for the following adolescent rights: • The right to good reproductive health. • The right to decide freely and responsibly on all aspects of one's sexuality. • The right to information and education about sexual and reproductive health so that good decisions can be made about relationships and having children. • The right to own, control, and protect one's own body. • The right to be free of discrimination, coercion, and violence in one's sexual decisions and sexual life.	**LARGE GROUP DISCUSSION (20 MIN.)** The trainer should: • Introduce the concept of reproductive rights as specified in the content section on the left-hand side of the page. • Ask Px to identify reproductive rights that apply to adolescents and write answers on a flipchart. • Using *Transparency 1.3: International Policy Consensus on Adolescent Reproductive Rights* and the content on the left-hand side of the page, fill in any missing information.  • Ask Px the following questions: ? How are adolescent health services affected when providers believe clients have the same rights to services as adults? ? How are services affected when providers believe that adolescent clients have no rights?

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• The right to expect and demand equality, full consent, and mutual respect in sexual relationships. • The right to quality and affordable reproductive health care regardless of sex, creed, color, marital status, or location. This care includes: – Contraception information, counseling, and services. – Prenatal, postnatal, and delivery care. – Healthcare for infants. – Prevention and treatment of RTIs. – Legal, safe abortion services and management of abortion-related complications. – Prevention and treatment of infertility. – Emergency services. • The right to privacy and confidentiality when dealing with health workers and doctors. • The right to be treated with dignity, courtesy, attentiveness, and respect. • The right to express views on the services offered. • The right to gender equality and equity. • The right to receive reproductive health services for as long as needed. • The right to feel comfortable when receiving services.	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• The right to choose freely one's life/sexual partners. • The right to celibacy. • The right to refuse marriage. • The right to say no to sex within marriage. **Source:** IPPF. 1991. *Rights of the Client.* London: IPPF.	
OBSTACLES/BARRIERS THAT MIGHT PREVENT ADOLESCENT RIGHTS FROM BEING FULFILLED The following is only a partial list of obstacles/barriers that may prevent adolescent rights from being fulfilled: • Provider's personal views. • Heavy client load, lack of time. • Local laws, customs, or policies. • Religion. • Provider was not adequately trained. • No clinic guidelines exist to ensure adolescent rights are met. • Community pressure. • Family pressure. • Peer pressure. • RH services are not accessible to adolescents. • Hours of RH services for adolescents are inconvenient.	**GROUP WORK (45 MIN.)** The trainer should: • Divide Px into groups or pairs according to the area or clinic in which they work. • Provide each pair or group with *Px Handout 1.1: Adolescent Reproductive Rights.*  • Go around the room and assign each group or pair 2-3 **rights** listed on *Px Handout 1.1.* • Ask each pair or group first to identify the obstacles or barriers that might prevent each of the assigned rights from being fulfilled. • Ask Px to list specific steps they can take in their clinic to remove each barrier or obstacle. • Reconvene the larger group and ask each small group to present their list.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• There is no method for providing client feedback.	• Ask for additional contributions from members of the larger group. **UNIT SUMMARY (5 MIN.)** The trainer should: • Summarize the unit content. • Link content to the next session.

UNIT 2:
ADOLESCENT VULNERABILITES, RISK-TAKING BEHAVIORS, AND THEIR CONSEQUENCES

INTRODUCTION:

Understanding adolescent risk-taking behavior and young people's vulnerabilities enables providers and counselors to better serve youth. Some risk-taking behavior leads to serious life-long consequences, while other risk-taking results in injuries or poor decisions that can be corrected or forgiven. Providers need to discuss with young people the far-reaching outcomes of sexual risk-taking and to help them learn from their experiences.

UNIT TRAINING OBJECTIVE:

To help providers identify adolescent vulnerabilities and understand adolescent risk-taking behavior and its consequences in order to better serve adolescent clients and address their reproductive health needs.

SPECIFIC LEARNING OBJECTIVES:

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

1. Identify the vulnerabilities of adolescents.
2. Identify risk-taking behaviors of adolescents.
3. Discuss the consequences of risk-taking behaviors and vulnerabilities.

TRAINING/LEARNING METHODOLOGY:

- Trainer presentation
- Brainstorming

MAJOR REFERENCES AND TRAINING MATERIALS:

- Alan Guttmacher Institute. 1998. *Into a new world: Young women's sexual and reproductive lives*. New York: The Alan Guttmacher Institute.
- Family Health International. 1997. *Reproductive health of young adults: Contraception, pregnancy and sexually transmitted diseases*. Research Triangle Park, NC: Family Health International.

- McCauley, A.P., and C. Salter. 1995. Meeting the needs of young adults. *Population Reports*. Series J. (41).
- Senderowitz, J. 1995. Adolescent health: Reassessing the passage to adulthood. *World Bank Discussion Papers.* 272.
- Vereau, D. 1998. *Improving interpersonal communications skills for counseling adolescents on sexual and reproductive health.* Lima, Peru: Pathfinder International.
- WHO/UNFPA/UNICEF. 1999. Programming for adolescent health and development. *WHO Technical Report Series.* 886.

RESOURCE REQUIREMENTS:

- Markers
- Flipchart
- Overhead projector
- Screen

EVALUATION METHODS:

- Pre- and post-test
- Reflections
- Where Are We?
- Participant evaluation form
- Trainer observation and assessment of group work

TIME REQUIRED: 55 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

- Prepare Transparency 2.1.

Specific Objective #1: Identify the vulnerabilities of adolescents

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
VULNERABILITIES OF ADOLESCENTS Gender issues have a marked influence on the socio-economic vulnerabilities of adolescents, as well as on their emotional and physical health, particularly in traditional cultures. These vulnerabilities are outlined in the following text. **Physical Vulnerabilities** • Adolescence is a time of rapid growth and development, creating the need for a nutritious and adequate diet. • Adolescents often have poor eating habits. • Poor health in infancy and childhood, often resulting from impoverished conditions, can persist into adolescence and beyond. • Repeated and untreated infections and parasitic diseases, frequent diarrhea and respiratory diseases, malnutrition, defects, and disabilities can contribute to compromised physical and psychological development. • Some young women may have undergone female genital cutting, which can result in significant physical and/or emotional difficulties, especially concerning sexual and reproductive matters. **Emotional Vulnerabilities** • Mental health problems can increase during adolescence due to the hormonal and other physical changes of puberty, along with changes in adolescents' social environment.	**BRAINSTORMING (15 MIN.)** The trainer should: • Write on 3 pieces of flipchart the three areas of adolescent vulnerability (physical, emotional, and socioeconomic). • Ask Px to brainstorm the different types of physical, emotional, and socioeconomic vulnerabilities that are common among adolescents. • Using the content on the left-hand side of the page, fill in any missing information.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Adolescents often lack assertiveness and good communication skills, thereby rendering them unable to articulate their needs and withstand pressure or coercion from their peers or adults. • Adolescents may feel pressure to conform to stereotypical gender roles. • Young people are more vulnerable than adults to sexual, physical, and verbal abuse because they are less able to prevent or stop such manifestations of power. • Often there are unequal power dynamics between adolescents and adults since adults sometimes view adolescents as children. • Young people may lack the maturity to make good, rational decisions. **Socioeconomic Vulnerabilities** • During adolescence, young people's need for money often increases, yet they typically have little access to money or gainful employment. • Poverty and economic hardships can increase health risks owing to poor sanitation, lack of clean water, and the inability to afford health care and medications. • Disadvantaged young people are also at greater risk for substance abuse and may feel forced to resort to work in hazardous situations, including commercial sex work. • Young women also face gender discrimination that affects food allocation, access to health care, the	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
ability to negotiate safer sex, and opportunities for social and economic well-being. • Some young women marry very young to escape poverty, but as a result may find themselves in another difficult and challenging situation. • Many young people are also at risk because of diverse socioeconomic and political reasons. These especially vulnerable youth include street children, child laborers, the internally displaced or refugees, youth in war circumstances, young criminals, those orphaned because of AIDS and other circumstances, and other neglected and/or abandoned youth.	

Specific Objective #2: Identify risk-taking behaviors of adolescents

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
REASONS FOR ADOLESCENT RISK-TAKING BEHAVIOR • Major physical, cognitive, emotional, sexual, and social changes occur during adolescence that affect young people's behavior. • New social relationships, especially with peers, begin to gain greater importance as family influence decreases. • Curiosity, sexual maturity, a natural inclination toward experimentation, and peer pressure lead to risky behavior such as unprotected sex, substance use, reckless driving, and dangerous recreational activities. • A sense of omnipotence, feelings of invulnerability, and impulsiveness can lead to a lack of future planning and can enhance risk-taking, thereby compromising protective behavior. • Adolescents must attain social and economic maturity and autonomy in culturally specific ways during their second decade of life. This involves moving away from dependence on the family, both psychologically and emotionally. • In some cultures, young men are encouraged to take risks as a way of proving their masculinity.	**TRAINER PRESENTATION (15 MIN.)** The trainer should: • Present the content on the left-hand side of the page. • Emphasize that some risk-taking can have life-long consequences, especially sexual risk-taking, which can lead to unwanted pregnancy or STI/HIV. • Ask Px if there any questions or comments.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
TYPES OF RISK-TAKING BEHAVIOR AND ITS CONSEQUENCES • Impulsive decision-making resulting in dangerous situations. • Reckless behavior resulting in accidents and injuries. • Provoking, arguing, and testing limits with peers and adults, resulting in emotional and physical damages. • Experimentation with substances, resulting in short- and long-term consequences that include effects on most other risk-taking behavior (i.e. decision-making and sexual activity). • Unprotected sexual activity, resulting in immediate and long-term health, emotional, psychological, social, and economic consequences. **Important things to remember** • Risk-taking among adolescents varies with cultural factors, individual personality, needs, social influences and pressures, and available opportunities. • Adolescents tend to test their limits and underestimate the risks involved; this type of behavior is age-appropriate, but adults must help adolescents avoid serious consequences. **Source:** Vereau, D. 1998. *Improving interpersonal communications skills for counseling adolescents on sexual reproductive health*. Lima, Peru: Pathfinder International.	

Specific Objective #3: Discuss the consequences of risk-taking behaviors and vulnerabilities

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
ADOLESCENT HEALTH PROBLEMS • Some risk-taking results in injuries and poor decisions that can be mended or forgiven. Adults can help young people to learn from their experiences. • Other risk-taking results in very serious consequences, such as an unwanted pregnancy or HIV, that can have devastating and multi-layered repercussions. Providers should help young people understand the far-reaching consequences of sexual risk-taking. • In addition to risk-taking, the vulnerabilities discussed in SO #1 can also lead to a variety of health problems. **Nutritional Problems** • Undernourishment and overnourishment are increasing problems among youth. • Anemia, resulting from inadequate iron, is a significant problem for both adolescent boys and girls, but it can be more serious for girls because of blood loss during menstruation. More iron is also required during pregnancy. About 27% of adolescents are estimated to be anemic in developing countries. • Calcium deficiency is a nutritional problem in some countries. Rapid growth during adolescence requires an increased intake of calcium.	**BRAINSTORMING (20 MIN.)** The trainer should: • Ask Px to brainstorm possible health problems that disproportionately affect adolescents given the vulnerabilities and risk-taking behaviors that were discussed in SO #1 and #2. For example, as adolescent girls begin to menstruate, they are more prone to anemia. • List the problems on a flipchart. • Using *Transparency 2.1: Health Problems of Adolescents,* fill in any missing information.  **UNIT SUMMARY (5 MIN.)** The trainer should: • Summarize the unit content. • Link content to the next session.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Vitamin A deficiency is another nutritional problem in some countries. **Injuries** • Unintentional injury is the leading cause of death among young people; interpersonal violence is increasing. **Psychological Problems** • Mood fluctuations, transient depressive feelings, and anxiety are most common, but are usually mild and episodic. • Increased depression, sometimes as serious as thinking of or attempting suicide, disproportionately affects adolescents. **Substance Misuse** • Illicit drug use is becoming more widespread; tobacco and alcohol use patterns are established in youth and young adulthood. **Reproductive Health Problems** • Maturation issues: Menstrual irregularities and hormonal imbalances often accompany the menses in the early years before regular menstruation is established. In addition, boys experience premature ejaculation. • Unwanted pregnancy: High proportions of pregnancies among 15 to 19-year-old women are untimely or unwanted. For example, 81% of pregnancies among 15-19 year olds are untimely or wanted in Botswana, 32% in the Philippines, and 57% in Peru.	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Too-early childbearing: Worldwide, more than 10% of all births are to women 15-19, and in the least developed countries, teen pregnancies account for 17% of all births. In Zambia, for example, 61% of current 20-24 year olds had a child by age 20; in Bangladesh, 66%; and in Guatemala, 50%. • Unsafe abortion: Most of the estimated 1–4.4 million abortions among adolescents per year are unsafe because they are performed illegally, under hazardous conditions, and/or by unskilled practitioners. • Compared to older women, young women experience increased complications from pregnancy, childbirth, and unsafe abortion. • Young people face increased health risks from sexual activity, including STIs and HIV. Each year, more than one-half of all new HIV infections occur in young people under 25, and more than two-thirds of all reported STIs occur among this group in developing countries. **Source:** Vereau, D. 1998. *Improving interpersonal communications skills for counseling adolescents on sexual reproductive health*. Lima, Peru: Pathfinder International.	

UNIT 3:
ADOLESCENT BEHAVIOR AND LIFE SKILLS

INTRODUCTION:

Social relationships and pressures, along with issues of self-perception, can create psychosocial and behavioral concerns during adolescence that, in turn, influence sexual decision-making and reproductive health. In understanding these issues and being aware of skills that empower young people, the provider/counselor can work with adolescents to help them learn and utilize skills that contribute to healthy development.

UNIT TRAINING OBJECTIVE:

To help providers and counselors recognize and understand adolescent psychosocial and behavioral concerns, as well as the life skills that are necessary for achieving healthy development.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Discuss psychosocial and behavioral concerns of adolescents.
2. Discuss the life skills that are necessary for the healthy development of adolescents.

TRAINING/LEARNING METHODOLOGY:

- Trainer presentation
- Role play
- Discussion
- Group work
- Assertiveness practice

MAJOR REFERENCES AND TRAINING MATERIALS:

- Advocates for Youth. 1995. *Life planning education: a youth development program*. *(revised edition).* Washington, DC: Advocates for Youth.

- Mensch, B.S., J. Bruce, and M. Greene. 1998. *The unchartered passage: Girls' adolescence in the developing world.* New York: Population Council.
- Moore, K., and D. Rogow. 1994. Family planning, gender, and adolescents. *Family planning and reproductive health: Briefing sheets for a gender analysis.* New York: Population Council.
- Vereau, D. 1998. *Improving interpersonal communications skills for counseling adolescents on sexual and reproductive health.* Lima, Peru: Pathfinder International.
- Weiss, E., and G. Gupta. 1998. *Bridging the gap: Addressing gender and sexuality in HIV prevention.* Washington, DC: ICRW.

RESOURCE REQUIREMENTS:

- Ball or small object
- Blank paper
- Markers
- Flipchart
- Additional pens/pencils for Px (if necessary)

EVALUATION METHODS:

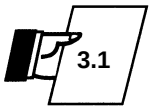
- Pre- and post-test
- Reflections
- Where Are We?
- Participant evaluation form
- Trainer observation and assessment of group work

TIME REQUIRED: 1 hour, 55 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

- Review Participant Handout 3.1 to make sure the situations listed are relevant and/or to add others that are meaningful to the group.
- Prepare copies of Participant Handouts 3.1 and 3.2
- SO#2: Obtain a small ball for the assertiveness practice exercise.

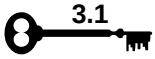
Specific Objective # 1: Discuss psychosocial and behavioral concerns of adolescents

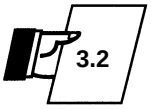
CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
PSYCHOLOGICAL AND BEHAVIORAL CONCERNS Certain social relationships and pressures, along with concerns generated by self-perceptions, become very strong during adolescence. These, in turn, have significant influence on sexual decision-making and reproductive health. They include: **Gender Roles** • Gender roles are masculine or feminine behaviors expressed according to cultural or social customs and norms. • Although boys and girls, worldwide, are treated differently from birth onward, it is during adolescence when gender role differentiation intensifies. • While experiences vary by culture, options, in general, expand for boys and contract for girls. – Boys achieve more autonomy, mobility, and power, whereas girls tend to get fewer of these privileges and opportunities. – Importantly, boys' power relative to girls' translates into dominance in sexual decision-making and expression, often leaving girls unable to fully assert their preferences and rights and to protect their health.	**ROLE PLAY: GENDER ROLES (40 MIN.)** **Note:** *In addition to the "Gender Role" discussion, other aspects of psychosocial and behavioral concerns are included in the role play, such as peer relationships/peer pressure, parental relationships, and self-esteem.* The trainer should: • Select 6 Px or ask for 6 volunteers (3 women and 3 men) to perform the role play. • Distribute *Gender Role Case Studies (Px Handout 3.1).*  • Ask the observers to select one of the case studies *(Px Handout 3.1*) to be discussed by the actors before the group. (Names can be changed, if desired, to correspond with the culture.) • Ask the women to play the roles of the men and ask the men to play the roles of the women. Px should interpret the roles in the way they want (traditional or otherwise) and be able to rationalize their interpretation. • Encourage actors to choose a more progressive role or a more traditional role. Both will bring out key points and further discussion.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
Peer Relationships/Peer Pressure • Adolescents develop very close relationships with their peers, conforming to language, dress, and customs. This helps them feel secure and gives them a sense of belonging to a large group. • Given the significance of peer influence, this power can sway adolescents toward greater or lesser risk-taking. – For example, research has shown that adolescents tend to conform their sexual behavior, including timing of sexual debut and use of contraceptives, to what they perceive their peers are modeling. • Peer pressure, combined with gender inequities within a sexual relationship, can mean that males have undue power to dictate sexual decisions to females. **Relationships with Parents/Other Adults** • During adolescence, relationships with parents become more conflicted as the young person tests limits and moves toward greater independence. • At the same time, parents have significant influence over, and responsibility for, adolescent children. – The impact of parental influence is confirmed by research, as is the influence of other caring adults in young people's lives; such relationships tend to strengthen adolescents' resilience and ability to avoid risk-taking behavior.	• According to their roles, the actors should discuss/debate the case study for 5-10 minutes (the trainer should decide when the points are sufficiently made). • Ask the actors how they felt about being forced to take on a gender role. • Ask other Px to share what they observed. • Ask the "men" (i.e., the female Px) to name three things that they can no longer do as "men" and three things that they can now do as "men." • Ask the "women" to name three things that they can no longer do as "women" and three new things that they can do as "women." • Lead a general discussion about gender roles and their implications for sexual decision-making.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
– When possible, providers can play an important role in encouraging parent/child communication. **Self-Esteem** • Self-esteem is the ability to feel confidence in, and respect for, oneself. It is a feeling of personal competence and self-worth. • While self-esteem involves feelings about oneself, it derives, to a great extent, from interactions with family, friends, and social circumstances throughout life. • Self-esteem plays a key role in a young person's sense of how well s/he can deal with life's options and challenges. • Self-esteem can be challenged during adolescence by rapid physical and social changes and the development of one's own values and beliefs. Yet, self-esteem is critically important at this stage in life. • Specifically for reproductive health, self-esteem influences how young people make judgments about relationships, sex, and sexual responsibility. • Adults can help adolescents strengthen their self-esteem by showing respect and by demonstrating confidence in adolescents' abilities. **Source:** Vereau, D. 1998. *Improving interpersonal communications skills for counseling adolescents on sexual reproductive health*. Lima, Peru: Pathfinder International.	

Specific Objective #2: Discuss the life skills that are necessary for the healthy development of adolescents

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
LIFE SKILLS FOR HEALTH DEVELOPMENT Adolescents need skills to: • Help clarify their needs and rights. • Express themselves effectively. • Decide upon a course of action. Among the most important life skills are assertiveness and decision-making. **Assertiveness** • Demonstrating assertiveness does not mean imposing beliefs or views upon another person, but involves expressing beliefs, thoughts, and feelings in a direct, clear way at an appropriate moment. • To be assertive implies the ability to say "yes" or "no" depending on what one wants. For example: – "I don't want to have sex." – "Yes, I want to have sex if we use a condom." • Being able to express what is truly felt or desired can have important consequences for adolescent reproductive health. Being clear and assertive can help: – Avoid guilt and increase self-respect. – Resist peer pressure to engage in sex, drug use, etc.	**TRAINER PRESENTATION (5 MIN.)** The trainer should: • Using the content on the left-hand side of the page, review life skills and the concept of assertiveness. **ASSERTIVENESS PRACTICE EXERCISE (25 MIN.)** The trainer should: • Explain that this exercise will help Px understand how adolescents might need to use assertiveness for effective communication. • Ask the Px to sit in a circle and play the role of teenagers who will respond assertively to statements you will read. See *Trainer's Tool 3.1: List of Statements to Practice Assertiveness*.  • Toss a ball (or other small object) to a Px who will go first. • After his/her response, ask the Px to evaluate how assertive the response was and to provide examples of other assertive responses. • Repeat with another Px using the next statement and so on until you complete the statements. ? Ask Px, was it difficult to respond assertively? If so, why? Were the

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
– Effectively negotiate safe sex to prevent unwanted pregnancy and *STI*s, including HIV. – Resist unwanted sexual overtures from adults. – Identify and obtain needed services for pregnancy prevention, prenatal and postpartum care, and *STI*/HIV diagnosis, counseling, and treatment. **Decision-Making** • Decision-making involves an array of conclusions and actions to achieve intended results. • Adolescents must make decisions frequently, ranging from simple (and marginally consequential) to major (and very consequential) decisions, such as: – What shall I wear today? – Should I have sexual relations? • Depending on the culture and on a person's "locus of control," the potential to make decisions varies, as does the young person's sense of her/his ability to make decisions. – Some cultures and social policies define in detail what is expected adolescent behavior, such as appropriate dating behavior. This limits options for decision-making. – With an "external locus of control," a person believes that external factors (such as fate or luck) determine what happens to her/him. With an "internal locus of	topics and dynamics useful in working with adolescents? • Review the concept of decision-making found in the content section on the left-hand side of the page. **GROUP WORK AND DISCUSSION (40 MIN.)** The trainer should: • Explain that this exercise will help Px understand a variety of challenging situations that young people may have to face. (Review the exercises to make sure they are relevant and/or add others that are meaningful to your group.) • Break Px into small groups (4-6), explaining that each group will predict consequences for different decisions adolescents might make. • Hand each group a list of decisions *(Px Handout 3.2)* and blank paper.  • Explain that groups will think about each decision and predict the 3 most likely consequences. Then, circle the best possible consequence and put a line through the worst one. • Allow 15 minutes for this process. • Reconvene the large group. • Write the first decision on the flipchart and ask each group to name one positive consequence they predicted.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
control," people believe that their own aptitudes, skills, and efforts determine what happens to them. • Young people who think they can determine what happens, within the range of available options, will be more likely to make their own decisions and thus feel greater commitment to these decisions and more satisfaction from them. **Source:** Vereau, D. 1998. *Improving interpersonal communications skills for counseling adolescents on sexual reproductive health*. Lima, Peru: Pathfinder International.	• List 3 or 4 consequences and then ask for the best possible consequence of this decision. • Repeat with negative consequences and the worst possible consequence. • Conclude the activity using the following discussion points. **Discussion Points** ? How similar or different were the groups' predictions? Why do you think that is so? ? Is it possible for two people to make the same decision and experience very different consequences? How could that happen? ? How carefully do young people usually consider consequences when making decisions? ? Which decision had a negative consequence you had not thought of? ? Some people say that fate determines what happens to a person. Others say that we are each in control of our own destiny. What do you think? **UNIT SUMMARY (5 MIN.)** The trainer should: • Summarize the unit content. • Link content to the next session.

UNIT 4:
COMMUNICATING WITH THE ADOLESCENT CLIENT

INTRODUCTION:

Clear and effective communication is the starting point in helping an adolescent achieve healthy development and reproductive health. Being able to understand the perspective of the adolescent will enable the provider/counselor to respond appropriately, creating a positive and effective service experience. Positive provider-client interaction benefits the adolescent because s/he will feel more comfortable expressing her/his concerns or problems, thereby enabling the provider to more effectively serve the adolescent's needs.

UNIT TRAINING OBJECTIVE:

To enable the provider/counselor to communicate clearly and effectively with adolescents by understanding the adolescent's perspective and responding to specific needs of the adolescent client.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Explain ways that the provider can establish trust with the adolescent client.
2. Demonstrate behaviors conducive to counseling adolescent clients.
3. Demonstrate good counseling techniques to be used with adolescent clients.

SIMULATED SKILL PRACTICE:

- Through role play, participants demonstrate asking effective questions.
- Through role play, participants demonstrate the clarification technique to help adolescents explore ideas and feelings.

TRAINING/LEARNING METHODOLOGY:

- Trainer presentation
- Discussion
- Verbal/nonverbal communication exercise

- Value clarification exercise
- Role play
- Brainstorming
- Graffiti exercise

MAJOR REFERENCES AND TRAINING MATERIALS:

- Levenberg, P., and A. Elster. 1995. *Guidelines for adolescent preventative service implementation and resource manual*. Chicago: American Medical Association.
- Nare, C., K. Katz, and E. Tolley. 1996. *Measuring access to family planning education and services for young adults in Dakar, Senegal*. Research Triangle Park, NC: Family Health International.
- Rinehart, W., S. Rudy, and M. Drennan. 1998. GATHER guide to counseling. Population Reports. Series J (48).
- Senderowitz, J. 1999. Making reproductive health services youth friendly*. Research, Program and Policy Series.* Washington, DC: FOCUS on Young Adults/Pathfinder International.
- Vereau, D. 1998. *Improving interpersonal communications skills for counseling adolescents on sexual and reproductive health.* Lima, Peru: Pathfinder International.
- Zimbabwe National Family Planning Council. 2000. *Zimbabwe youth reproductive health and counseling: A trainer's manual*. Harare: Zimbabwe National Family Planning Council.

RESOURCE REQUIREMENTS:

- Flipchart
- Markers
- Overhead projector
- Screen
- Signs
- Tape

EVALUATION METHODS:

- Pre- and post-test
- Participant evaluation form
- Reflections
- Where Are We?
- Trainer observation and assessment of group work
- Participation in group discussion
- Trainer observation and assessment of participants during role plays

TIME REQUIRED: 4 hours, 30 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

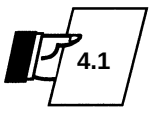
- Prepare Transparency 4.1.
- Prepare copies of Participant Handouts 4.1, 4.2, and 4.3.
- SO#3: Prepare 2 signs for exercise on exploring attitudes and values. Label the signs "agree" and "disagree."
- Be familiar with the legality and practice of confidentiality in the region/country.
- Consult with local youth to make a list of slang terms used to refer to different body parts, dating, and sex.

Specific Objective #1: Explain ways that the provider can establish trust with the adolescent client

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
FEELINGS OF THE ADOLESCENT Understanding the realities and mind-set of the adolescent client will foster better communication and responsiveness to adolescents' needs. When an adolescent is face-to-face with a provider (or an adult staff member) s/he may feel: • Shy about being in a clinic (especially for RH) and about needing to discuss personal matters. • Embarrassed that s/he is seeking RH care. • Worried that someone s/he knows might see her/him and tell the parents. • Inadequate to describe what is concerning her/him and ill-informed about RH matters in general. • Anxious that s/he has a serious condition that has significant consequences (e.g. *STI*, pregnancy). • Intimidated by the medical facility and/or the many "authority figures" in the facility. • Defensive about being the subject of the discussion or because s/he was referred against her/his will. • Resistant to receiving help because of overall rebelliousness or other reasons fostering discomfort or fear.	**TRAINER PRESENTATION (10 MIN.)** The trainer should present the content on the left-hand side of the page. **ROLE PLAY (20 MIN.)** The trainer should: • Explain that the role play is focused on the importance of the non-medical staff of the clinic and how their actions can impact the adolescent client's experience. • Select 4 Px (or accept volunteers) for the role play. Two role plays will be enacted: 1. An adolescent client and an insensitive receptionist. The adolescent attempts to make sure s/he is in the right place, asks what to do, inquires about procedures, etc. (and is very anxious and uncomfortable). The receptionist is busy, over-worked, believes adolescents should not seek RH care, and is indifferent to the adolescent's needs and sensitivities. 2. An adolescent client and a trained, sensitive receptionist. The actors perform the same scenario as above, but the receptionist is understanding and wants to help make the overall clinical interaction a positive and effective experience.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
ESTABLISHING TRUST WITH THE ADOLESCENT The adolescent is going through dramatic biological and psychological changes in general. Seeking health care may be challenging and difficult for her/him. Each staff person who may interact with adolescents must understand these circumstances and feelings and must be prepared to assist in a helpful, non-judgmental way. The following are **tips for good communication:** • Be genuinely open to an adolescent's question or need for information (ranging from "Where is the toilet?" to "Should I use birth control?"). • Do not use judgmental words or body language that suggest disapproval of adolescents being at the clinic, of their behavior, or of their questions or needs. • Understand that the young person has various feelings of discomfort and uncertainty. Be reassuring in responding to the adolescent, making him or her feel more comfortable and confident. • If sensitive issues are being discussed, help ensure that conversations are not overheard. **Source:** Vereau, D. 1998. *Improving interpersonal communications skills for counseling adolescents on sexual reproductive health*. Lima, Peru: Pathfinder International.	• Lead a discussion among the Px about what difference each scenario would make in the overall clinical experience of the adolescent. • Encourage the actors to express how they felt assuming roles during the role play.

Specific Objective #2: Demonstrate behaviors conducive to counseling adolescent clients

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
RESPONDING TO THE ADOLESCENT CLIENT While all clinic staff must be supportive and helpful to the adolescent, those who provide services have additional challenges. Important among these are fostering comfort and encouraging trust and rapport. **Fostering Comfort** The more an adolescent client can be made comfortable, the more likely s/he will open up about her/his concerns, play a role in determining treatment and follow-up, and comply with medical decisions. Three important characteristics of comfort for the adolescent client are: • Privacy: This characteristic relates primarily to the facility and requires a separate space where counseling and/or examination can take place without being seen or overheard and where the interaction is free from interruptions. • Confidentiality: This characteristic relates to the provider and requires that s/he assure the client that all discussions and matters pertaining to the visit will not be transmitted to others. – If, in some circumstances, the counselor/provider believes it necessary to share information with others (for example, to	**BRAINSTORMING AND TRAINER PRESENTATION** **(10 MIN.)** The trainer should: ? Ask Px, what are common concerns or needs that adolescents have regarding client-provider interactions. • Present *Responding to the Adolescent Client* from the content on the left-hand side of the page. **SMALL GROUP DISCUSSIONS** **(50 MIN.)** The trainer should: • Explain that this exercise will address the importance of confidentiality, some exceptions to the general practice, and the legal climate within the country. • Divide the Px into 3 groups, providing them with flipcharts. Each group will discuss confidentiality and present conclusions. • Distribute *Small Group Discussion Topics* (*Px Handout 4.1)*  • Ask each group to work on their respective assignment (Group A-Assignment A, Group B-Assignment B, Group C-Assignment C).

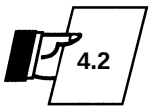
CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
prevent further sexual abuse), the counselor/provider should explain why it is important and explain to when, how, and with whom the information will be shared. • Respect: This characteristic involves the way that the counselor/provider relates to the adolescent, requiring recognition of the client's humanity, dignity, and right to be treated as capable of making good decisions. – Respect also assumes that one can be different and have varying/alternate needs that are legitimate and deserve a professional response. **Encouraging Trust and Rapport** Increasing an adolescent's trust in and rapport with the counselor/provider will facilitate discussion and enhance the likelihood that needs will be revealed and addressed. Important conditions for trust and rapport include: • Allowing sufficient time for the adolescent client to become comfortable enough during the visit to ask questions and express concerns. • Showing an understanding of and empathy with the client's situation and concerns. • Demonstrating sincerity and willingness to help. • Exhibiting honesty and forthrightness, including an ability to admit when one does not know the answer.	• Allow each group 20 minutes to work on a specific task. • Reconvene the large group. • Ask each group to report back its conclusions to the Px. • Lead a discussion (including suggested additions, ideas, and experiences). • Allow 10 minutes for each group, 30 minutes total.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Reinforcing the decision to seek counseling and/or health care for felt concerns. • Expressing non-judgmental views about the client's needs and concerns. • Demonstrating responsibility for fulfilling one's professional role in assisting the adolescent client. • Exhibiting confidence and professional competence in addressing ARH issues.	

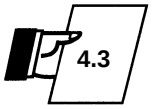
VERBAL/NONVERBAL COMMUNICATION
 	
Health care **providers need to explore the many different nonverbal and verbal behaviors** they use when communicating with clients.
 	
Sometimes, without realizing it, providers communicate one message **verbally**, while communicating the opposite message **nonverbally.**
 	
Nonverbal communication is a complex and often unconscious mixture of actions, behaviors, and feelings that **reveal the way we really feel** about something.
 	
Nonverbal communication is especially **important because it communicates to clients the level of interest, attention, warmth, and understanding** we feel towards them.
 	
Positive nonverbal cues include:
• Leaning toward the client.
	VERBAL/NONVERBAL COMMUNICATION EXERCISE (30 MIN.)
	
	The trainer should:
	• Ask the Px to form pairs.
	• One person should talk for 5 minutes about a personal problem or concern.
	• The other should try to communicate interest, understanding, and help in any way s/he wishes **nonverbally** (s/he may not speak).
	• Have the pairs switch roles and repeat the exercise for 5 minutes.
	• Stop and allow 2 to 3 minutes for the pairs to talk freely to each other.
	• Discuss the exercise with the entire group. Some questions to raise are:
	  ? How did it feel to talk for five uninterrupted minutes?
	  ? How did it feel to be prevented from talking?

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Smiling without showing tension. • Facial expressions that show interest and concern. • Maintaining eye contact. • Encouraging, supportive gestures such as nodding one's head. **Negative nonverbal cues include:** • Not making/maintaining eye contact. • Glancing at one's watch obviously and more than once. • Flipping through papers or documents. • Frowning. • Fidgeting. • Sitting with the arms crossed. • Leaning away from the client. Providers should **remember ROLES** when communicating the adolescent: **R** = **Relax** the client by using facial expressions that show interest. **O** =**Open up** the client by using a warm and caring tone of voice. **L** = **Lean** towards the client, not away from him or her. **E** = Establish and maintain **eye contact** with the client. **S** = **Smile**	? Did you feel your partner understood you? How did you know? ? Did anyone feel helped? Why or why not? ? Why is silence so difficult to tolerate? ? Give examples of contradictory verbal/nonverbal messages. ? What happens when nonverbal behavior does not match verbal messages? ? Do we sometimes show negative emotions or feelings to clients during counseling sessions? In what ways? The objective of this exercise is to make participants aware of nonverbal ways of communicating, particularly when listening to clients, and to demonstrate the power of nonverbal communication. • Quickly summarize using the *Verbal/Nonverbal Communication* content on the left-hand side of the page.

Specific Objective #3: Demonstrate good counseling techniques to be used with adolescent clients

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
COUNSELING THE ADOLESCENT CLIENT FOR BEHAVIOR CHANGE **Counseling** is a person-to-person, two-way communication during which the counselor: • Provides adequate information to help the adolescent make an informed decision. • Helps the adolescent evaluate her/his feelings and opinions regarding the problem for which help was sought. • Acts as emotional support for the adolescent. Counseling is **not**: • A method to provide solutions to the adolescent's problems. • A method for giving instructions. • The promotion of a life plan that has been successful for the counselor. The **purpose of counseling the adolescent on reproductive health issues** is to help the adolescent to: • Exercise control over her/his life. • Make decisions using a rational model for decision-making. • Cope with her/his existing situation. Achieving control over behavior, understanding oneself, anticipating consequences of actions, and making long-term plans are characteristics of	**TRAINER PRESENTATION (20 MIN.)** The trainer should present *Counseling the Adolescent Client for Behavior Change* and *Fostering Good Communication* from the content on the left-hand side of the page. **VALUE CLARIFICATION EXERCISE (30 MIN.)** The trainer should: • Explain that the purpose of the exercise is to explore feelings, attitudes, and values regarding different sexuality issues. • Put up signs reading "Agree" and "Disagree" around the room. • Distribute *Px Handout 4.2: Clarifying Sexual Values*. Encourage Px to respond honestly to the statements.  • Explain that you will read the statements one at a time. After each one, Px should move to the sign corresponding to their response. • When Px have moved to the various signs, ask them to explain their reasons for their response. • Supplement their ideas and correct any incorrect information.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
maturity—one of the goals of adolescent counseling. **FOSTERING GOOD COMMUNICATION** Several **principles** help assure effective counseling with adolescents: • The service provider must **accept responsibility for leading the analysis of and reflection on the issues** troubling the young person, encouraging her/him to explore and express feelings. • The counselor **avoids giving advice and recipes or magic formulas** for solving problems. Rather, the counselor helps the adolescent to evaluate her/his own behavior and the possible solutions to the problem. • The provider **respects the adolescent, encouraging her/his ability** to help her/himself, to trust in her/himself, and to take responsibility for her/his decisions. • Counselors should **consider adolescents as individuals**, emphasizing their qualities and potential, respecting their rights as people, and promoting the exercise of their capacity to think and make decisions. • The counselor must **accept adolescents and not judge them** as good or bad. The counselor should help them to examine their conduct and make changes they consider necessary. This will promote ownership of decisions, greater self-confidence, and self-control.	• Proceed until each statement has been read and responded to. • At the end, explain that the purpose of this exercise is not to persuade others to adopt certain positions, but to listen and reflect on what we think and feel about various issues. Better understanding of one's own values, and how they differ from others', enables counselors to be more accepting and less judgmental. **ROLE PLAY: ASKING QUESTIONS (30 MIN.)** The trainer should: • Explain that the purpose of the exercise is to practice and improve asking effective questions. • Show *Transparency 4.1* and review types of questions, stressing the advantages of open-ended questions.  • Play the role or request a volunteer to play an adolescent who has contracted an *STI* and has made an appointment for counseling. • Have Px take turns asking questions as they would during a counseling session. • Ask Px to analyze which questions were effective or not and why.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
Several **techniques** help assure good communication with adolescents: **Create a good, friendly first impression** • Start on time; don't make the client wait. • Smile and warmly greet the client. • Introduce yourself and what you do. • Ask her/his name and what s/he likes to be called. **Establish rapport during the first session** • Face the adolescent, sitting in similar chairs. • Use the adolescent's name during the session. • Demonstrate a frank and honest willingness to understand and help. • Begin the session by allowing the adolescent to talk freely before asking directive questions. • Congratulate the adolescent for seeking help. **Eliminate barriers to good communication** • Avoid judgmental responses of body or spoken language. • Respond with impartiality, respecting the adolescent's beliefs, opinions, and diversity or expression regarding her/his sexuality.	**ROLE PLAY TO PRACTICE THE CLARIFICATION TECHNIQUE (30 MIN.)** The trainer should: • Explain that this exercise is to learn to use the clarification technique in order to help the adolescent client explore ideas and feelings, and to help clarify confusing or vague messages. • Distribute *Px Handout 4.3: Lines to Practice Clarification Technique.*  • For the first round, ask for 6 volunteers. Three should play adolescents and 3 should be counselors, with pairs seated facing each other. • The first "adolescent" speaks line #1 to her/his "counselor." The counselor responds, attempting to clarify what the adolescent means with specific reference to the boldface words. • The 2nd and 3rd pairs repeat this process with lines #2 and #3. • Ask Px to discuss the "counselor's" use of the clarification technique, making comments and suggestions. • Two more groups of 3 pairs complete the exercise, with discussions after each group.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
Use "active listening" with the client • Show your sincere interest and understanding, and give your full attention to the client. • Sit comfortably; avoid movements that might distract the adolescent. • Put yourself in the place of the adolescent while s/he speaks. • Be more aware of the problem without being intrusive or taking away her/his control over the issue. • Observe the tone of voice, words used, and body language expressed, and reflect verbally to underscore and confirm observed feelings. • Give the adolescent some time to think, ask questions, and speak. Be silent when necessary, and follow the rhythm of the conversation. • Periodically repeat what you've heard, confirming that both you and the adolescent have understood. • Clarify terms that are not clear or need more interpretation. • Summarize the most relevant information communicated by the client, usually at the end of a topic. **Provide information simply** • Use an appropriate tone of voice. • Speak in an understandable way, avoiding technical terms or difficult words. • Understand and use where appropriate the terms/expressions	**GRAFFITI EXERCISE (15 MIN.)** The trainer should: • Tape newsprint to the walls. • Hand out markers to participants. • Ask participants to write on the newsprint terms that young people use to talk about sex and men's and women's bodies. • Allow 5 minutes for writing. • Reconvene the large group. • Review the terms on the newsprint and supplement answers with the trainer's list of terms used by local youth.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
adolescents use to talk about their bodies, dating, and sex. • Use short sentences. • Do not overload the adolescent with information. • Provide information based on what the adolescent knows or has heard. • Gently correct misconceptions. • Use audiovisual materials to help the adolescent understand the information and to demonstrate information in more concrete terms. **Ask appropriate and effective questions** • Use a tone that shows interest, attention, and friendliness. • Begin sessions with easy questions, gradually moving up to more difficult questions. • Try not to take notes except in a structured interview that has an established order for special cases. • Ask one question at a time and wait for the response. • Ask open-ended questions that permit varied responses and require thought. Allow for explanations of feelings or concerns. **Examples:** "How can I help you?" and "What's your family like?" • Ask in-depth questions in response to a previous question and to solicit more information.	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
Example: "Can you explain that better?" • Avoid biased questions that can direct the client's response. **Example:** "Have you heard that the condom makes sex less pleasurable?" • Avoid questions that begin with the word "Why" since the adolescent may think you are blaming her/him. • Ask the same question in different ways if you think the adolescent has not understood. **Recognize and take advantage of teachable moments** • Use a positive approach when discussing developmental change. • Evaluate learning by asking the adolescent to describe a healthy RH behavior that s/he is practicing. • Reinforce health messages from other settings. • Provide printed or other materials that are developmentally and culturally appropriate. • Provide practical advice, encouragement, and factual information. • Don't underestimate the potential usefulness or effectiveness of education and counseling. **Source:** Levenberg, P. and A. Elster. 1995. *Guidelines for Adolescent Preventive Services (GAPS).* Chicago: American Medical Association.	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
CHALLENGES IN COUNSELING THE ADOLESCENT During the counseling session, there are two actors: The counselor and the adolescent. Just as the counselor's personal characteristics and skills can facilitate or hinder the process, so can the adolescent's behavior or mood. The following are some situations that require appropriate handling: • **Silence:** Silence can be a sign of shyness, anger, or anxiety. – *If it occurs at the beginning of a session*, the provider can say, "I realize it's hard for you to talk. This often happens to people who come for the first time." – *If s/he seems angry*, the counselor can say, "Sometimes when someone comes to see me against her/his will and doesn't want to be here, it is difficult to speak. Is that what is going on?" – *If the client is shy*, the provider can legitimize the feeling by saying, "I'd feel the same way in your place. I understand that it's not easy to talk to a person you've just met." – *If the adolescent has difficulty expressing her/his feelings or ideas*, the counselor can use some brochures or posters to encourage discussion or refer to a story or anecdote so the adolescent can talk about others rather than her/himself.	**TRAINER PRESENTATION (20 MIN.)** The trainer should: • Present the content on the left-hand side of the page. • Ask Px if they have any questions or comments. **UNIT SUMMARY (5 MIN.)** The trainer should: • Summarize the unit content. • Link content to the next session.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
– *If the adolescent cannot or will not talk*, the counselor should propose another meeting. • **Crying**: Try to evaluate what provoked the tears and assess if it makes sense in the given situation. – *If the client is crying to relieve tension*, the counselor can give the adolescent permission to express her/his feelings by saying, "It's okay to cry since it's the normal thing to do when you're sad." – *If the client is using crying as manipulation*, the counselor can say, "Although I'm sorry you feel sad, it's good to express your feelings." – *If the crying is consistent with the situation*, the counselor should allow her/him to freely express emotions and not try to stop the feeling or belittle its importance. • **Threat of suicide**: All suicide threats or attempts must be taken seriously. It is essential to determine if attempts were made in the past, if s/he is really considering suicide, and the reasons for doing so—or if it is something said without thinking. – It is best to refer the adolescent to a psychiatrist or psychologist and accompany her/him to the appointment. • **Refusal of help**: The counselor should discreetly try to find out why the adolescent feels this way.	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
– *If the client has been sent against her/his will*, the counselor can say, "I understand how you feel. I'm not sure I can help you, but maybe we could talk for a minute and see what happens." • **Need to talk**: Challenges in counseling may also include a situation where the client is very vocal and wants an outlet to express other concerns that may not be directly related to the immediate counseling need as perceived by the service provider. – Give the client the opportunity to express her/his needs and concerns. If you cannot help the client, show that you are listening to the concerns that s/he is trying to express. When possible, direct the client to someone who can help with the problem. – The counselor may say, "I can see that you are very concerned about this problem. I wish that I could do something to help you. Have you discussed this with . . ." – If you cannot help the client or direct her/him to someone who can provide assistance, then demonstrate care and concern about the client's problem. However, be clear when you cannot help with the problem.	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
COMMUNICATING AND COUNSELING ABOUT SEXUALITY WITH ADOLESCENTS Communicating with and counseling adolescents about sexuality can be challenging because it is a sensitive topic about which adolescents often feel emotional, defensive, and insecure. Good communication and counseling about sexuality requires: • Considering the adolescent's age and sexual experience. • Demonstrating patience and understanding of the difficulty adolescents have in talking about sex. • Assuring privacy and confidentiality. • Respecting the adolescent and her/his feelings, choices, and decisions. • Ensuring a comfort level suitable for the adolescent to ask questions and communicate concerns and needs. • Responding to expressed needs for information in understandable and honest ways. • Exploring feelings as well as facts. • Encouraging the adolescent to identify possible alternatives. • Leading an analytical discussion of the consequences, advantages, and disadvantages of available options. • Assisting the client to make an informed decision.	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Helping the adolescent plan how to implement her/his choice. These approaches will foster the making of good decisions by the adolescent. When **the adolescent makes a decision** with appropriate information, s/he will feel a sense of satisfaction and will feel **capable of voluntarily modifying her/his behavior**. Adolescents must often make significant decisions on the following sexual and/or reproductive health matters: • How to discourage and prevent unwanted sexual advances. • Whether or when to engage in sexual relations. • How to prevent pregnancy and *STI*s, such as HIV. • Whether or when to conceive a child. • Whether to continue or terminate a pregnancy. • What kind of antenatal care to seek and where to go. • How to deal with sexual abuse and/or violence. Most of these decisions can be worked through during counseling sessions that follow the described approaches. Sexual abuse and violence are more difficult and require additional help. **Counseling in Cases of Sexual Abuse and/or Violence** Sexual abuse is any sexual activity carried out against a person's will.	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
Often, sexual abuse is perpetrated by an adult, whether by deceit, black mail, or force, against a child or someone not mentally or physically mature enough to understand or prevent what is happening. Sexual abuse has a significant impact on an adolescent's health, mental state, and on her/his life in general. It can cause serious future sexual and reproductive health problems. If violence is associated with the abuse, even more severe physical and emotional problems can result. **A qualified, multi-disciplined staff should deal with these cases.** The **objectives of the counseling session** addressing sexual abuse are: • Provide psychological and emotional support. – Be understanding but not pitying. • Help the adolescent not to feel guilty. – Explore feelings of guilt. – Tell the adolescent s/he is not responsible for what happened. • Help the adolescent recover her/his sense of self-esteem. – To regain self-confidence. – To trust others. • Counteract anxiety or depression. • Refer her/him to a specialist. – Explain why the referral is necessary.	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
– If possible, accompany the adolescent to the referral appointment. **Note:** *Sexual abuse will be covered in detail in Unit 11*. **Source:** Vereau, D. 1998. *Improving interpersonal communications skills for counseling adolescents on sexual reproductive health*. Lima, Peru: Pathfinder International.	

UNIT 5:
THE RH VISIT AND THE ADOLESCENT CLIENT

INTRODUCTION:

The adolescent client has different needs and problems than an adult client due to physical and emotional immaturity. Both screening and history taking must be tailored to the adolescent client. This unit explores what should be included in screening and history taking, as well as ways in which the RH visit can be made less stressful for the adolescent client.

UNIT TRAINING OBJECTIVE:

To prepare providers to serve the needs of the adolescent client during the RH visit, paying special attention on screening and history taking.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Identify the elements that should be included in screening and history taking for adolescent reproductive health service provision.
2. Explain the physical exam and how it can be tailored to the needs of the adolescent client.

TRAINING/LEARNING METHODOLOGY:

- Discussion
- Group work

MAJOR REFERENCES AND TRAINING MATERIALS:

- Armstrong, K.A., and M.A. Stover. 1994. Smart start: An option for adolescents to delay the pelvic examination and blood work in family planning clinics. *Journal of Adolescent Health.* 15 (5):389-95.
- Lane, C., and J. Kemp. 1984. Family planning needs of adolescents. *JOG Nursing*. March/April (Supplement): 61S-65S.
- Leppert, P.C. 1994. The adolescent's first pelvic exam. *Contemporary Adolescent Gynecology*. Summer:25-30.

- Levenberg, P., and A. Elster. 1995. *Guidelines for adolescent preventive services clinical evaluation and management handbook.* Chicago: American Medical Association.
- Moeller, T., and G. Bachman. 1995. Be prepared to deal with sexual abuse in teen patients. *Contemporary Adolescent Gynecology.* Winter:20-25.
- Shapiro, K., and E. Israel. 2000. *Module 12: Prevention and management of reproductive tract infections.* Watertown, MA: Pathfinder International.
- Waszak, C.S. 1993. Quality contraceptive services for adolescents: Focus on interpersonal aspects of client care. *Fertility Control Reviews*. 2 (3):3-6.

RESOURCE REQUIREMENTS:

- Flip chart
- Markers
- Space for group work

EVALUATION METHODS:

- Pre- and post-test
- Participant evaluation form
- Where Are We?
- Reflections
- Trainer observation and assessment of group work
- Verbal feedback
- Participation in group discussion

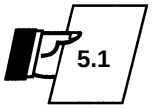
TIME REQUIRED: 1 hour, 15 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

- Prepare copies of Participant Handout 5.1.

Specific Objective #1: Identify the elements that should be included in screening and history taking for adolescent reproductive health service provision

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
SCREENING The objective of screening is the early detection of disease, problems, abuse, or high risk behavior. • A screening test should ideally: – Be inexpensive. – Be easy to administer. – Not cause the patient discomfort or harm. • Adolescents should be screened for: – Age-appropriate physical and psychosocial development. – Sexual activity: Are they at risk for *STI*s or pregnancy? – Substance abuse. – Physical and sexual abuse. – Nutritional status. – Vision. – TB. • In addition to administering tests or conducting physical exams, history-taking can also be used as a tool for screening for substance abuse, sexual abuse, and emotional problems.	**DISCUSSION AND GROUP WORK (45 MIN.)** The trainer should: • Explain what screening is. ? Ask Px, what screening should be done for adolescents? • List the suggestions on a flip chart. • Explain that part of screening includes taking a medical history. • Divide Px into 2 groups. • Give each group markers and a piece of flipchart. • Ask one group to determine what information should be gathered during history taking for males and the other group to determine what should be included for females. • Ask both groups to explain why each question should be asked. • Allow 20 minutes for the groups to complete their work. • Reconvene the large group. • Ask each group to present their work to the whole group. • Add any missing information.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
Menstrual History (female clients only) A complete menstrual history should include: • The date of menarche. • Frequency and regularity of menstrual cycles. • Date of onset of the most recent period or bleeding episode. • An estimate of the number of pads used each day. • Whether the adolescent has cramps or pain, clotting, or symptoms of dizziness or nausea with menses. • Whether the adolescent has unusual vaginal discharge or difficult urination. **Obstetric History (female clients only, if applicable)** An obstetric history should include: • Number of children she has. • Number of times she's been pregnant. • Her delivery history. **Physical History** A physical history should cover: • Any current or past physical problems and their onset, duration, and progression. • Whether the client thinks s/he is too heavy or too thin. • If the client has questions about how her/his body is growing.	• Review the *Reproductive History Form (Px Handout 5.1)*.  ? Ask Px, what questions might be added or deleted?

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Her/his eating habits and what foods s/he eats. • Any past surgeries or illnesses, including what, if any, treatment was provided. • Any allergies. **Psychological/Psychosocial History** A psychological/psychosocial history should include: • Information about her/his family (is it nuclear, joint, separated?). • Information about her/his accommodation. Does s/he live at home, at school? What is that accommodation like? What about sanitation facilities? • History of depression or other mental illness. • History of substance abuse either by her/himself or by any of her/his family members. • Any incidents of domestic violence that s/he has experienced or witnessed. • If s/he has experienced any form of sexual or verbal harassment/abuse. **Family History** • Adolescents are not always well informed about their families' medical/obstetric histories. If possible, gather information from the adolescent's parents. • The family history should include the parents' and siblings' medical history.	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
If known, grandparents' medical history is also helpful. **Social History** • The adolescent's social activity may give clues about the extent of her/his sexual activity. • Ask about family, friends, school, or work. • Provide an opening for her/him to talk about peer pressure to have sex or to use drugs. **Sexual History** • The main impediment to obtaining clinical information about sexual behavior is the client's embarrassment. • Stress that what you discuss will be confidential. Sexual history should cover: • If s/he dates or is in a sexual relationship. • Her/his sexual knowledge, attitudes, and behaviors. Ask what s/he knows about *STI*s and how to prevent them. • Reproductive goals. • Contraceptive knowledge or use (past and present). • If anyone has touched her/him sexually when s/he didn't want to be touched. • Her/his plans for sexual activity in the future.	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Physical attraction—to men or women, to both, or to neither. • The number of sexual partners s/he has had.	

Specific Objective #2: Explain the physical exam and how it can be tailored to the needs of the adolescent client

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
FEMALE PHYSICAL EXAMINATION **General Physical Examination** • Conduct a general physical examination of all systems. • Examine her for signs of anemia. **Breast Examination** • The breast examination should become part of the general medical evaluation once girls have breasts. • The main part of the examination is visualization. • Examination for breast cancer is not necessary until at least age 18. Breast cancer is rare during adolescent years. • The most common concerns girls have about their breasts are whether they are too big or too small, when they are going to grow, and why one is bigger than the other. Reassure the client that there is no right or wrong breast size, that she is normal, and that it is common for one breast to be bigger than the other. **Vaginal Examination** • The pelvic examination may be deferred in young adolescents who have regular menstrual cycles or who give the typical history of irregular cycles soon after menarche, and who have a normal hematocrit, deny sexual activity, and will reliably return for a follow-up visit.	**GROUP WORK (25 MIN.)** The trainer should: • Divide Px into 2 groups. • Provide each group with a piece of flipchart and a marker. • Ask both groups to brainstorm what information should be included in a physical examination for both sexes. • Have the groups record their answers on the flipchart. • Allow 10 minutes. • Reconvene the larger group. • Ask each group to present their conclusions. Ask both groups to explain why each examination should be conducted. • Fill in any missing information using the content on the left-hand side of the page. ? Ask Px, what can be done to make the physical examination less stressful for the adolescent client? ? Ask Px to review the procedures that are normally conducted during an RH visit in their own clinics and to reflect on how many of these procedures are absolutely necessary when dealing with an adolescent client. How can some of these procedures be modified to make the RH visit more positive?

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
If a pelvic exam is necessary, then the following techniques can reduce anxiety that the adolescent client may be feeling. • A virginal adolescent may fear that an object placed in the vagina will tear the hymen. If so, tell her that the hymen only partially covers the vaginal opening. It allows menstrual blood to flow. Explain that the vagina is an elastic organ and that it can stretch when she relaxes. • Let her see and touch the speculum. • Get her permission before you touch her with your hand or the speculum. • Before the exam begins, tell her she will feel you gently touch her leg and then her labia. • Examine the external genitalia for ulcers, warts, discharge, trauma, or pubic lice. • As you insert the speculum, ask her to bear down and take slow, deep breaths. • Take great care to carry out all parts of the exam gently and smoothly to minimize discomfort and anxiety. **MALE PHYSICAL EXAMINATION** **General Physical Examination** • Conduct a general physical examination of all systems. **Genital Examination** • Visually inspect the genital area, including the anus for ulcers, warts,	• Using the content found under *How to Make the Physical Examination Less Stressful for the Adolescent Client*, supplement Px's answers. **UNIT SUMMARY (5 MIN.)** The trainer should: • Summarize the unit content. • Link content to the next session.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
urethral discharge, trauma, or pubic lice. • If the young man is not circumcised, gently retract the foreskin to look for ulcers on the glans penis. **HOW TO MAKE THE PHYSICAL EXAMINATION LESS STRESSFUL FOR THE ADOLESCENT CLIENT** • Explain why the visit is important. • Respect the adolescent's sensitivity about privacy. • Explain what you are doing before you begin each step of the exam. • Protect her/his physical privacy as much as possible. Allow the client to keep on her/his clothes except for what must be removed. Make sure to cover the parts of the body that are exposed. Never leave any part of the body exposed when not being examined. • Reassure the client that any results of the exam will remain confidential. • A good rapport between the provider and client is essential. Try to establish trust. • Provide reassurance throughout the exam. • Give constant feedback in a non-judgmental manner. "I see you have a small sore here, does it hurt?" • Offer to have the exam performed by a provider of the same sex, if	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
possible, or make sure there is a same sex attendant in the room during the exam. • Delay pelvic and blood test, if the adolescent desires. A complete social-medical history should be taken and a pregnancy test administered. If the adolescent is not pregnant and does not report current physical symptoms of a STI, you may delay doing a pelvic or blood test for up to 6 months. A pelvic exam should not be delayed for teens that are at risk of STI or pregnancy. • Have the counselor or another person that the adolescent chooses stay with the client during the visit.	

UNIT 6:
SAFER SEX AND PROTECTION FOR ADOLESCENTS

Introduction:

Protection against infection and pregnancy involve many of the same strategies and services. Adolescents need to be able to assess their risk of STI/HIV or of an unwanted pregnancy. In addition, young people also need to know how to protect themselves by practicing safer sex. Providers must be able to openly discuss the range of sexual activities that adolescents engage in and provide accurate information on the risk involved with those activities, as well as on strategies that can be used to reduce risk.

UNIT TRAINING OBJECTIVE:

To prepare providers to effectively counsel adolescents on safer sex, including using protection.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Discuss safer sex messages and techniques for the prevention of sexually transmitted diseases (STIs) and unwanted pregnancy.
2. Identify reasons why adolescents may not practice safe sex.

TRAINING/LEARNING METHODOLOGY:

- Questionnaire
- Discussion
- Small group work
- Trainer presentation

MAJOR REFERENCES AND TRAINING MATERIALS:

- Brick, P., C. Charlton, H. Kunins, and S. Brown. 1989. Teaching safer sex. Hackensack, New Jersey: The Center for Family Life Education, Planned Parenthood of Bergen County.
-

Family Health International. 1997. Reproductive health of young adults: Contraception, pregnancy and sexually transmitted diseases. Research Triangle Park, North Carolina: Family Health International.

- Hunter-Geboy, C. 1995. *Life planning education a youth development program.* Washington, DC: Advocates for Youth.
- Sundari, T.K., M. Berer, and J. Cottingham, eds. 1997. Dual protection: Making sex safer for women*. Beyond acceptability: Users' perspectives on contraception.* London: Reproductive Health Matters for World Health Organization.

RESOURCE REQUIREMENTS:

- Pencils
- Colored note cards or index cards (5 for each participant)
- Tape
- Paper

EVALUATION METHODS:

- Pre- and post-test
- Participant evaluation form
- Reflections
- Where Are We?
- Participation in group discussion

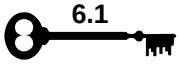
TIME REQUIRED: 1 hour, 40 minutes

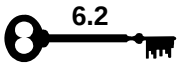
WORK FOR TRAINERS TO DO IN ADVANCE:

- Prepare copies of Participant Handouts: 6.1and 6.2.
- Make three large signs labeled “HIGH RISK,” “LOW RISK,” and “NO RISK.” Write “HIGH RISK” in red letters, “LOW RISK” in visible yellow/orange letters, and “NO RISK” in green letters so that the three signs resemble a stoplight.
- Using Trainer’s Tool 6.2, prepare index cards stating risk behaviors related to STIs/HIV and unwanted pregnancy.

Specific Objective #1: Discuss safer sex messages and techniques for the prevention of sexually transmitted infections (STIs) and unwanted pregnancy

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
INTRODUCTION Protection against infection and pregnancy involve many of the same strategies and services. Traditionally, young women have come to the clinic for prenatal care or contraception, thus presenting an opportunity to also prevent and treat STIs. Young men can also be involved in both contraception and STI prevention if their need for information and treatment is addressed. • According to WHO, about one half of all of the people infected with HIV are under the age of 25. • About half of all new HIV infections are among 15-24 year olds. • An estimated 1 in 20 youths contract STIs each year, and one-third of all STIs occur among 13-20 year-olds (110 million STIs/year). • In many African countries, up to 20% of all births are to women ages 15-19, and 40-70% of women have become pregnant or mothers by the end of their teens. • In many Latin American countries, 35% of women hospitalized for septic abortion are under age 20. • In many countries, maternal deaths are 2-3 times greater in women ages 15-19 than in women ages 20-24.	**TRAINER PRESENTATION (5 MIN.)** The trainer should present the introduction from the content section on the left-hand side of the page.

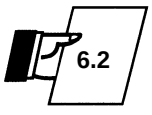
CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
These statistics document the extent of unprotected sexual activity among youth and demonstrate the clear need to protect young people both against STIs and pregnancy. **SAFER SEX** Sexually transmitted infections are infections that are spread through sexual contact, including vaginal, anal, and oral intercourse. Some can be spread through touching and kissing. Safer sex is anything that can be done to lower the risk of STIs and pregnancy. Safer sex reduces risks and can be practiced without reducing pleasure. **SAFER SEX TECHNIQUES** Abstinence is considered safe, but this depends on the definition of abstinence. If abstinence is the absence of sexual intercourse, it will prevent pregnancy, but not necessarily prevent all STIs. **THE RANGE OF "SAFER SEX"** "Safer Sex" describes a range of ways that sexually active people can protect themselves from STIs, including HIV infection. Practicing safer sex also provides protection from pregnancy. **No Risk** There are many ways to share sexual feelings that are **not risky**. Some of them include hugging, holding hands, massaging, rubbing against each other with clothes on, sharing fantasies, and self masturbation.	**QUESTIONNAIRE AND DISCUSSION (20 MIN.)** The trainer should: • Introduce the topic of safer sex using the content under *Safer Sex* and *Safer Sex Techniques* on the left-hand side of the page. • Pass out *Px Handout 6.1: Sexual Safety Questionnaire* and ask Px to spend about 10 minutes completing the questionnaire.  • Using *Trainer's Tool 6.1: Sexual Safety Questionnaire Answer Key*, read off the questions and ask Px to give the correct answers.  • Discuss questions that Px found difficult or answers with which they did not agree. **THE RISK GAME (30 MIN.)** The trainer should: • Hang up signs labeled HIGH, LOW, and NO RISK on the wall in a row. • Divide Px into 3-4 teams.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
Low Risk There are activities that are **probably safe,** such as masturbating your partner or masturbating together as long as males do not ejaculate near any opening or broken skin on their partners; using a latex condom for **every** act of sexual intercourse (penis in vagina, penis in rectum, penis in mouth); using a barrier (latex dental dam, a cut-open condom, or plastic wrap) for oral sex on a female or for any mouth to rectum contact. **Medium Risk** There are activities that carrier some risk, such as introducing an injured finger into the vagina or anus or sharing sexual toys (rubber penis, vibrators) without cleaning them. Oral sex without a latex barrier is risky in terms of HIV, although it carries less risk than unprotected anal or vaginal intercourse. Some STIs, like gonorrhea, are easily passed through oral sex while others, like chlamydia, are not. **High Risk** There are activities that are **very risky** because they lead to exposure to the body fluids in which HIV lives. These are having unprotected anal or vaginal intercourse. **Dual Protection** **Dual protection is the consistent use of a male or female condom alone or in combination with a second contraceptive method, such as COCs or DMPA. Often adolescents come to a clinic for contraception and are given a method that protects them only from pregnancy. As providers, we should ensure that all adolescents are using a method or combination of methods that protect them from both**	• Hand out tape and index cards with different risk behaviors to each group. Each group should get the same number of cards. • Explain to Px that the signs on the wall refer to the different behaviors on the cards. • Instruct Px to place the index cards under the sign that matches the behavior to the level of risk. The level of risk refers to STIs/HIV. • Allow 5-10 minutes for groups to place their index cards under the appropriate risk level. • Reconvene the large group. • Ask Px to review the index cards on the wall and decide if the behaviors are under the appropriate sign. • Use *Trainer's Tool 6.2. Answer Key to Risk Game* and the content on the left-hand side of the page to correct any mistakes or misunderstandings.  ? Ask Px, which behaviors are high risk for both unwanted pregnancy and STI/HIV? ? Ask Px, are there other behaviors that have not been included? • Rate any behaviors they suggest. • Conclude by discussing the importance of encouraging the use of dual protection among sexually active adolescents.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
pregnancy and STIs/HIV.	

Specific Objective #2: Identify reasons why adolescents may not practice safe sex

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)

REASONS WHY ADOLESCENTS MAY NOT PRACTICE SAFE SEX
 	
Ignorance
• Think they are not vulnerable to pregnancy or STIs/HIV. “It can’t happen to me” or "I don't have sex often enough to get pregnant or contract a STI/HIV."
• May not have adequate or accurate information about protection.
  – School sex education is often inadequate or non-existent.
  – Parents and others are reluctant to provide practical information. Some believe that providing information encourages sexual activity, though this has been proven to be untrue.
  – Media gives unrealistic notions of sexuality and usually omits any mention of protection.
• May have misinformation or myths about methods and their side effects.
• Don't know that methods are available.
• Don’t know where, how, or when to get methods.
• Myths about dangers of contraception
	LEARNING EXERCISE (40 MIN.)
	
	The trainer should:
	• Hand out 5 note cards or index cards to each Px.
	• Ask them to write one reason why adolescents practice unprotected sex on each of their 5 cards.
	• Allow 5 minutes for Px to write.
	• Collect all of the cards and discuss each card.
	• Group together cards that are alike.
	• Supplement answers from the list in the content section on the left-hand side of the page.
	• Ask Px to discuss how they would counsel an adolescent based on the reasons given for why s/he did not use protection.
	• Distribute *Px Handout 6.2: Talking About Condoms* and explain to Px that these are some of the responses that can be suggested to an adolescent who is having trouble negotiating condom use.
	
	 

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
are common and difficult to defuse. • May not believe that protection is needed with a regular partner. • May not believe that protection is needed if their partner looks healthy. • May think that STI/HIV transmission only occurs among "certain people" (i.e. commercial sex workers, poor people, or "other" ethnic groups). • May not be aware of alternatives to risky sex, such as mutual masturbation, etc. **Denial** • "Sex just happened." • "I only had sex once." • “My partner would not expose me to any risk.” • "Sex should be spontaneous." • Peers are not using protection so why should they? • Don't think they will get pregnant or contract a STI. • Didn't expect to have sex. **Lack of Access** • Access to contraceptive services for adolescents is limited by law, custom, or clinic/institutional policy. • Availability and cost of different methods may restrict access. • Irregular supply of methods available.	• Emphasize that the responses listed in *Px Handout 6.2* will be used later in Unit 9 when demonstrating proper counseling techniques. **UNIT SUMMARY (5 MIN.)** The trainer should: • Summarize the unit content. • Link content to the next session.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Spontaneous act—method not available when needed. • Provider's attitude towards contraception may prevent her/him from distributing protective methods to adolescents. **Coercion** • Boyfriend wants her to get pregnant. • Boyfriend/girlfriend won't let her/him use protection. • Boyfriend makes her have sex. • May have the attitude that condoms ruin sex or are unromantic. • Family coercion to conceive. **Fear** • Fear of rejection by partner. • Fear of the lack of confidentiality at the place where they obtain methods. • Fear of using something new—fear of the unknown. • Fear of side effects. • Fear about the proper use of protective methods. • Fear of where to keep protective methods so that no one sees them. • Fear that something may go wrong if they start using certain methods or products too early in life. • Fear that their parents will find out they are having or planning to have	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
sexual relations. • Fear that their peers will know they are sexually active. • Fear of physical examination, especially pelvic exam. • Fear of being asked questions by medical staff. • Fear of being labeled as "cheap" or "loose." **Embarrassment** • Service providers are sometimes judgmental and/or moralistic about adolescent sexual activity. • Embarrassed to buy condoms. • Retail outlets often place protective methods behind the counters so that customers must request them. • May be embarrassed to use a method at the time of intercourse. **Other factors** • Lack the skill and expertise to negotiate condom use. • Stopped using contraceptives because of the side effects. • Are impulsive and sexual activity is often unplanned. Even when sex is anticipated, often do not have protection available. • Believe that the suggestion of protection implies mistrust of one's partner and her/his faithfulness. • Adolescents desire conception. For a girl, it may be a way to keep a relationship or a boyfriend; for a boy,	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
conception may be a way to prove manhood; or they may be married. • May lack the communication and negotiation skills to discuss protection. • Thinks the partner "is taking care of protection." • Ambivalence about becoming pregnant. • Do not know how to dispose of condoms.	

UNIT 7:
CONTRACEPTIVE OPTIONS FOR ADOLESCENTS

INTRODUCTION:

Early pregnancy can have dire physical, social, and economic consequences for the adolescent. Providers should help young people avoid early pregnancy by counseling them on the importance of delaying childbearing and by providing appropriate contraceptive methods. Dispelling myths and misinformation about contraception and addressing the side effects of different methods helps ensure that the adolescent client will accept a method of contraception and continue to use it properly.

UNIT TRAINING OBJECTIVE:

To increase the provider's knowledge of contraceptive options for adolescents.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Explain the importance of delaying childbearing.
2. Identify contraceptive options for adolescents.
3. Identify common side effects and their impact on adolescent clients.
4. Identify and respond to misconceptions and rumors raised by adolescents.

TRAINING/LEARNING METHODOLOGY:

- Discussion
- Group work
- Trainer presentation
- Role play
- Mind mapping

MAJOR REFERENCES AND TRAINING MATERIALS:

- Cromer, B., R. Smith, J. Blair, et al. 1994. A prospective study of adolescents who choose among levornorgestrel implant (Norplant), medroxyprogesterone acetate (Depo-Provera), or the combined oral contraceptive pill as contraception. *Pediatrics.* 94:687.
- Family Health International. 1997. *Reproductive health of young adults: Contraception, pregnancy and sexually transmitted diseases.* Research Triangle Park, North Carolina: Family Health International.
- IPPF. 2000. IMAP statement on contraception and STI/HIV protection for adolescents. *IPPF Medical Bulletin*. 34 (Dec.):1-3.
- Polaneczky, M., G. Slap, C. Fork, et al. 1994. The use of levonorgestrel implants (Norplant) for contraception among adolescent mothers. *New England Journal of Medicine.* 331:1201.

RESOURCE REQUIREMENTS:

- Flip Chart
- Markers
- Slips of paper, tape
- Overhead projector
- Screen

EVALUATION METHODS:

- Pre- and post-test
- Participant evaluation form
- Reflections
- Where Are We?
- Trainer observation and assessment of group work
- Participation in group discussion

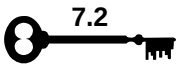
TIME REQUIRED: 3 HOURS, 40 MINUTES

WORK FOR TRAINERS TO DO IN ADVANCE:

- Prepare Transparency 7.1 and 7.3.
- Using available local data or Trainer's Tool 7.1, fill in recent data from your country and for two comparison countries in the chart on Transparency 7.2.
- Prepare Participant Handouts 7.1, 7.2, 7.3, and 7.4A-D.
- Obtain a small prize, if doing the optional exercise.

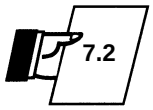
Specific Objective #1: Explain the importance of delaying childbearing

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
HEALTH RISKS OF EARLY PREGNANCY • **Cephalopelvic disproportion (CPD):** Adolescents younger than 17 often have not reached physical maturity and their pelvises may be too narrow to accommodate the baby's head. In these cases, obstructed delivery and prolonged labor are more likely, thereby increasing the risk of hemorrhage, infection, and fistula. • **Pre-eclampsia (hypertension of pregnancy):** If pre-eclampsia is left uncontrolled, it can progress to extreme hypertension, seizures, convulsions, and cerebral hemorrhage. • **Anemia:** The World Bank reports that anemia is 2 times more common in adolescent mothers than among older ones. • **Unsafe abortion:** Few young women have sufficient money to pay for an abortion. They tend to wait later in their pregnancy before seeking an abortion and often resort to cheaper and more dangerous methods. • **Premature Birth:** Infants born to adolescent mothers are more likely to be premature, of low birth weight, and to suffer consequences of retarded fetal growth. • **Spontaneous Abortion and Still Births:** Young adolescents under the	**TRAINER PRESENTATION AND DISCUSSION (15 MIN.)** The trainer should: ? Ask Px, what are the health risks related to early pregnancy? • Using *Transparency 7.1: Health Risks of Early Pregnancy* and the content on the left-hand side of the page, fill in any missing information.  • Using *Trainer's Tool 7.1 Demographic Data* or available local data, fill in *Transparency 7.2: Pregnancy Outcomes by Age*.  **MIND MAPPING (30 MIN.)** The trainer should: • Draw a picture of a tree on a flipchart. • The trunk of the tree should be labeled "Unwanted pregnancy." See

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
age of 15 are more likely to experience spontaneous abortion and still births than older women. **PSYCHOLOGICAL, SOCIAL, AND ECONOMIC CONSEQUENCES OF ADOLESCENT PREGNANCY** **For Girls** • Pregnancy often means the end of formal education. In most countries in sub-Saharan Africa, girls are expelled from school if pregnant. In Kenya, as many as 10,000 girls leave school every year due to pregnancy. • Adolescent pregnancy changes a girl's choice of career, opportunities, and future marriage. In many countries, unmarried mothers resort to low paying and risky jobs, domestic work, and even to prostitution to support their children. • Early marriage due to an unplanned pregnancy is frequently an unhappy, unstable one that leads to divorce. Both mother and child face the stigma of illegitimacy. • Young mothers are often ill prepared to raise a child, which may lead to child rearing problems like child abuse or neglect. • Girls resorting to commercial sex work are at higher risk for gender-based violence, substance abuse, and STIs such as HIV. **For Boys** • In some societies, early fatherhood may enhance a young man's social	*Trainer's Tool 7.2: Mind Mapping: Consequences of Unwanted Pregnancy*.  • Ask Px to remember some of the reasons adolescents may not practice safe sex that were discussed in the previous SO. Px should concentrate on reasons related to not using contraception. Write these reasons in the tree roots. • Ask Px to think of as many social, psychological, and economic consequences of an unwanted pregnancy as possible for the adolescent mother, father, and infant. • Each Px answer should be drawn as a piece of fruit on the tree. • Supplement answers with the content on the left-hand side of the page. • Show *Transparency 7.3: Adolescent Unmet Need for Contraception*.  • Explain that an early pregnancy has serious consequences for the adolescent mother, father, and child. It is important that childbearing is delayed as much as possible. *Transparency 7.3* shows the extent of unmet need for contraception. The provision of quality RH services is necessary to respond to this unmet need, thus reducing unwanted pregnancy.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
status, which may encourage boys to practice unprotected sex. • Some boys refuse to take responsibility for the pregnancy which can contribute to hardship for the mother and child and also can lead to future remorse. • Boys who become fathers lose opportunities for education and future economic advancement. Those who marry leave school to support their new families. • Young fathers are often ill prepared to raise a child, which may lead to child rearing problems like child abuse or neglect. • Premature marriages are frequently unstable and end in divorce.	

Specific Objective #2: Identify contraceptive options for adolescents

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
See Px Handout 7.2	**SMALL GROUP WORK (1 HOUR)** The trainer should: • Ask Px to break up into groups. • Divide the methods listed in *Px Handout 7.1: Adolescent Contraception Worksheet* among the groups.  • Ask each group to fill in the columns: *"safety appropriateness and special considerations for the adolescent client"* and *"counseling issues"* for each of their assigned methods. • Allow 20-30 minutes for group work. • Reconvene the large group. • Ask each group to present their conclusions to the larger group. Allow each group 5 minutes for their presentation. • Distribute the *Px Handout 7.2: Adolescent Contraception: Selection Guidelines for Contraceptive Methods.*  • Using *Px Handout 7.2,* discuss any misinformation and supplement answers.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
	OPTIONAL EXERCISE The trainer should: • Divide Px into 3 groups and label the groups “A,” “B,” and “C.” • Ask each group to come up with 4 questions about contraceptive methods that a young person might ask a health provider. • Ask Px to put away their handouts. • Instruct Group A to ask Group B a question. Group B’s answer should be thorough. • Group A should critique the answer and discuss whether it is correct, wrong, or only partially correct. • Group C should rate B's answer, giving a rating of 1-10 (10 being the highest). • Next, Group B should ask one of their questions to Group C. Group A should rate Group C’s answer. • Continue the rounds with different groups asking questions, answering, and scoring. • Provide a small reward to the group with the highest score.

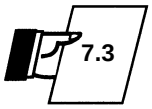
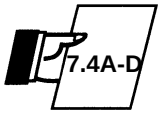
Specific Objective #3: Identify common side effects and their impact on adolescent clients

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
COMMON SIDE EFFECTS AND THEIR IMPACT ON CLIENTS **Most side effects from contraceptive methods pose no health risk to clients.** However, providers should take them seriously because they can be uncomfortable, annoying, or worrisome to clients. **For example**: A young woman who is using DMPA can experience spotting or amenorrhea. She may be worried that she will no longer be able to have children when she stops using the injection. **Some young women tolerate side effects better than others**; it is a very individual matter. **For example**: Some adolescents may not be bothered by weight gain but other young women may become very upset by a weight gain of even a few pounds (which may or may not be due to using a family planning method). Menstrual changes may be very worrisome to some clients and be seen as beneficial by others. **Side effects are the major reason that clients stop using a method**; therefore, providers should: • Treat all client complaints with patience, seriousness, and empathy. • Offer clients an opportunity to discuss their concerns. • Reassure the client that side effects are reversible.	**TRAINER PRESENTATION AND GROUP DISCUSSION (30 MIN.)** The trainer should: • Present key points on counseling about side effects found in the content section on the left-hand side of the page. • Have the Px discuss their experiences with side effects. • Give suggestions on how they would counsel clients to deal with them. • List the suggestions on a flipchart and add suggestions as necessary.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Differentiate side effects from complications. • Offer clients good technical and practical information, as well as good advice about how to deal with side effects. • Provide material for the client on side effects in local languages. • Provide follow-up.	

Specific Objective #4: Identify and respond to misconceptions and rumors raised by adolescents

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
Rumors are **unconfirmed stories** that are **transferred** from one person to another **by word of mouth**. Rumors are common among adolescents because so much information (or misinformation) is passed between and among them. In general, rumors arise when: • An issue or information is important to people, but it has not been clearly explained. • There is nobody available who can clarify or correct the incorrect information. • The original source is perceived to be credible. • Clients have not been given enough options for contraceptive methods. • People are motivated to spread them for political reasons. A **misconception** is a **mistaken interpretation of ideas or information**. If a misconception is filled with elaborate details and becomes a fanciful story, then it acquires the characteristics of a rumor. Rumors develop and can play a big role with adolescents because they are often ignorant about such matters as reproductive health and are eager to fill "in the blanks." Unfortunately, rumors and misconceptions are sometimes spread by health workers who may themselves be misinformed about certain methods or	**TRAINER PRESENTATION AND GROUP DISCUSSION** **(30 MIN.)** The trainer should: • Ask Px to explain the differences between a rumor and a misconception. • Write their responses on a piece of flipchart and validate their answers. • Cite reasons why rumors and misconceptions might be believable. • Distribute pieces of paper to Px. • Ask Px to write down common rumors that they have heard about different methods of protection. • Have Px tape their slips of paper to the wall. • Go around the room and have Px identify the underlying and immediate causes of some of the rumors they have heard. • Discuss the methods for counteracting rumors and misconceptions found in the content section on the left-hand side of the page. • Explain the importance of knowing both immediate and underlying reasons for rumors and misconceptions.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
who have religious or cultural beliefs pertaining to contraception that they allow to impact their professional conduct. The **underlying causes** of rumors have to do with people's knowledge and understanding of their bodies, health, medicine, and the world around them. Often, rumors and misconceptions about contraception make rational sense to clients and potential clients, especially to ill-informed young people. People usually believe a given rumor or piece of misinformation due to **immediate causes** (e.g., confusion about anatomy/physiology). Methods for Counteracting Rumors and Misconception • When a client mentions a rumor**, always listen politely. Don't laugh.** • **Define** what a rumor or misconception is. • **Find out where the rumor came from** and talk with the people who started it or repeated it. Check whether there is some basis for the rumor. • **Explain the facts** using accurate information, but keep the explanation simple enough for young people to understand. • **Use strong scientific facts** about contraceptive methods to counteract misinformation. • Always **tell the truth**. Never try to hide side effects or problems that might occur with various methods.	• Distribute *Px Handout 7.3: Immediate and Underlying Causes of Rumors* to illustrate your point.  **GROUP EXERCISE (30 MIN.)** The trainer should: • Divide the Px into groups. • Give each group one contraceptive method—COCs, IUD, Condoms, and DMPA. • Ask the groups to identify common rumors and misconceptions about the method and possible ways of combating these. • Have one of the groups present a rumor. • Ask Px to identify what the immediate reason could be for its popularity, some of the underlying reasons for the rumor, and how to counteract them. • Distribute *Px Handouts 7.4A-D: Rumors and Misinformation* 

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• **Clarify information** with the use of demonstrations and visual aids. • **Give examples of people who are satisfied users** of the method (only if they are willing to have their names used). This kind of personal testimonial is most convincing. • **Reassure the client** by examining her and telling her your findings. • **Use good counseling** techniques to inform the client about methods of contraception. • **Use visual aids** and actual contraceptives to explain the facts. • **Take the rumors seriously.**	**ROLE PLAY (20 MIN.)** The trainer should: • Ask for two volunteers to role play one of the rumors. • Have one Px play a client concerned about the rumor, the other a health worker counteracting the rumor. • Have Px discuss the role play. If time allows, ask other volunteers to role-play other rumors. **UNIT SUMMARY (5 MIN.)** The trainer should: • Summarize the unit content. • Link content to the next session.

UNIT 8:
STI/HIV AND ADOLESCENTS

INTRODUCTION:

According to WHO, about one half of all of the people infected with HIV are under the age of 25 and about half of all new HIV infections are among 15-24 year olds. One-third of all STIs occur among 13-20 year-olds. Given the inter-relationship between STI and HIV infection, it is imperative that providers successfully prevent new cases of STI/HIV infection and manage existing cases of STIs within the adolescent population. In low-resource settings, the use of syndromic management has proven effective in diagnosing and treating urethritis, genital ulcers, and abdominal pain. However, syndromic management is somewhat limiting due to the fact that it is not effective in diagnosing and treating vaginal discharge.

UNIT TRAINING OBJECTIVE:

To familiarize providers with successful STI/HIV prevention and management strategies for adolescents.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Describe the impact of STI/HIV on adolescents.
2. Identify prevention strategies used successfully in preventing STI/HIV transmission in adolescents.
3. Summarize appropriate syndromic and clinical management of STIs.

TRAINING/LEARNING METHODOLOGY:

- Discussion
- Question and answer
- Group work
- Game
- Trainer presentation

MAJOR REFERENCES AND TRAINING MATERIALS:

- Family Health International. 1997. *Reproductive health of young adults: Contraception, pregnancy and sexually transmitted diseases.* Research Triangle Park, North Carolina: Family Health International.
- Family Health International. 2000. Adolescent Reproductive Health. *Network*. 17 (3):1-35.
- Johnson, T. 1999. *The adolescent AIDS epidemic in Kenya*. Nairobi: Population Communication Africa.
- Joint United Nations Programme on HIV/AIDS (UNAIDS). 1998. *AIDS epidemic update: December 1998.* Geneva: UNAIDS.

RESOURCE REQUIREMENTS:

- Pencils
- Paper
- Tape
- Newsprint or flipchart
- Markers
- Prize for the game in SO#1

EVALUATION METHODS:

- Pre- and post-test
- Participant evaluation form
- Reflections
- Where Are We?
- Trainer observation and assessment of group work
- Participation in group discussion
- Assessment of case study analysis

TIME REQUIRED: 3 hours, 25 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

- SO#2: Prepare slips of paper for the group work.
- Obtain local data on prevalence of STI/HIV.

Specific Objective # 1: Describe the impact of STI/HIV on adolescents

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
WHY ARE YOUTH AT RISK FOR STIS/HIV? • Adolescent women are biologically more susceptible than older women to STIs. • The young female genital tract is not mature and is more susceptible to infection (a biological risk for girls). More cervical epithelial tissue is exposed at the opening of the vagina into the cervix and this tissue is more susceptible. • Women often do not show symptoms of chlamydia and gonorrhea, the most common STIs, and having another STI increases their susceptibility to HIV. Adolescent women become infected with HIV/AIDS at twice the rate of adolescent men. • Sexual violence and exploitation, lack of formal education (including sexuality education), inability to negotiate with partners about sexual decisions, and lack of access to reproductive health services work together to put young women at especially high risk. • Both adolescent boys and girls may have immune systems that have not previously been challenged and have not mobilized defenses against sexually transmitted infections. • Sexual intercourse is often unplanned and spontaneous.	**TRAINER PRESENTATION (5 MIN.)** The trainer should explain that adolescents often think that they are too young or inexperienced to get an STI. They think that they are not at risk because they believe that "only promiscuous or bad people get STIs." As a provider, you play an important role in teaching adolescents about how to prevent STIs as well as providing treatment for those who contract a STI. **LEARNING EXERCISE: YOUTH AT RISK COMPETITION (20 MIN.)** The trainer should: • Divide Px into 2 groups. • Ask each group to come up with as many biological and social reasons as they can that put youth at risk for STIs and record them on newsprint. One group should list risks for adolescent boys and one for adolescent girls. • Allow 10 minutes for groups to discuss. • Reconvene the large group. • Ask each group to present their lists. The group with the most reasons gets a prize. • Discuss the lists and supplement with information from the content.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)

• Adolescents lack basic information concerning the symptoms, transmission, and treatment of STIs.
• Adolescents often have multiple, short-term sexual relationships and do not consistently use condoms.
• Youth are subject to dangerous practices such as FGM, anal intercourse to preserve virginity, and scarification.
• Young men sometimes have a need to prove sexual prowess.
• In some cultures, girls are not empowered to say no.
• Young men may have their first sexual experiences with sex workers.
• Young women may have their first sexual experiences with older men.
• Youth lack accurate knowledge about the body, sexuality, and sexual health.
• There is a lack of political will to educate youth: no health/sexuality education, poor communication between youth and elders, and lack of materials directed at youth.
• Youth lack control and are subject to early marriage, forced sex, girl trafficking, and poverty.
• Youth often have little access to income and may engage in sex work for money or favors.
• Youth may be more prone to infection because of anemia/malnutrition.
	DISCUSSION AND GROUP WORK (45 MIN.)
	
	The trainer should:
	
	• Ask Px to form 4 small groups.
	• Ask each group to discuss for 20 minutes and report back on the following:
	  ? Is there data available on STI prevalence in your working area, clinic, or ward? If so, what kind of STIs do you see in your clinic?
	  ? What are the common STIs you see among youth coming to your clinic?
	  ? What educational materials directed at youth are available in your community? What kind of services do you render to youth in your working area?
	  ? Are there laws, policies, regulations, or community norms that prevent you from serving youth?
	  ? How often do adolescents come for protection against both STIs/HIV and pregnancy (dual protection)?
	  ? Are there myths or rumors about STIs/HIV that interfere with care and treatment? If yes, describe some of them.
	• Reconvene the large group.
	• Allow 20 minutes for presentations on the small group discussions.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Young people may be afraid to seek treatment for STIs. • Substance abuse or experimentation with drugs and alcohol is common among adolescents and often leads to irresponsible decisions, including having unprotected sex. • Adolescents may feel peer pressure to have sex before they are emotionally ready to be sexually active. • Young people often confuse sex with love and engage in sex before they are ready in the name of "love." A young person can be pressured into having sex or can pressure someone else by claiming that intercourse is a way to demonstrate love. • Young people may want sexual experience or may look for a chance to experiment sexually, which can lead to multiple partners, therefore increasing their chance of contracting and spreading STIs.	
LONG TERM HEALTH CONSEQUENCES OF STIS/HIV • Generally, the long-term health consequences of STIs are more serious among women. • Women and girls are less likely to experience symptoms, so many STIs go undiagnosed until a serious health problem develops. • Adolescents who contract STIs are also at risk of chronic health problems, including permanent infertility, chronic pain from PID, and cancer of the cervix.	**BRAINSTORMING (15 MIN.)** The trainer should: • Ask Px to brainstorm the long-term health consequences of STI. • Ask Px to brainstorm the long-term social consequences of STIs. • Fill in any missing information with content from the left-hand column.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Adolescents who contract syphilis may develop heart and brain damage if the syphilis is left untreated. • STIs are a risk factor for HIV transmission and for acquiring HIV, which leads to chronic illness and death. • STIs can be transmitted from an adolescent mother to her infant during pregnancy and delivery. Infants of mothers with STIs may have lower birth weights, be born prematurely, and have increased risk of other disease, infection, and blindness from ophthalmia neonatorum. **LONG-TERM SOCIAL CONSEQUENCES OF STIS/HIV** • Discrimination and exclusion from mainstream social groups – Loss of friendship groups – Diminished income potential – Possible eviction from residence – Blamed and treated as a "bad person" • Difficulty in finding marriage partner • Cannot participate fully in community activities/education due to ill health • Infertility and the loss of community credibility • Possible judgment and/or rejection by service providers	

Specific Objective #2: Identify prevention strategies used successfully in preventing STI/HIV transmission in adolescents

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
PREVENTION STRATEGIES FOR YOUNG PEOPLE Young people should have information about and be encouraged to: • **Delay onset of sexual activity.** Abstain from vaginal and anal intercourse until married or in a stable relationship. • **Learn how to use condoms.** Young adolescents should practice using condoms before becoming sexually active. If young people are already sexually active, it is important to make sure they know how to use condoms correctly. • **Use condoms.** These may be discontinued only when pregnancy is desired or when both partners in a stable relationship know for certain they are disease-free. • **Limit the number of partners.** Stick with one partner. • **Avoid high-risk partners.** Girls and boys should avoid older partners, sex workers, drug users, and truck drivers. • **Recognize symptoms of STIs.** If a person experiences burning with urination, discharge from the penis/vagina, and/or genital sores, young people and their partners should not have sex and should come to the clinic for treatment. • **Discuss sexual issues.** Young men and women must feel comfortable	**SMALL GROUP DISCUSSION (30 MIN.)** The trainer should: • Put colored candy or small pieces of colored paper in a bag or hat. Make sure you have 4-5 different colors. • Pass the bag around the room. • Break Px into smaller groups based on the color they chose. • Pass out different colored paper of different sizes to each group. For example, each group should have many pieces of large blue paper and many pieces of smaller yellow paper. • Ask Px to write on the larger pieces possible prevention strategies for STIs, i.e. encourage abstinence. • Ask Px to write on the smaller pieces of paper ways that these prevention strategies could be implemented, e.g. abstinence education. • Allow 20 minutes for writing. • Ask each group to tape their answers on the wall with the smaller pieces of paper underneath the prevention strategies. • Reconvene the large group. • Discuss answers. Try to group answers so that in the end you have one comprehensive list.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
communicating with their partners about sex and their sexual histories. A communicative relationship is essential to emotional and physical health.	

Specific Objective #3: Summarize appropriate syndromic and clinical management of STIs

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
APPROACHES TO THE MANAGEMENT OF STIS **Etiologic:** A diagnosis is based on the results of laboratory tests that can identify the specific organism causing the infection. Thus, it is possible to treat only for one infection. Results of laboratory tests should be returned quickly for effective treatment. **Clinical:** Provider makes a diagnosis (or educated guess) about which organism is causing infection based on the patient's history, signs, and symptoms. **Syndromic:** The patient is diagnosed and treated based on groups of symptoms or syndromes, rather than for specific STIs. All possible STIs that can cause those symptoms are treated at the same time.	**PRESENTATION AND QUESTION AND ANSWER (20 MIN.)** The trainer should: • Using the content in the left-hand column, present each approach to STI management. • Ask Px: ? What is needed for the etiologic approach? *Response: Patient must have symptoms, provider must be able to do a good physical examination and take laboratory samples, there must be skilled laboratory technicians, the lab must have working equipment and reagents, and the patient must return for results later. The client must be informed that it takes time for results to return from the lab.* ? What is needed for the clinical approach? *Response: The patient must have symptoms and a trained provider must be able to take a history and do a complete physical examination in a private space.* ? What is needed for the syndromic approach? *Response: The patient must have symptoms, and the provider must have knowledge of the prevalence of various STIs in the region, training in the use of flowcharts or a guide to*

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
	what signs and symptoms make up each syndrome, and the ability and private space to do a physical examination.
STI MANAGEMENT A 20-year-old male comes to the clinic for treatment. <u>Using Etiologic Management</u> The provider takes a history, does a physical exam, and notes a thick discharge from the penis. With a drop of the discharge, s/he makes a slide so a gram stain can be conducted immediately. The provider takes another sample of discharge to be tested later for chlamydia, the results of which will be ready in one week. The patient waits for two hours for the results of the gram stain, which is positive for gonorrhea. The provider gives treatment for gonorrhea and asks the patient to return in one week for results of the chlamydia test. The patient is asked to bring his partner for treatment and is counseled and given condoms. <u>Using Clinical Management</u> The provider takes a history and does a physical exam. If s/he sees a urethral discharge, s/he may diagnose gonorrhea because the discharge is thick and yellow in color. S/he treats the patient for gonorrhea and asks the patient to bring his partner(s) in for treatment. The provider counsels the patient and gives him condoms.	**SMALL GROUP WORK/LARGE GROUP DISCUSSION (50 MIN.)** The trainer should: • Describe the following case to Px: *A 20 year-old single man complains of burning on urination, discharge from his penis, and says he had a new sexual partner three days ago. On examination of the urethra, a thick, yellowish discharge can be seen.* • Divide Px into 3 groups and give each group markers and a piece of the flipchart. • Ask each group to do the following: – Choose one person to write on a piece of flipchart and another to present to the large group. – Discuss and describe the diagnosis and treatment of the patient in the case study using etiologic management (group 1), clinical management (group 2), and syndromic management (group 3). Include time, resources, and training needed. (5 min.) – Discuss and list separately the advantages and disadvantages of the STI management approach assigned to the group. (25 min.) • Reconvene the large group.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<u>Using Syndromic Management</u> The provider takes a history and does a visual inspection of genitals. There is a thick yellow urethral discharge. S/he treats the patient for the urethritis syndrome that, according to her/his national guidelines, includes treatment for gonorrhea and chlamydia. S/he asks the patient to bring his partner for treatment, counsels him, and gives him condoms.	• Ask the spokesperson from each group to present their conclusions. • Provide more information as needed from the content section on the left-hand side of the page. • Allow 20 minutes for discussion.

4. Syndromic Management of Vaginal Discharge
 	
Management of vaginal discharge has the following problems:
 	
1. Vaginal discharge most often indicates vaginitis. A number of studies have shown that the most common causes of vaginal discharge are bacterial vaginosis (BV), Trichomonas vaginalis (TV), and candidiasis. Of these, only TV can be sexually transmitted.
 	
2. Most women with cervicitis do not have any symptoms.
 	
3. Often vaginal discharge is either normal or related to vaginal infections. In many settings, 40-50% of women will say "yes" when asked if they have discharge. This can lead to massive overtreatment of STIs. Studies of the validity of syndromic management have shown that vaginal discharge should not be used as a routine screening tool.
 	
4. There is some evidence that syndromic management of vaginal
	DISCUSSION (15 MIN.)
	
	The trainer should:
	
	• Discuss what Px think are problems associated with the syndromic management of vaginal discharge.
	
	• Ask whether Px have encountered similar problems in the management of vaginal discharge.
	
	• Ask the following questions:
	
	  ? Do you think that asking questions to assess the patient's risk of STI may give more information? If so, how?
	
	  ? Is it useful to know the prevalence of specific STIs in your area? If so, why?
	
	• Explain to Px that the approach to syndromic management of vaginal discharge is changing.
	
	• Discuss *A New Approach to Syndromic Management of Vaginal Discharge* found in the content section on the left side of the page.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
discharge can be improved by examining the cervix to determine whether there is a cervical discharge or inflammation, but this requires training, tools, time, and supplies. **A New Approach to Syndromic Management of Vaginal Discharge** • We now know that vaginitis itself may have serious consequences. Bacterial vaginosis is associated with PID. BV and trichomoniasis are associated with pre-term labor and also with an increase in HIV transmission. • Treat vaginal discharge as vaginitis only, unless you have convincing reasons to believe the patient is at high risk for STI. This means not treating her partner initially. Treat with an antifungal if she has evidence of candida. • Assess the STI risk of any adolescent with vaginal discharge carefully. If you or she suspects high risk, treat her for cervicitis and vaginitis, and try to ensure partner treatment. • One of the best ways to reach young women at risk who are without symptoms is to target their partners. Find ways to welcome men to your clinic, reach out to men in the community, and make sure any men you treat for STIs have their partners treated and that they know how to use condoms.	• Present summary of the discussion. – The management of vaginal discharge is problematic, regardless of the approach. – In general, treat vaginal discharge as vaginitis unless you believe the patient is at high risk. – A careful risk assessment can add to the accuracy of the diagnosis. **UNIT SUMMARY (5 MIN.)** The trainer should: • Summarize unit content. • Link content to the next session.

UNIT 9:
COUNSELING THE ADOLESCENT ON SAFER SEX

INTRODUCTION:

Adolescents often do not have access to information and services regarding their sexual and reproductive health. This lack of access can result in misinformation and the inability to make responsible and appropriate decisions about protecting themselves from disease and pregnancy. Providers and counselors have an important role to play in both educating young people and facilitating responsible decision-making.

UNIT TRAINING OBJECTIVE:

To prepare providers to effectively counsel adolescents on safer sex, including contraception.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Explain the reasons for reproductive health counseling and factors influencing counseling outcomes.
2. Demonstrate how to counsel adolescents about safer sex and protection.
3. Identify several ways to counsel and motivate young men to make responsible choices.

SIMULATED SKILL PRACTICE:

Through role plays and the use of Competency Based Training (CBT) skills checklists from the modules of the *Comprehensive Family Planning and Reproductive Health Training Curriculum*, as well as the Counseling Cue Cards, participants will practice and demonstrate their interpersonal communication and counseling skills for speaking with adolescents. The simulated practice should include ways of addressing misconceptions and rumors, counseling adolescents and their partners on assessing risk and various methods of protection, and providing a method that protects against pregnancy and STI/HIV.

TRAINING/LEARNING METHODOLOGY:

- Discussion

- Group work
- Trainer presentation
- Role play simulated skills practice

MAJOR REFERENCES AND TRAINING MATERIALS:

- Barker, G. 1999. *Listening to boys: Some reflections on adolescent boys and gender equity.* Alexandria, VA: AWID Conference Paper.
- Sundari, T.K., M. Berer, and J. Cottingham, eds. 1997. Dual protection: Making sex safer for women*. Beyond acceptability: Users' perspectives on contraception.* London: Reproductive Health Matters for World Health Organization.
- Brick, P., C. Charlton, H. Kunins, and S. Brown. 1989. *Teaching safer sex.* Hackensack, NJ: The Center for Family Life Education, Planned Parenthood of Bergen County.
- Center for Communication Programs, Population Information Program, John Hopkins School of Public Health. n.d. CDROM. *HIM: Helping involve men*. Baltimore, MD: John Hopkins School of Public Health.
- Family Health International. 1997. *Reproductive health of young adults: Contraception, pregnancy and sexually transmitted diseases.* Research Triangle Park, NC: Family Health International.
- Pathfinder International, Focus on Young Adults. 1998. Reaching young men with reproductive health programs. *In Focus.* December.
- Hunter-Geboy, C. 1995. *Life planning education a youth development program.* Washington, DC: Advocates for Youth.

RESOURCE REQUIREMENTS:

- Flip Chart
- Markers
- Counseling Cue Cards
- IEC Materials

EVALUATION METHODS:

- Pre- and post-test
- Participant evaluation form

- Reflections
- Where Are We?
- Trainer observation and assessment of group work
- Participation in group discussion
- Observation and assessment of participants during role plays using the *CBT Skills Assessment Checklist*.

TIME REQUIRED: 4 hours

WORK FOR TRAINERS TO DO IN ADVANCE:

- Prepare Participant Handouts 9.1, 9.2, and 9.3

Specific Objective #1: Explain the reasons for reproductive health counseling and factors influencing counseling outcomes

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)

REASONS FOR COUNSELING
 	
• When the client-provider interaction is positive and the client feels that s/he was actively involved in the choice of a method, the chances are increased that s/he will:
  – Decide to adopt a method.
  – Use the method correctly.
  – Continue to use the method (increasing compliance and decreasing risk).
  – Increase effectiveness of method due to correct use.
  – Recognize side effects.
  – Cope successfully with minor side effects.
  – Return to see the service provider.
  – Not believe myths or rumors and even work to counteract them among family and community.
  – Motivate others to use protection.
• A well-informed, satisfied client also has advantages for the service provider due to:
  – Fewer unwanted pregnancies and STIs to handle.
  – Higher continuation rates.
	DISCUSSION (15 MIN.)
	
	The trainer should:
	
	• Ask Px to discuss their ideas regarding:
	  – Why counseling is a vital element of family planning services.
	  – The advantages of a well-informed and satisfied client for service providers.
	  – How counseling affects a client's satisfaction and continuation of a method.
	• List all suggestions on a flipchart and elaborate as necessary from the content on the left side of the page.

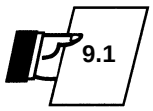
CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
– Fewer time-consuming minor complaints and side effects. • Satisfied clients often return for reproductive health services and refer other clients. • Increased trust and respect between client and provider. • Client knowledge of when to return. • Increased job satisfaction. • Confidence as number of clients increase. • Promotion/recognition.	
FACTORS INFLUENCING COUNSELING OUTCOMES In every counseling session, many different factors influence counseling outcomes. These factors should be taken into consideration when counseling. *Service Provider Factors* • Provider attitudes and behaviors • Style of provider (mutual participation model vs. authoritarian or provider-controlled model) • Provider knowledge and skills (communication and technical) • Provider method bias • Provider's own value system • Differences in client-provider ethnicity, caste, social class, language, gender, or education	**SMALL GROUP WORK (25 MIN.)** The trainer should: • Divide the Px into 3 small groups. • Ask the groups to identify factors that influence counseling outcomes in reproductive health service provision. • Assign service provider factors to Group 1, client factors to Group 2, and programmatic factors to Group 3. • Give some examples of what is meant by a "factor" in order to help the groups understand their assigned task. • Have each group present the factors they have identified on a flipchart. • Fill in where necessary with factors from the left-hand column and **summarize the main points.**

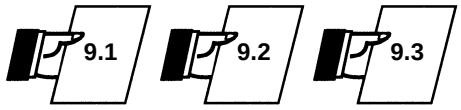
CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Provider is available and acceptable to client • Provider ensures confidentiality *Client Factors* • Ability to obtain method of choice, or second choice if precautions exist • Level of trust and respect towards provider • Provider's credibility as perceived by the client • Feels privacy and confidentiality are assured • Feels s/he is being treated with respect and dignity • Attitude and acceptance • Past history (experience with method of protection) • Client motivation • Demographic factors of the client *Programmatic Factors* • Number of methods available • Reliability of method supply • Privacy and confidentiality of surroundings • Social/cultural needs are met • Overall image of professionalism conveyed by clinic and provider	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Overcrowded waiting room/clinic • Convenient hours • Client friendly • Good referral system in place • Publicity—promoting services • Place is clean, easy to access • IEC materials	
COUNSELING ADOLESCENTS ON PREVENTION OF PREGNANCY AND STIS • Listen attentively to their concerns and make non-judgmental comments. • Reassure patients about confidentiality. • Assess the client's level of sexual activity by taking a sexual history. • Initiate discussion of contraception and protection from STIs. Include abstinence as a reasonable option. • Warn patients about which methods will not protect them from STIs and HIV. Recommend the use of a male or female condom for this purpose. • Give adolescent clients the opportunity to demonstrate condom use on a penis model or a pelvic model if it is a female condom. • Help clients learn to negotiate condom use.	**DISCUSSION (15 MIN.)** The trainer should: • Lead a discussion on effectively counseling adolescents on prevention of pregnancy and STIs using the content on the left-hand side of the page. • Ask Px if they have any other suggestions for effective counseling.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Suggest ways to help clients use their method correctly. • Dispel any misinformation about contraceptives. • Inform patients of non-contraceptive health benefits of their chosen method. • Use actual samples of methods to give adolescents the opportunity to learn about them, see them, and manipulate them. • Demonstrate usage of methods during counseling. • Help clients learn to assess and change their own risky behavior. • Advise clients about signs of STIs and how to seek treatment.	

Specific Objective #2: Demonstrate how to counsel adolescents about safer sex and protection

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
OBJECTIVES OF ROLE PLAY 1. To enable Px to practice interpersonal communication skills and apply the principles and steps of counseling using the CBT Skills Assessment Checklist. 2. To serve as a self-evaluation mechanism with which Px can assess her/his knowledge base of contraceptive methods and counseling skills. 3. To enable the trainer to objectively assess Px counseling skills and knowledge of contraceptive methods using the CBT Skills Assessment Checklist.	**ROLE PLAY, SIMULATED SKILLS PRACTICE, AND DISCUSSION (2 HOURS, 30 MIN.)** The trainer should: • Ask another trainer to assist. The two trainers should use role play to demonstrate examples of what constitutes "bad" counseling and "good" counseling. • The demonstration of a bad procedure should come first, followed by analysis and feedback. • When performing the *good* counseling role play, apply the GATHER steps in correct sequence so that Px can observe an example of how that approach should work. • Have Px use *Px Handout 9.1: CBT Skills Assessment Checklist for ARH Counseling Skills*.  • Ask Px to analyze the demonstration and provide feedback on what was positive or negative, what was missing, and whether there was wrong or incomplete information presented. • After the trainer demonstration, ask the Px to perform role plays using scenarios found in *Px Handout 9.2*, method-specific checklists *(Px Handout 9.1)*, counseling cue cards

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
	(Px Handout 9.3), and IEC materials if available. Each Px should participate in two role plays as actors (more if the trainer feels a Px needs more practice).  • If there is time, ask Px to include the client instructions found on the back of each cue card in their role play. ***NOTE:*** *If a particular exam or procedure would normally be done when providing a contraceptive method, Px should announce to the observers what they would do if they were in the clinic (i.e. now I would take the BP).* • Each Px is expected to participate actively in the role play process, as both a player and observer, and in group discussions and feedback. • Divide Px into two groups of equal size for simultaneous role play with one trainer per group. • Trainers should switch groups after the first one or two role plays in order to get as many trainer observations of individual Px counseling skills as possible. • Each Px should play the role of counselor and client (or client's family member, depending on the role play). • Observe and assess each Px for both counseling content, process, and participation in the exercise.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
	• Allow *actors/players* about 10 minutes to prepare, limit each role play to five or six minutes, and allow about 15 minutes for feedback and analysis of the process and content. • Encourage and guide the Px in constructive critique in analyzing what was good about the way the counselor handled the counseling and in suggesting what could be improved. • Remind Px not to confuse the actual participant with the actor's role, and that feedback and critique must not be personalized. • The trainer's role during feedback/ discussion should be to stimulate, guide, and keep track of time. • The trainer may wish to provide general feedback at the end of the Px discussion. • Upon completion of role plays, the trainer will need to provide feedback to individual Px, and discuss and sign off the *CBT Skills Assessment Checklist for ARH Counseling Skills* with each Px. • Summarize the major points observed in the exercise and respond to Px questions with the entire group.

Specific Objective #3: Identify several ways to counsel and motivate young men to make responsible choices

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
COUNSELING AND MOTIVATING YOUNG MEN Young men have special counseling needs and should receive special attention from providers to motivate them to make responsible choices regarding RH practices. Just as young women often prefer to talk to other young women about protection and sexual issues, young men often prefer to talk to other young men about these issues. **Young Men's Special Counseling Needs** • Young men need to be encouraged to support young women's use of protection and to use protection themselves (condoms). • Young men generally report having their first sexual encounter earlier than their female counterparts. • It is important to talk to young men (14-18) about responsible and safe sex before they become sexually active. • Young men often have little information about sexuality, contraception, and safe sex. In addition, young men are far less likely than young women to be targeted by RH communications and strategies. • Young men are often more concerned about sexual performance and desire than young women.	**TRAINER PRESENTATION, ROLEPLAY, AND DISCUSSION (30 MIN.)** The trainer should: • Use a flipchart to review with Px young men's special counseling needs. • Divide the Px into 2 or 3 groups and have each group conduct a role play of a provider counseling a man (alone or with a woman partner). • Reconvene the large group. • Discuss the role plays with the Px, including young men's special counseling needs. • Ask the Px to list ideas on how to motivate and counsel young men. **UNIT SUMMARY (5 MIN.)** The trainer should: • Summarize the unit content. • Link content to the next session.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Young men often have serious misconceptions and concerns that protection will negatively impact their sexual pleasure and/or performance. • Young men are often concerned that women will become promiscuous if they use protection. • Young men should be urged to use condoms through media/materials. STI/HIV should be addressed at the same time. Counselors/providers should stress that condoms are inexpensive, accessible, have no side effects, and offer dual protection. • Many young men do not know how to use condoms correctly. Providers should always demonstrate correct condom use, using a model when possible. • Young men are often not comfortable going to a health facility, especially if it serves women primarily. Providers should make themselves available where young men are in order to discuss safer sex, including using protection whenever possible (e.g. at schools, sporting events, work places, etc.). • If young men prefer, male counselors should be available to counsel. • Program planners should differentiate young men by age groupings of one to two years as they experience rapid developmental and emotional changes in adolescence.	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
Adolescent programs can be more male-friendly by: • Creating a separate entrance, a separate space (room), or special hours for young men. • Hiring more male clinic staff or counselors. • Offering free condom supplies. • Training staff on young men's RH needs. • Treating male clients more respectfully and sensitively.	

UNIT 10:
SEXUAL IDENTITY AND ORIENTATION

INTRODUCTION:

Sexual orientation can be a difficult subject to address because it sometimes conflicts with personal, cultural, or religious values and attitudes regarding sexuality. However, as providers and counselors, it is important to understand that a range of sexual orientations and identities exist. Adolescence is a time of sexual experimentation and defining a sexual identity. An adolescent client who is struggling with her/his sexual identity often experiences deep emotional turmoil that sometimes can lead to suicide. While providers and counselors may hold their own personal opinions regarding sexual orientation, it is their responsibility to provide accurate and unbiased information and services to all adolescent clients. Many gay and lesbian youth avoid health services for fear that they will be judged or that their sexual orientation will be disclosed to others. Providers and counselors can help clients overcome this fear by maintaining strict practices of confidentiality and serving clients in a non-judgmental manner.

UNIT TRAINING OBJECTIVE:

To help providers respond to issues of sexual orientation.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Identify the different types of sexual expression and orientation.
2. Respond to issues of sexual expression or orientation.

TRAINING/LEARNING METHODOLOGY:

- Group work
- Fishbowl exercise
- Trainer presentation

MAJOR REFERENCES AND TRAINING MATERIALS:

- American Academy of Pediatrics Committee on Adolescence. 2001. Statement of homosexuality and adolescence. *SEICUS Reports.* 29 (Apr.-May):23-25.

- Filiberti Moglia, R., and J. Knowles. 1993. *All about sex: A family resource on sex and sexuality.* New York: Three Rivers Press.

WEBSITES:

- International Gay and Lesbian Human Rights Commission
  http://www.IGLHRC.org

- International/National/Gay/Lesbian Rights Group
  http://www.igc.org/lbg/intl.html

- International Gay, Lesbian, Bisexual and Transgendered Resources
  http://www.contact.org/gay.htm

- Youth Resource Directory-GLBT Youth Links
  http://www.youthresource.com/links.htm

- International Lesbian, Gay, Bisexual, and Transgendered Youth and Student Organization
  http://www.iglyo.org

RESOURCE REQUIREMENTS:

- Markers
- Paper
- Tape

EVALUATION METHODS:

- Pre- and post-test
- Participant Reaction Form
- Where Are We?
- Reflections
- Quality of group work

TIME REQUIRED: 1 hour, 15 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

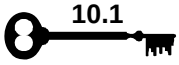
- SO#1: Prepare slips of paper with the definitions of sexual orientation and identity for the group exercise.
- SO#2: Prepare 3 slips of paper with one case study written on each. See *Trainer's Tool 10.1: Fishbowl Exercise*.

Specific Objective #1: Identify the different types of sexual expression and orientation

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
DEFINITIONS OF SEXUAL ORIENTATION & IDENTITY **Sex** refers to physiological attributes that identify a person as a male or female (genital organs, predominant hormones, ability to produce sperm or ova, ability to give birth). **Gender** refers to widely shared ideas and norms concerning women and men including ideas about what are "feminine" and "masculine" characteristics and behavior. Gender reflects and influences the different roles, social status, and economic and political power of women and men in society. ***Heterosexuality***–Sexual orientation in which a person is physically attracted to people of the opposite sex. ***Homosexuality***–Sexual orientation in which a person is physically attracted to people of the same sex. ***Bisexuality***–Sexual orientation in which a person is physically attracted to members of both sexes. ***Transvestism***–Person who dresses and acts like a person of the opposite gender. Both heterosexuals and homosexuals can behave this way. It may be just a phase or it can be permanent. ***Transexual***–Person desires to change or has changed their biological sex because her/his body does not correspond to her/his sexual identification. Sexual orientation varies.	**GROUP EXERCISE (25 MIN.)** The trainer should: • Using the definitions in the content section on the left-hand side of the page, write the words to be defined on a piece of flipchart. • Write definitions on small pieces of paper (to be done ahead of time). • Divide the group into 2 teams. • Divide the slips of paper with the definitions between the 2 groups. • Ask each group to match their definitions to the correct word on the flipchart. They should then tape their slip of paper to the matching word on the flipchart. • When the groups have finished, review their work. Correct any misinformation with the content on the left-hand side of the page. • Ask Px if they have any questions or comments.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
Transgendered– Person who lives as the gender opposite to their anatomical sex, (i.e. man living as woman but retaining his penis & sexual functioning). Sexual orientation varies. • The provider does not have to be an expert on sexual orientation. Providing an understanding ear and referring the adolescent to resources is often enough.	

Specific Objective #2: Respond to issues of sexual expression or orientation

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
SEXUAL ORIENTATION AND IDENTITY • Adolescence is a time of sexual experimentation and defining a sexual identity. Therefore, sexual behavior or conduct in adolescence does not necessarily equal sexual orientation. • Sexual conduct can be an act or rebellion. • Some gangs require initiation rites such as gang rape or homosexual acts. • Provider's need to stress that homosexual, bisexual, and transexual/transgendered behavior is normal regardless of the provider's personal views. • Adolescence is a period of change, and an adolescent's sexual identity may not be her/his permanent identity. • On the other hand, adolescence is a period when sexual identity starts to be defined. An adolescent who realizes s/he may be gay, bisexual, or transgendered may feel isolated and depressed, which can sometimes lead to suicide. It is the provider's responsibility to help the adolescent cope with her/his sexual orientation and accept her/himself. • The provider does not have to be an expert on sexual orientation. Providing an understanding ear and referring the adolescent to resources is often enough.	**TRAINER PRESENTATION (10 MIN.)** The trainer should: • Present the content information on the left-hand side of the page. • Ask Px if there are any questions or comments. **FISHBOWL EXERCISE (35 MIN.)** The trainer should: • Using *Trainer's Tool 10.1: Fishbowl Exercise*, write each of the client descriptions on a separate piece of paper.  • Arrange the chairs in a circle, placing two chairs in the center. • Select 2 Px, one to play the role of a counselor or provider and the other to play the role of a client. • Give the "client" a piece of paper describing the details of her/his character. • Instruct the client not to reveal who her/his character is but to act according to what is written in the description. • Instruct the "provider/counselor" that the goal of this exercise is to provide counseling in a nonjudgmental manner. The provider should make

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)

	sure the information s/he gives the client is helpful and accurate.
	
	• Ask the rest of the Px to sit in the outside circle. They should observe and critique the interaction between the "client" and the "provider/ counselor."
	
	• After 5 minutes, stop the exercise and ask the following questions:
	
	  ? Did the "provider/counselor" provide accurate and helpful information to the "client" in a non-judgmental manner?
	
	  ? If yes, what things did the "provider/counselor" do that led to a positive interaction?
	
	  ? What could the "provider/counselor" have done to improve the interaction between her/himself and the "client"?
	
	  ? Ask the "client" how the character s/he played felt in this situation?
	
	• Repeat this exercise several times with other case studies. For each case study, choose two different Px to act as the "provider/counselor" and the "client."
	
	UNIT SUMMARY (5 MIN.)
	
	The trainer should:
	
	• Summarize the unit content.
	
	• Link content to the next session.

UNIT 11:
SEXUAL ABUSE

INTRODUCTION:

Sexual abuse is often not recognized as a reproductive health issue. In some cultures, the subject of sexual abuse is often not discussed. However, as providers and counselors, it is important to recognize this problem as a reproductive health issue. If sexual abuse is not dealt with in a professional, nonjudgmental manner, it can lead to further sexual and reproductive health problems. Providers and counselors should possess good counseling skills and accurate knowledge of sexual abuse in order to help the adolescent client.

UNIT TRAINING OBJECTIVE:

To help providers recognize and respond to sexual abuse as reproductive health issue.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Explain the importance of sexual abuse as a reproductive health issue.
2. Identify physical and behavioral indicators of sexual abuse.
3. Demonstrate how to screen for sexual abuse.
4. Develop a strategy for responding to survivors of sexual abuse.

SIMULATED SKILL PRACTICE:

- Through role plays and the use of Observer's Role Play Checklist, participants will practice and demonstrate their skills in screening for sexual abuse. The trainer and other Px will provide constructive feedback to help improve the screening skills of each Px.

TRAINING/LEARNING METHODOLOGY:

- Trainer presentation
- Role play
- Brainstorming

- Group work
- Mind mapping
- Discussion
- Value clarification

MAJOR REFERENCES AND TRAINING MATERIALS:

- Advocates for Youth. 1995. *Child sexual abuse 1: An overview.* Washington, DC: Advocates for Youth.
- Chalfen, M.E. 1993. Obstetric-gynecologic care and survivors of childhood sexual abuse. *Clinical Issues in Perinatal Women's Health Nursing*. 4 (2):191-5.
- Cyprian, J., K. McLaughlin, and G. Quint. 1994. *Sexual violence in teenage lives: A prevention curriculum.* Burlington, VT: Planned Parenthood of Northern New England.
- de Bruyn, M. and N. France. 2001. *Gender or sex: Who cares. Skills building resource pack on gender and reproductive health for adolescents and youth workers with a special emphasis on violence, HIV/STIs, and unwanted pregnancy.* Chapel Hill, NC: IPAS.
- Filiberti Moglia, R., and J. Knowles. 1993. *All about sex: A family resource on sex and sexuality.* New York: Three Rivers Press.
- Hatcher, R., S. Dammann, and J. Convisser. 1990. *Doctor, am I a virgin again?: Cases and counsel for a healthy sexuality.* Atlanta, GA: Emory University School of Medicine.
- Heise, L., K. Moore, and N. Toubia. 1995. *Sexual coercion and reproductive health: A focus on research.* New York: Population Council.
- IPPF. 2000. *Statement on gender-based violence.* London: IPPF.
- Moeller, T., and G. Bachmann. 1995. Be prepared to deal with sexual abuse in teen patients. *Contemporary Adolescent Gynecology.* Winter:20-25.
- Seng, J.S., and B.A. Peterson. 1995. Incorporating routine screening for history of childhood sexual abuse into well-woman and maternity care. *Journal of Nurse Midwifery.* 40 (Jan.-Feb.):26-30.
- Seng, J.S., and J.A. Hassinger. 1998. Relationship strategies and interdisciplinary collaboration. Improving maternity care with survivors of childhood sexual abuse. *Journal of Nurse Midwifery*. 43 (Jul.-Aug.):287-95.

RESOURCE REQUIREMENTS:

- Flip chart
- Markers
- Projector
- Screen
- Prizes (candy or some other small objects like key chains, pens)

EVALUATION METHODS:

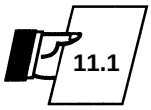
- Pre- and post-test
- Participant Reaction Form
- Where Are We?
- Reflections
- Observation and assessment of role plays using the Observer Checklist
- Quality of group work
- Participation in discussions

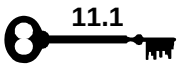
TIME REQUIRED: 4 hours, 15 minutes

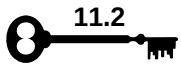
WORK FOR TRAINERS TO DO IN ADVANCE:

- Prepare copies of Participant Handouts 11.1, 11.2, 11.3, 11.4.
- SO#3: Prepare slips of paper with the barriers written on them.
- Be abreast of the current law relating to rape and sexual abuse.

Specific Objective #1: Explain the importance of sexual abuse as a reproductive health issue

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
INTRODUCTION Adolescents experience many different types of violence, both physical and sexual. Issues facing the adolescent include domestic violence, sexual abuse, sexual assault, sexual harassment, and gang-related violence. Although all forms of violence have a significant impact on adolescents, this unit will focus on sexual abuse and rape given their direct effect on young people's reproductive health. **SEXUAL ABUSE** Sexual abuse includes all forms of sexual coercion (emotional, physical, and economic) against an individual. It may or may not include rape. Any type of unwanted sexual contact is considered sexual abuse. **Rape** is defined as the use of physical and/or emotional coercion, or threats to use coercion, in order to penetrate a child, adolescent, or adult either vaginally, orally, or anally against her/his will. Rape is not a form of sexual passion; it is a form of violence and control. ***Acquaintance rape***—When the person who is attacked knows the attacker. ***Marital rape***—When one spouse forces the other to have sexual intercourse. ***Stranger rape***—When the person who is attacked does not know the attacker. ***Gang rape***—When two or more people sexually assault another person.	**BRAINSTORMING (15 MIN.)** The trainer should: ? Ask Px, what are the types of violence that adolescents experience? • Write answers on a piece of flipchart. ? Ask Px, which of these types of violence are related to sexual abuse and rape? ? Ask Px, why it is important to discuss sexual abuse? How does it relate to the RH work that you do? • Using the content in the first paragraph on the left-hand side of the page, introduce the topic of sexual abuse and rape within the context of overall violence. **TRUTH OR MYTH (15 MIN.)** The trainer should: • Distribute *Px Handout 11.1: Sexual Abuse Truth or Myth* to Px.  • Allow 10 minutes for them to complete the Truth or Myth exercise. • Ask for a volunteer to answer each question.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
Incest—When a person is sexually abused by his/her own family member. Perpetrators may be a: • Parent. • Partner. • Ex-Partner. • Boyfriend. • Family member. • Person living in the home. • Teacher. • Neighbor. • Acquaintance. • Stranger. Often adolescents are abused by someone they know and trust, although boys are more likely than girls to be abused outside of the family. Sexual abuse occurs in rural, urban, and suburban areas and among all ethnic, racial, and socio-economic groups.	Using the answer key *(Trainer's Tool 11.1*), review Px answers.  • Fill in any missing information from the content on the left-hand side of the page. • Emphasize that any time a person says "no" to any type of sexual contact, that it means NO!
WHY IS SEXUAL ABUSE A REPRODUCTIVE HEALTH PROBLEM? Sexual abuse and/or rape can impact an adolescent's reproductive health through: • Lacerations and internal injuries. • Unwanted pregnancy and its consequences (unsafe abortion, bad pregnancy outcomes, etc.).	**MIND MAPPING (15 MIN.)** The trainer should: • Write "sexual abuse" on the flipchart. • Explain that this is a mind mapping exercise. The point is to list direct and indirect consequences of sexual abuse and to indicate the relationships between them in order to create a tree.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• STIs, including HIV/AIDS. • Abortion-related injury. • Gynecological problems. • Sexual dysfunction. In addition to reproductive health problems, sexual abuse can cause fear, depression, and suicide. Sexual abuse survivors are more likely to participate in high-risk activities such as substance abuse, early sexual debut, having sex more often, and not practicing safe sex, making them more vulnerable to unintended pregnancy and STIs. This is often a result of feeling vulnerable and unable to say "no" to things they do not want to do, as well as feeling unworthy or incapable of undertaking self-protective behavior, as in the case of contraception.	• Use *Trainer's Tool 11.2: Consequences of Sexual Abuse* for instructions on how to facilitate the mind mapping exercise.  ? Ask Px, what are reproductive health consequences of sexual abuse? • Use *Trainer's Tool 11.2* and the content on the left-hand side of the page to correct or supplement answers. • Conclude by emphasizing the last paragraph in the content section on the left-hand side of the page.
CERTAIN ADOLESCENTS ARE AT INCREASED RISK OF SEXUAL ABUSE, INCLUDING RAPE • Adolescents who live in extreme economic poverty (forced into sex for money or to become street hawkers who may be assaulted while working) • Youth with a physical or mental disability • Youth who have a separate living arrangement from their parents • Street youth	**DISCUSSION (10 MIN.)** The trainer should: ? Ask Px, which adolescents may be more vulnerable to sexual abuse? • Fill in any missing information from the left-hand side of the page.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Adolescents with a mental illness • Substance abusers • Adolescents with substance abuse in the family • Orphans • Neglected youth • Adolescents whose parent(s) was physically/sexually abused as a child • Adolescents who live in a home with other forms of abuse, prostitution, or with transient adults • Adolescents who are in a juvenile home/jail • Homosexual youths who may be at greater risk because they are often socially marginalized	

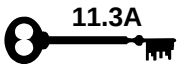
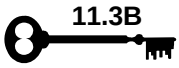
Specific Objective #2: Identify physical and behavioral indicators of sexual abuse

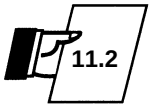
CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
PHYSICAL INDICATORS • Difficulty in walking or sitting • Torn, stained, or bloody underclothing • Pain, swelling, or itching in genital area • Abdominal pain • Abrasions or lacerations of the hymen, labia, perineum, posterior forchette, and breasts • Bruises, bleeding, or lacerations in external genitalia, vaginal, or anal areas • Unexplained vaginal or penile discharge • Perineal warts • Labial fusion • Oral infections (gonorrhea in the mouth) • STIs, especially HPV, HSV, and PID • Poor sphincter tone • Recurrent urinary tract infections • Pregnancy	**BRAINSTORMING GAME (35 MIN.)** The trainer should: • Divide the group into 2 teams. • Give each team 2 pieces of flipchart and markers. • Explain that this is a contest to see which team can come up with the most correct answers within an allotted time period. • Ask the teams to think of as many physical indicators of sexual abuse as they can and write them down on a piece of flipchart. • Allow 5 minutes for brainstorming. • Reconvene the large group. • Ask each team to present their answers on the flipchart. • Fill in any missing content from the left-hand side of the page. • Total the number of correct answers for each team. • Ask the teams to break up again and think of as many behavioral and emotional indicators of sexual abuse as they can. • Allow 5 minutes. • Reconvene the large group. • Ask each team to present their answers on the flipchart.

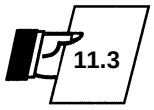
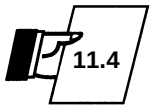
CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
BEHAVIORAL AND EMOTIONAL INDICATORS • Sexualized behavior (early onset of sexual activity, excessive masturbation) • Post-traumatic stress disorder • Inability to distinguish affectionate from sexual behavior • Low self-esteem • Fear • Anxiety • Guilt • Shame • Depression, withdrawal • Hostility or aggressive behavior • Suicide attempts • Sleeping disorders • Eating disorders • Substance abuse • Intimacy problems • Sexual dysfunction • Runaway behavior • Problems in school • Perpetration of sexual abuse to others Some of these behavioral and emotional indicators are controversial. The only	• Fill in any missing content from the left-hand side of the page. • Total the number of correct answers for each team. The team who has the most combined points wins. • Give a prize to the winning team. • Conclude by emphasizing the last paragraph in the content section on the left-hand side of the page.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
agreed upon indicators are sexualized behavior, including early onset of sexual activity, the inability to distinguish affectionate from sexual behavior, and post-traumatic stress disorder. Other behavioral indicators may be associated with sexual abuse; however, these symptoms do not necessarily differentiate sexually abused adolescents from those with problems other than sexual abuse. Because indications of sexual abuse are not always evident or straightforward, it should be stressed that **there is no substitute for a good history.**	

Specific objective #3: Demonstrate how to screen for sexual abuse

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
BARRIERS TO SCREENING FOR SEXUAL ABUSE Addressing sexual abuse in clinics can seem overwhelming to providers. The following are barriers that providers may express concern about: • Time constraints. • Lack of training about the issue. • Feeling there is nothing they can do to help. • The clinic is not the place to address sexual abuse. • More important health issues to be addressed. • Women's reluctance to talk about their experiences. • Belief that sexual abuse is a private or shameful issue. • Belief that sexual abuse does not occur with their patients. • Belief that sexual abuse is so prevalent that it is seen as a normal part of life. • There are no services for survivors of sexual abuse, so they should not bother to screen for sexual abuse. **However, these barriers are not insurmountable.** Already RH/FP clinics are seeing survivors of sexual violence. Staff members already discuss sensitive and	**BRAINSTORMING (20 MIN.)** The trainer should: • Write each barrier on a slip of paper or photocopy *Trainer's Tool 11.3A: List of Barriers to Screening* and cut so that each barrier is a slip of paper.  • Explain that addressing sexual abuse in clinics can seem overwhelming to providers. • Ask Px to draw a slip of paper out of a hat or bowl. There will probably not be enough barriers for every Px, so pair some Px together. ? Ask Px, how would you respond to this barrier? (For example: time constraints—RH clinics are already seeing survivors of sexual abuse and dealing with the sexual abuse may prevent RH problems in the future.) • Allow 5 minutes for discussion. • Ask each Px to read her/his barrier and response. • Supplement answers using *Trainer's Tool 11.3B.*  ? Ask Px, can you think of other barriers to screening for sexual abuse? • Emphasize that these barriers are not insurmountable.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
personal topics with clients. Screening for sexual abuse is the next logical step in the provision of comprehensive care.	**SCRIPTED ROLE PLAY (5 MIN.)** The trainer should: • Ask for two volunteers. • Using *Px Handout 11.2: Roleplay*, assign each volunteer a role.  • Ask the volunteers to read the roleplay. ? Ask Px, how did you interpret the roleplay? ? Ask Px, what things did you see and hear? ? Ask Px, what did you learn from the roleplay? *Response: We don't blame people for being robbed, but often we blame victims of sexual abuse or assault.*
SCREENING The following text outlines how to successfully screen a client: • Ensure confidentiality – Service environment that ensures privacy. – Restrict access to a client' s information to authorized personnel only. – Reassure the client that any course of action will only be taken	**DISCUSSION (15 MIN.)** The trainer should: • Present the information in the content section on the left side of the page. ? Ask Px, what is the best time during the RH visit to screen for sexual abuse? • Read the suggested questions. • Ask Px for other questions that might work in their culture.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
with the client's permission (within the limitations of the law). • Ask questions in a non-judgmental and empathetic manner. – Need for direct and indirect questions depending on the client. – Many adolescents are reluctant to acknowledge a history of abuse, even when questioned directly. Some clients may only disclose their experience over a period of time. If you suspect sexual violence, it is important to follow-up with sensitive inquiries during subsequent visits. Be patient. **Adapted from:** IPPF 2000. *Statement on gender-based violence.* London: IPPF. **When to Screen** Before physical examination while the client is fully clothed. **Questions that Can Be Asked** Some of these questions have been used successfully by other providers. "Many of the adolescents I see have felt that someone their own age or older, sometimes a relative, pressured them into sexual activities. I'm talking to all my patients about this, so even if it's not happening to them, they might be able to help a friend in that situation." "There are lots of reasons why kids your age have nightmares or fears. In some case, it is because someone has sexually abused them. Is that a possibility with you?"	• Ask Px what follow-up questions could be asked if the patient reveals sexual abuse. • Fill in any missing content. **ROLE PLAY (25 MIN.)** The trainer should: • Divide Px into groups of three. One Px will play the role of the adolescent, one the role of the provider, and the other will be the observer. • Distribute the case studies (*Px Handout 11.3)* and the *Observer's Role Play Checklist (Px Handout 11.4)*.   • Ask Px to switch roles using the three role plays so that each Px has a chance to practice screening for sexual abuse. • The observer should use the *Observer's Checklist* to assess the demonstration and provide feedback on what was positive, negative, or missing. • Reconvene the large group. • Ask for feedback from the actors and the observers. ? Ask Px, was it difficult or uncomfortable asking questions about sexual abuse?

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
"Have you ever been touched sexually against your will? If so, when did this happen? By whom?" **When the Patient Reveals Sexual Abuse** Ask whether it is still going on? Does the patient still have contact with the abuser? How old is the perpetrator and what is his or her relationship to the patient? What is the nature of the abuse? What type of coercion was used? **PHYSICAL EXAM** • A same-sex nurse or attendant should remain in the room during the exam. • The patient's parent(s) should be asked to leave so that the young person is afforded total privacy. • Some survivors of sexual abuse may find a physical exam traumatizing. Always allow the client to reschedule, and never act impatient or annoyed if they ask to reschedule. • Tell the patient that s/he is in control of this exam. The patient should tell you to stop any time that s/he feels uncomfortable. • It is important that the provider reports observations in a non-emotional, non-judgmental way. "I see you have a small cut here, does it hurt?" • Do not explain the diagnosis or ask further questions about the possibility	**DISCUSSION (5 MIN.)** The trainer should: ? Ask Px, what conditions should be present when conducting a physical exam on a patient who you suspect or know has been sexually abused? • Supplement or correct answers with content of the left-hand side of the page.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
of sexual abuse until after the client is fully clothed and the exam is over. • If necessary, translate all information into client's language to make sure they understand.	

Specific Objective #4: Develop a strategy for responding to survivors of sexual abuse

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)

WHAT CAN THE PROVIDER REALISTICALLY DO IN CASES OF SEXUAL ABUSE?
 	
They can:
 	
• Recognize that sexual violence exists.
  – Provide information on sexual abuse/assault in the waiting room.
  – Display posters with messages that sexual violence is not acceptable and that it is not an adolescent's fault if it happens.
 	
• Conduct a full history and physical exam.
 	
• Ensure treatment of any medical problems.
 	
• Screen and treat STIs or refer client for screening and treatment.
 	
• In the case of rape, offer emergency contraception if it has been less than 72 hours since the assault occurred.
 	
• In the case of rape, offer a pregnancy test or refer.
 	
• Offer referral for abortion if appropriate and possible.
 	
• Gather simple forensic evidence.
 	
• Counsel. Provide understanding and compassion.
 	
• Refer the adolescent to legal or social services that deal with sexual abuse.
	BRAINSTORMING AND GROUP WORK (1 HOUR, 30 MIN.)
	
	The trainer should:
	
	• Break Px into 4 groups.
	
	• Read the following scenario: K_ comes in to your clinic because she thinks she might have a STI. After talking with her, you discover that her older cousin has been forcing her to have sex.
	
	• Ask each group to brainstorm what steps they would take to make sure the client was safe and received assistance. This should include other services to which they can be referred.
	
	• Allow 10-15 minutes for brainstorming.
	
	• Reconvene the large group.
	
	• Ask each group to share their conclusions.
	
	• Using the content on the left-hand side of the page, fill in any missing information or correct any misunderstandings.
	
	? Ask Px, what could currently be done in your workplace if such a situation occurred? What has been successful? What hasn't?
	
	• Ask Px to divide into small groups made up of colleagues from their own facility or area if possible.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Try to establish a safe place for the adolescent to go temporarily (if the abuse is going on inside the home). • At the very least, try to identify one person who can be a source of support for the adolescent. • Offer the option of reporting the assault/abuse to appropriate authorities. • Work with parents and the community to recognize that sexual abuse is an important RH problem. Sexual abuse is a very complex problem. The provider can only do so much. It is important to do what one can and not to feel discouraged because one cannot solve the whole problem.	• Ask Px groups to develop a strategy to respond to problems of sexual abuse that can be used in their own clinics. Strategies should reflect resources available at individual clinics. • Allow 30 minutes for groups to develop their clinic strategies. • Reconvene the large group. • Ask each group to present their strategies. • Encourage Px to share their strategies with the director/manager of their clinic upon their return to work. **UNIT SUMMARY (5 MIN.)** The trainer should: • Summarize the unit content. • Link content to the next session.

UNIT 12:
PREGNANCY, BIRTH, AND POSTPARTUM ISSUES

INTRODUCTION:

The birth of a child can be both an exhilarating and an exhausting experience. Women have many emotional and physical needs during pregnancy, birth, and the postpartum period that must be met. However, a pregnant adolescent may have additional or different needs than those of an older woman. In order to successfully help the adolescent through this period, providers need to distinguish how an adolescent's emotional and physical needs are different than those of an adult woman and develop appropriate responses to these needs.

UNIT TRAINING OBJECTIVE:

To help providers understand and respond to the emotional and physical needs of the adolescent during pregnancy, labor and delivery, and the postpartum period.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Identify the essential components of routine prenatal care for adolescents.
2. Describe the physical and emotional needs of adolescents during labor and delivery.
3. Recognize adolescent needs during the postpartum period.
4. Discuss parenting and infant feeding.

TRAINING/LEARNING METHODOLOGY:

- Lecturette
- Trainer presentation
- Discussion
- Group work
- Brainstorming

MAJOR REFERENCES AND TRAINING MATERIALS:

- Biancuzzo, M. 1999. *Breastfeeding the newborn: Clinical strategies for nurses*. St. Louis, MO: Mosby, Inc.
- Bledsoe, C., and B. Cohen. 1993. *Social dynamics of adolescent fertility in sub-Saharan Africa.* Washington, DC: National Academy Press.
- Department of Health, Philippines. 1994. *Health work is team work! An operations manual for community volunteer health workers.* Manila: Department of Health.
- Family Health International. 1997. *Reproductive health of young adults: Contraception, pregnancy and sexually transmitted diseases.* Research Triangle Park, NC: Family Health International.
- Friedman, H. and K. Edstrom. 1983. *Adolescent reproductive health: An approach to planning health service research.* Geneva: World Health Organization.
- Klein, S. 1995. *A book for midwives: A manual for traditional birth attendants and community midwives*. Palo Alto, CA: The Hesperian Foundation.
- Marshall, M., and S. Buffington. 1998. Module 2: Quality antenatal care*. Life-saving skills manual for midwives.* 3rd edition*.* Washington, DC: American College of Nurse-Midwives.
- McCauley, A. P., and C. Salter. 1995. Meeting the needs of young adults*. Population Reports.* Series J. (41).
- Mishra, S., and C. S. Dawn. 1986. Retrospective study of teenage pregnancy and labor during 5 years period from January 1978 to December 1982 at Durgapur Subdivisional Hospital. *Indian Medical Journal.* 80 (Sept.):150-152.
- Wallace, H., K. Giri, and C. Serrano. 1995. *Health care of women and children in developing countries.* 2nd edition. Oakland, CA: Third Party Publishing Company.
- World Bank. 1987. *World tables, 1987*. Washington, DC: World Bank and International Finance Corporation.

RESOURCE REQUIREMENTS:

- Flipchart
- Markers
- Tape
- Overhead projector
- Screen

EVALUATION METHODS:

- Pre- and post-test
- Participant Reaction Form
- Where Are We?
- Reflections
- Quality of group work
- Participation in discussions

TIME REQUIRED: 2 hours, 40 minutes

WORK FOR TRAINERS TO DO IN ADVANCE:

- Prepare Transparency 12.1

Specific Objective #1: Identify the essential components of routine prenatal care for adolescents

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
PHYSICAL CARE OF A PREGNANT ADOLESCENT How is providing care for an adolescent different from providing care for an older pregnant woman? **Risk Assessment** Assess whether you think your patient is at high risk. Your adolescent patient is already at risk if she is under 16 years of age. To determine additional risk, take a history and look for the following: • Parity: first pregnancy. • Delivery site: not planned or prepared. • Family support: not enough food, rest, money, or help with work. • History of anemia. • History of abdominal surgery. • History of genital tract surgery or circumcision. • History of blood transfusion. • History of STIs including HIV/AIDS. • History of sickle cell disease, heart disease, diabetes, epilepsy, asthma, or tuberculosis. • History of drug or alcohol use. • Received Tetanus Toxoid.	**TRAINER PRESENTATION AND BRAINSTORMING (40 MIN.)** The trainer should: • Remind Px that we already know that pregnant adolescents are at higher risk for premature labor, hemorrhage, obstructed or prolonged labor, iron-deficiency anemia, spontaneous abortion and resorting to unsafe abortion. • Prepare a flip chart. • Ask Px to brainstorm what information they would collect from an adolescent to determine her level of risk. • Write down Px suggestions on the flipchart. ? Ask Px, why is each piece of information important? • Using a second piece of flipchart, ask Px to brainstorm what physical and laboratory examinations they would do to address risk factors common to adolescents. • Using a third piece of flipchart, ask Px to brainstorm what should be included in the prenatal counseling session. • Supplement answers with information in the content section on the left-hand side of the page.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
In addition to taking a full history, the provider should also do the following: • Measure height—women under 5 feet or 1.6 meters tall may be more at risk if short stature is due to disease or malnutrition. • Measure the pelvis to rule out CPD. • Measure fundal height to check for small-for-date fetus. **Anemia** • At the first prenatal visit, ask the adolescent about her diet. Ask her to recall what she ate the day before. Ask if she is avoiding any foods because she is pregnant. Ask if she can afford to eat regularly and well. Ask what foods she dislikes. • Examine her for anemia. Look at her eyelids, nailbeds, gums, and palms. Severe pallor indicates a hemoglobin under 8 grams and severe anemia. Other signs of anemia include tiredness, fainting, dizziness, shortness of breath, and a fast heartbeat. • Check hemoglobin at the first visit and every 2 months during pregnancy. If the hemoglobin falls below 8 grams (55%) on any visit, it should be checked every visit until it returns to normal. • Counsel her about foods rich in iron and folic acid. Give or prescribe ferrous sulfate 320 milligrams (60 mg elemental iron) 2 times a day. If her hemoglobin is 8 grams or less, increase her iron to 1 tablet 3 times a	• Show *Transparency 12.1: Percentage of Adolescents that Receive Prenatal Care or Deliver in Hospitals/Health Facilities* and discuss the challenge of increasing the number of adolescents who have access to prenatal care or safe delivery. 

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
day for the rest of her pregnancy. Also, give folic acid 500 microgram (mcg) each day. • Check for other causes of anemia, such as parasites. • At each visit, check to make sure she is taking her iron pills. **Pregnancy Induced Hypertension (pre-eclampsia)** • Ask if she has had any: epigastric pain (heart burn) not related to malaria, headaches, visual problems (double vision, partial vision, rings around lights), and edema or swelling of hands, face, and feet. • Take her blood pressure at every visit. A normal blood pressure should be below 140/90. If the BP is elevated, check reflexes and urine. **Nutritional Counseling** • Adolescents are not usually very knowledgeable about good nutrition. Nutritional advice must consider both the fetus and the mother since they compete for the same nutrients. • Adolescents stop growing in height about 4 years after menarche. If the pregnant adolescent has not stopped growing, she will need a higher nutrient intake than an adolescent who has completed growth. • Take a diet history. Ask her what she ate yesterday and how much. • Decide whether you think her diet is adequate.	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Adolescents should eat more protein than they usually do. • Lactation in adolescents can result in loss of calcium from the bones, so additional calcium is needed. This is especially true if pre-pregnancy nutrition is poor. • Prenatal zinc supplementation is associated with improved pregnancy outcome in adolescents, so adequate zinc in the diet is important. • Discuss foods that are good for her: – **Rich sources of iron–** Egg yolk, ground nuts, dried navy and lima beans, dried apricots, dried peaches, prunes, figs, dates, raisins and molasses, fish and meat, sunflower seeds, nuts, and amaranth leaves. – **Rich sources of folic acid–** Dark green leafy vegetables, liver and fish, nuts, legumes, eggs, whole grains, and mushrooms. Cooking food too long destroys folic acid. – **Rich sources of calcium–** Milk, yogurt, cheese, green leafy vegetables, bone meal, beans (especially soy), and shellfish. – **Rich sources of Vitamin C–** Most fruits and vegetables. Cooking destroys Vitamin C. – **Rich sources of Vitamin A–** Dark yellow and green leafy vegetables and some orange fruit. Cooking food too long can destroy Vitamin A.	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
COUNSELING IN PRENATAL PERIOD The pregnant adolescent and her partner or family members should be counseled on the following: • Protecting herself from HIV infection by using condoms. • Preparing for delivery and postnatal period. • Advice on hospital delivery (or at a minimum, delivery by a trained provider). • How to recognize signs of labor or danger. • Use of contraceptives after delivery. • Decrease in workload and rest in third trimester.	

Specific Objective #2: Describe the physical and emotional needs of adolescents during labor and delivery

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
INTRODUCTION The birthing process is both physically and emotionally demanding. The woman's body goes through transformation of tissues and organs and tremendous changes in hormones that affect every bodily system. The combination of these changes impact women's emotions, ranging from exhilaration, anticipation, and anxiety during early labor to fear, a sense of being overwhelmed, loss of control, and a desire to end the process immediately towards the end of labor. **BIRTH PREPARATION DURING THE PRENATAL VISIT** During the prenatal visit(s), providers can help adolescent women to develop a birth plan that will focus on: • What to do if any danger signs of pregnancy occur. • Identifying the person(s) to provide physical and emotional support during labor. • When to check in with the health staff if they suspect that labor is beginning. • How they will get to the hospital or clinic. Childbirth preparation classes will give both the adolescent and her support person(s) the necessary information and techniques to make labor more comfortable.	**DISCUSSION AND GROUP WORK (30 MIN.)** The trainer should: • Briefly present the information under the *Introduction* in the content section on the left-hand side of the page. • Explain that earlier during the training, the psychosocial characteristics of adolescents were discussed. • Ask Px to recall some of these characteristics and list them on a flip chart. • Divide Px into 2 groups. • Ask one group to discuss how to address the psychosocial characteristics of adolescents when preparing for delivery during the prenatal visit(s). For example, adolescents are present-minded and they don't plan ahead. Providers must help adolescents plan for delivery and answer questions such as: who will help with the delivery, how will they get to the hospital or clinic, what will they do in case of an emergency, etc.? • Ask the second group to discuss how to address the psychosocial characteristics of adolescents during labor and delivery. For example, adolescents often do not have adequate information about their bodies and what will occur during

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
It will often be necessary to repeat instructions. Have the client repeat instructions to you and ask her what she will do if: • Contractions increase in intensity, frequency, and duration. • Water begins to leak from the vagina, with or without contractions. • Danger signs occur. Build the adolescent's confidence by telling her that you know she will take the correct action when the time comes. Include the support person(s) in the instruction giving so that they can remind the young mother when anxiety interferes with recall. Give and repeat instructions when the adolescent presents with signs of false or early labor. **LABOR AND DELIVERY** The cardinal rule for birthing care for an adolescent is **NEVER LEAVE HER ALONE**. Support, comfort, and explanations of what is happening or going to happen will break the cycle of *fear* that produces *tension* and thereby increases the intensity of *pain*. Support also increases the likelihood that the adolescent will cooperate when you need her to do so. Friends, the adolescent's partner, family members, or anyone the adolescent identifies can and should be encouraged to be involved in providing physical care and emotional support.	labor and delivery. Fear of the unknown can be eased by providing support and explaining what is happening or will happen. • Allow 15 minutes for group work. • Ask each group to present their conclusions. • Fill in any missing content from the left-hand side of the page.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
Special Provider Characteristics for Managing Adolescents During the Birthing Process • The provider's demeanor to support adolescents during the birthing process requires patience, understanding, explanations, compassion, and caring. Adapt to the adolescent's individual needs in order to support her coping efforts. • Create an atmosphere of inclusion with family and/or identified support person(s). • When preparing to perform examinations and procedures, explain to the adolescent and her support person what you will be doing and why; perform maneuvers slowly and gently. • Use firm but caring speech to get the adolescent's attention. Shouting is never acceptable.	
GENERAL SUPPORT FUNCTIONS FOR THE LABORING ADOLESCENT • Ensure privacy and prevent the adolescent from being exposed to others as a sign of respect for the client as a person. • Keep the adolescent clean and dry. This promotes relaxation and reduces the risk of infection. Give special attention to cleaning away any blood, feces, and amniotic fluid from the genital area. Refresh the adolescent with cool wet cloths if she perspires heavily; change her damp clothing and bedding, if possible.	**LECTURETTE (15 MIN.)** The trainer should: • Give a brief lecturette on support for the laboring adolescent using information from the content section on the left-hand side of the page. Make sure to include information on the different stages of labor. • Ask if there are any questions of comments.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Provide mouth care—encourage the adolescent to brush her teeth; offer mouthwash, if available; apply ointment to the lips; offer sips of cool water or ice chips; and offer or ask the support person/family to bring hard candies or a wet cloth for the adolescent to suck on. • Since labor generates heat, fan the adolescent using a washcloth, a glove package, or by raising and lowering the hem of her gown/wrapper. Cool compresses to the back of neck, axilla, or groin bring relief and calm. • Rub her back if she is experiencing pain in her back. Applications of heat or cold can also help give comfort. • Encourage the adolescent to empty her bladder frequently. • Remember that medication is a relief measure and offer it wisely. **False Labor** • Facilitate relaxation and/or sleep. • Provide diversions to help pass the time, e.g. light sedation, warm bath, warm shower, hot drinks (such as tea with sugar, milk, or chocolate), or have a family member or support person give the adolescent a back rub. • Encourage walking to stimulate true labor or relieve false labor. **Early Labor** • Provide comfortable chairs for the adolescent and her support	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
person(s), and provide diversions to help pass the time, such as playing cards, games, books, magazines, radio, or television. • Encourage the adolescent to walk around. • Offer light meals (fruits, porridge) and liquids (water, juices, tea). • If the adolescent lives close to the facility, encourage her to remain at home during the early stages of labor. • Review with her and her support person when to return. **Active Labor** • **Do not leave the adolescent alone**. Strong, rapid contractions can make her feel frightened. • Help her cope with her fears and discomfort. Take your cues from her—ask her what she wants that would make her feel better. • When touching her, touch her gently. Position the adolescent comfortably using pillows or rolls of linen. Encourage her to lie on her side. • Guide her with breathing techniques as her labor progresses if she did not attend preparation classes. If she and her support person attended preparation classes, remind them at the critical point which breathing technique to use. Observe whether the adolescent is holding her breath when she should be breathing, and guide her in breathing.	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
Transition Labor • When signs of this phase of labor begin, provide support by encouraging relaxation breathing and lower back counter-pressure, if indicated. • Honor the adolescent's request for comfort measures within the limits of safety. • Provide IV fluids, if indicated. • Assist the adolescent to gain comfortable positions, e.g. side, standing, or squatting. • Continue to guide the breathing techniques; instruct the adolescent in panting breathing when she feels like pushing but should not yet push. • Help the client and her support person get in position for pushing (raised back, side, squatting, standing knee-chest, hand-knees). Avoid having the adolescent flat on her back during pushing. • Talk to the adolescent during the actual birth to minimize tension and fear from the intense sensations and to gain her cooperation for a controlled birth. **Remember the Support Person** • The support person should be made to feel welcome for their important function—working with the adolescent during labor. • Help the support person feel the importance of her/his support to the adolescent.	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Encourage the support person to provide physical comfort measures such as wiping the brow, giving sips of water or ice, fanning, and rubbing the adolescent's back. • Remind the support person to take breaks, nourishment, and fluids. This will enable her/him to give the adolescent what she needs. • Avoid sending the support person out of the room during examinations and/or procedures unless the adolescent wants the person to leave. The support person can help the adolescent to not focus on the exam or procedure.	

Specific Objective #3: Recognize adolescent needs during the postpartum period

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
IMMEDIATE POSTPARTUM CARE • As with most new mothers, the adolescent will be concerned if the baby is not close to her. • After the birth of the baby, the young mother's body goes through another set of dramatic, physical changes and a wide range of emotional responses such as pride, a feeling of accomplishment, fatigue, and hormonal shifts. • Adolescent mothers have the compound challenge of continuing to establish their own identify while they adjust to the role of being a mother. • The first hour after birth is a highly sensitive period for maternal-child bonding. Take every opportunity to facilitate and support this bonding process. Keep mother and baby together as much as possible, conduct the preliminary infant examination in the presence of the mother (and support person), and include her. – Show her unique aspects of her baby. – Have her touch the baby's head, feel molding, count fingers/toes. – Point out to her the baby's normal reflexes. – Assist the mother to breastfeed successfully with correct attachment, taking baby off the	**DISCUSSION (25 MIN.)** The trainer should: • Present the first three bullets under *Immediate Postpartum Care.* ? Ask Px, what can the provider do in the first hour of the postpartum period to facilitate mother-child bonding? • Use the content on the left-hand side of the page to supplement answers. ? Ask Px, what else should be included in immediate postpartum care? • Present the first two paragraphs under *Postpartum Period.* ? Ask Px, what might the adolescent mother be feeling in the postpartum period? This question should elicit a discussion around postpartum blues and other concerns that the adolescent mother may have. ? Ask Px, what is the provider's role during the postpartum period? • Use the content on the left-hand side of the page to supplement answers.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
breast, keeping the baby's nose unobstructed, and establishing comfortable positions for feeding. • Before the adolescent leaves the hospital or facility, explain the signs of postpartum complications and when to return to the hospital. **POSTPARTUM PERIOD** The period of six weeks following birth is a period of dramatic change and tremendous adjustment that affects the young mother physically and emotionally. The demands of mothering are high, and the adolescent mother will need support from those closest to her not to feel overwhelmed and tempted to give up. It is a critical time for learning and guidance, yet it must be given in a way that does not make the young mother feel incompetent. Help and guide her to carry out tasks as she is able within the limits of safety; praise her efforts; and offer corrections as "tips" for doing something. Home visits are a valuable tool during the postpartum period; They provide an opportunity to assess the environment for security and comfort and to communicate caring to the young mother. Engage the young mother and her family in making adjustments to enhance security and comfort. As the adolescent mother tries to cope with the demands of infant care (e.g. sleep deprivation, physical discomfort), the psychological shift into a role of greater responsibility, and rapidly altering hormone levels, dramatic mood swings characteristic of *postpartum blues* may	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
occur. Postpartum blues usually occur around the third to fifth day after birth and range from mild (feeling "down," teary, unexplained sadness, easily upset) to more profound with frequent bouts of crying for unexplainable reasons. It is normal for all women to experience a sense of loss after birth, but it may be more acute for the adolescent. Some causes of postpartum blues are: • Loss of physical attachment to the baby; empty space where the baby was. • Loss of attention, no longer "center-stage." • Adjustment to yet another self-image. • Loss of freedom to pursue adolescent interests with peers. • Heightened sense of insecurity and lack of self-confidence with resultant over-sensitivity to comments. **Provider's Role** The primary goal of health staff is to help the adolescent mother successfully take on the role and responsibilities of mothering. Adolescents need close monitoring to keep them focused on the wide range and seemingly endless tasks involved in caring for a baby. 1. Make home visits within 48 hours of discharge, if possible. 2. Schedule follow-up visits for 2, 4, and/or 6 weeks postpartum. 3. Help adolescents problem-solve the common physical discomforts of	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
postpartum recuperation and adjustment (increased perspiration, perineal pain, breast engorgement, constipation, hemorrhoids). 4. Make sure she is continuing her nutritional supplements, especially if breastfeeding. 5. Give genuine praise for any and all accomplishments in caring for her baby. 6. Encourage experienced caretakers (mother, grandmother, aunt) to work with the young mother, but they should NOT take over the direct care of the baby. Encourage support persons to remind the mother to drink fluids—something often forgotten by the new mother due to distraction and fatigue. 7. Keep the lines of communication open and be available to the young mother as situations arise for which she will need your support or the support of other young mothers whom she may have met during her antenatal period. During the 2-week postpartum visit, pay attention to the young mother's ability to cope with change and new responsibilities. Observe the mother-baby interaction and breastfeeding (attachment, removal, positioning, and style of feeding). Take a brief history focusing on progress in healing and involution; perform a modified physical exam inspecting breasts, abdomen, and perineum. During the 4- and/or 6-week postpartum visit, take a complete history and perform a complete physical examination.	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
Discuss with the adolescent mother her contraceptive needs. Explore with her how she is coping with mothering and physical, emotional, and/or baby problems. **Note:** *Breastfeeding by the adolescent mother will be covered in the next objective.*	

Specific Objective #4: Discuss parenting and infant feeding

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
WHAT DO ADOLESCENT PARENTS FEEL? For an adolescent mother or couple, child rearing presents many difficulties. There is a higher risk of infant morbidity and mortality. These may be due to biological factors or to poor parental care. • Adolescents may feel inadequate in caring for an infant and anxious about the baby's health. • They may feel resentment or depression over their loss of leisure and the great increase in responsibility. • The infant care needed may prevent the parents from improving economically and/or educationally. • Isolation from peers, crowded living conditions, and dependence on others, with consequent resentment, are additional hazards. **WHAT ADOLESCENT FATHERS NEED** • Acceptance and integration into pre- and postnatal services. • Counseling about the benefits of sound sexual/RH practices, including condom use. • Exposure to positive models of, or information about, effective parenting. • Encouragement to learn effective parenting skills, such as feeding,	**BRAINSTORMING AND DISCUSSION (15 MIN.)** The trainer should: • Divide a flipchart into 2 columns. • Label one column "Adolescent Fathers" and label the other "Adolescent Mothers." • Ask Px to brainstorm how they think new adolescent parents might feel. • Write their answers on a flip chart. • Ask Px to brainstorm what they think are the needs of adolescent mothers and fathers. Keep the ideas flowing freely without screening them. • After all of the ideas are given, summarize them and add any ideas that did not come up during the brainstorming. ? Ask Px, how do you think your clinic can support these needs or link adolescents with other people or services that can support them? **GROUP WORK AND DISCUSSION (30 MIN.)** • Divide Px into 2 groups. • Ask one group to decide what information they could give adolescent parents that would help them to become good parents. • Ask the other group to decide what information they would give

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
bathing, changing, playing, positive social interactions, and participating in health care decisions. • Continued access to economic and educational opportunity. **WHAT ADOLESCENT MOTHERS NEED** • Information about the importance of prenatal care and early access to such services, including trained providers during delivery. • Social support during pregnancy. • Postnatal support and health care for themselves and their infants. • Information about the importance of breastfeeding, immunization, nutrition, and growth monitoring. • Encouragement to learn effective parenting skills, such as feeding, bathing, changing, playing, positive social interactions, and making health care decisions. • Counseling about modern contraceptives to delay the next pregnancy. • A confidential, private, affordable, and welcoming service environment. • Continued access to economic and educational opportunity.	adolescent parents about infant feeding. • Remind both groups that they must be practical and consider only the information that they could reasonably give in the short time they might have, given the other activities of a busy clinic. • Allow 15 minutes for the discussion. • Ask one representative from each group to summarize the main points of their discussion.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
PARENTING **Immunization: When to immunize** • BCG: Birth or anytime after birth • DPT: 1 ½, 2 ½, and 3 ½ months • OPV: 1 ½, 2 ½, and 3 ½ months • Measles: 9 months and 12 months All immunizations should be completed before the child reaches 1 year. **Infant Feeding** Breast milk is the perfect milk for a baby: • It has all of the nutrients the baby needs. • It is easy for the baby to digest. • It gives the baby important protection from infections. • It is always fresh, clean, and ready to drink. Breastfeeding also has advantages for the mother and her family: • It slows the mother's bleeding after birth. • It helps prevent the mother from getting pregnant again too soon. • It does not cost money. Baby formula or milk from other animals has several problems: • It can be less nutritious, especially if it is not made correctly or is watered down.	**UNIT SUMMARY (5 MIN.)** The trainer should: • Summarize the unit content. • Link content to the next session.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• It is harder for the baby to digest. • It will not help prevent infections. • It can cause infections and illness in the baby if it is not made or stored correctly. • It can be expensive and hard to get. • It can cause diarrhea or even death if the water is dirty. **How to have enough milk** Breast milk is the best and only food the baby needs for the first 6 months. In order to produce enough milk, the mother needs to be healthy, drink plenty of fluids, eat plenty of nutritious food, and get plenty of rest. **When to stop breastfeeding** Babies should have only breast milk for the first 4-6 months. It is good to feed each baby for at least 2 years. Most older babies don't need to breastfeed as often as young babies. **Adapted from:** Klein, S. 1995. *A book for midwives: A manual for traditional birth attendants and community midwives*. Palo Alto, CA: The Hesperian Foundation. **The Adolescent and Breastfeeding** Breastfeeding is a particular challenge for adolescents. Young mothers often consider breastfeeding to be too confining of their movements and too demanding of their time. Help maintain a realistic perspective that supports the adolescent mother in making a decision that she is comfortable with and can successfully carry out. Help her achieve her identity and minimize role confusion	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
as she negotiates between her personal development needs and her role as a mother. **Supporting the Adolescent Mother to Choose Breastfeeding and Succeed** • Emphasize that she is the only one who can "mother" her baby when she breastfeeds. • Offer her a different perspective other than seeing breastfeeding as keeping her "tied down." Rather, explain that she is doing something important that no one else can take over. • Listen more than talk; teach more than preach. • Give practical suggestions to maximize the mother's success and confidence during antenatal and postnatal periods. Provide breastfeeding guidance from the moment of delivery. • Emphasize that breastfeeding is convenient and is rewarding to the mother. • Help her set realistic short-term goals, e.g. breastfeeding until she returns to school is better than not breastfeeding at all. • Present breastfeeding as "cool." • Connect her with a peer breastfeeding support group. Mother-to-mother support relationships have been vital in helping the young mother successfully sustain optimal breastfeeding practices.	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Focus on body image in a positive way, e.g., breastfeeding can help her return to her pre-pregnant shape. **Adapted from:** Biancuzzo, M. 1999. *Breastfeeding the newborn: Clinical strategies for nurses*. St. Louis, MO: Mosby, Inc. **Bottlefeeding** is an acceptable choice when this is the adolescent mother's overwhelming preference. The young mother should not be pressured toward any particular method of infant feeding once she knows the facts and has been assisted to decide what works for her situation and for her baby. Depending on the young mother's situation, she may have the option of using pre-mixed commercial formula or may have to mix liquid concentrate or powder with water. Adolescent mothers must be taught and supported to pay attention to the details of mixing formula so as not to overdilute the preparation. Overdiluting will result in the baby receiving inadequate nutrition, failing to gain weight, and will create a situation that could eventually be dangerous to the baby's kidneys. If the adolescent mother cannot afford commercial formula, she may choose to make formula. She must be advised: • Not to use plain cow's milk for an infant younger than 1 year old—its protein content is too high and is hard to digest its chemical make-up can burden the baby's kidneys, and is inadequate in vitamins and iron. • How to prepare, use, and store the formula.	

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• How to maintain cleanliness of the nipples, bottles, and formula-making paraphernalia. In some settings, formula will only be given to the baby by cup and spoon. The same practices for maintaining cleanliness are required. The adolescent mother should be: • Encouraged to hold and cuddle her baby during bottle-feeding. • Told to avoid propping up bottles because it will be difficult for her to see if the baby is choking and to see a need for burping. Propping also denies the baby stimulation of her/his senses—smell, sight, touch, hearing, and taste. • Educated in what digestive patterns to expect from the bottle-fed baby. • Reassured that the baby will need nothing more than breastmilk or formula during the first 6 months of life, after which time the baby will be able to transfer food to the back of the tongue in order to swallow.	

UNIT 13:
PROVIDING ADOLESCENT SERVICES

INTRODUCTION:

In order to successfully serve adolescent clients with reproductive health care, service programs must attract, adequately and comfortably meet the needs of, and retain these clients. By conducting a facility assessment, participants learn to evaluate the characteristics of youth-friendly services. The knowledge gained from the assessment can then be applied to services that are provided in their own clinics.

UNIT TRAINING OBJECTIVE:

To help providers evaluate and develop youth-friendly services in their RH/FP clinic or organization.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Identify ways to make programs youth-friendly.
2. Demonstrate how to evaluate and plan youth-friendly services.

SIMULATED SKILL PRACTICE:

- Facility assessment of youth-friendly services.

TRAINING/LEARNING METHODOLOGY:

- Facility assessment
- Group work
- Brainstorming
- Discussion

MAJOR REFERENCES AND TRAINING MATERIALS:

- Kisubi, W., E. Lule, C. Omondi, et al. 2000. *Integrating STI/HIV/AIDS services with MCH/FP programs.* Nairobi: Pathfinder International, Africa Regional Office.
- Nelson, K., L. MacLaren, and R. Magnani. 2000. *Assessing and planning for youth-friendly reproductive health services.* Washington, DC: FOCUS on Young Adults/Pathfinder International.
- Senderowitz, J. 1999. *Making reproductive health services youth friendly*. Washington, DC: FOCUS on Adults/Pathfinder International.

RESOURCE REQUIREMENTS:

- Flipchart
- Markers
- Tape
- Overhead projector
- Screen

EVALUATION METHODS:

- Pre- and post-test
- Participant Reaction Form
- Where Are We?
- Reflections
- Quality of group work (facility assessment) and presentations
- Quality of action plans

TIME REQUIRED: 6 Hours, 45 minutes (includes site visit for one-half day)

WORK FOR TRAINERS TO DO IN ADVANCE:

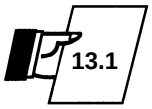
- Make arrangements for the clinic visit well in advance and check the arrangements again during the course (several days before the visit is scheduled). Depending on the number of participants and the number of nearby facilities, the trainer may want to arrange for more than one facility to be assessed and assign some groups to one facility and some groups to the other facility.
- Prepare copies of Participant Handouts: 13.1, 13.2, 13.3, and 13.4. Make sure you prepare extra copies of Participant Handout 13.1 so that Px can assess their own facility after the training.
- Prepare Transparency 13.1.

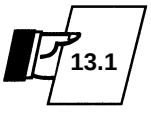
Specific Objective # 1: Identify ways to make programs youth-friendly

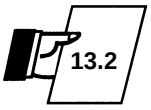
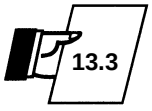
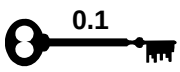
CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
MAKING SERVICES YOUTH-FRIENDLY Characteristics of youth-friendly services pertain to the providers, the health facility itself, and to the program design. In order to successfully serve adolescent clients with reproductive health care, service programs must attract, adequately and comfortably meet the needs of, and retain these clients. **Provider characteristics** include: • Specially trained staff. • Respect for young people. • Privacy and confidentiality. • Adequate time for client/provider interaction. **Health facility characteristics** include: • Separate space and special times. • Convenient hours. • Convenient location. • Adequate space and privacy. • Comfortable surroundings. • Peer counselors available. **Program design characteristics** include: • Youth involvement in design and continuing feedback.	**BRAINSTORMING (15 MIN.)** The trainer should: • Introduce the concept of youth-friendly services using the first 2 paragraphs from the content on the left-hand side of the page. • Ask Px to identify aspects or characteristics of a facility that could be considered "youth-friendly," writing down all suggestions on a flipchart. • When Px have had a chance to provide their ideas, show *Transparency 13.1: Characteristics of Youth-Friendly Services* and identify those items missing from the brainstormed list. 

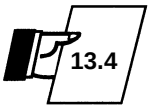
CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
• Drop-in clients welcomed and appointments arranged rapidly. • No overcrowding and short waiting times. • Affordable fees. • Publicity and recruitment that inform and reassure youth. • Both young men and young women welcomed and served. • Wide range of services available. • Necessary referrals available. • Educational material available on-site and to take. • Group discussions available. • Delay of pelvic examination and blood tests possible. • Alternative ways to access information, counseling, and services.	

Specific Objective #2: Demonstrate how to evaluate and plan youth-friendly services

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
ORGANIZING ADOLESCENT SERVICES 1. Conduct a needs assessment of adolescent services provided at the health facility. 2. Identify existing problems in providing an integral quality service for adolescent clients. 3. Identify human resources and materials available in the institution. 4. Develop proposals to solve the problems identified. 5. Present an action plan to implement the proposals. **HOW TO CONDUCT AN ANALYSIS OF EXISTING SERVICES** 1. Talk with the staff at the facility, especially the clinic manager providing RH services to assess willingness, to strengthen adolescent services. The head of the clinic will be key to leading all staff to change attitudes and practices toward adolescents. 2. Collect information using the assessment tool on the range and quality of adolescent services at the selected facility. The assessment tool will help you to: – Obtain general background information about the facility, its size, and its location.	**DISCUSSION AND FACILITY ASSESSMENT (1/2 DAY)** The trainer should: • Have arranged in advance for a facility assessment of youth-friendly services. Depending on the number of participants and the number of nearby facilities, the trainer may arrange for more than one facility to be assessed and assign some groups to one facility and some groups to the other facility. • Explain to Px that in order to improve services for adolescents, most, if not all, of the characteristics discussed in the previous strategic objective should be present in each facility. • Briefly discuss the information on *Organizing Adolescent Serv*ices found in the content section on the left-hand side of the page. • Pass out the *Clinic Assessment Tool* (*Px Handout 13.1)* to each Px.  • Explain to Px that they will visit a nearby facility and that each person will conduct her/his own assessment using the handout. The purpose of the assessment is to prepare each Px to conduct an assessment of his/her own facility. The assessment will take about a half day.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
– Gather information on client volume and the range of services provided. – Gather information about the staff providing services at the facility and their level of training. Determine whether any of the staff have had experience as a trainer. – Determine how the facility keeps track of services provided and information about clients. – Observe the administrative system and determine the presence or absence of treatment protocols related to providing services for adolescents. – Determine whether the facility has youth-friendly characteristics. Are the hours convenient for youth? Is the location of the facility convenient for youth? Is there adequate space and sufficient privacy? Does the facility have a peer education/counseling program? Are the fees for service affordable? Are youth involved in decision-making about how programs are delivered? Do the policies support providing services for youth? Does the facility inform the community about services for youth? Are administrative procedures youth friendly?	• Briefly discuss the information on *How to Conduct an Analysis of Existing Services* found in the content on the left-hand side of the page. • Instruct Px that they are observers only. They may ask questions, but they are not to criticize or correct staff or offer suggestions for improvement. They should be respectful of clients and their privacy and interfere as little as possible with hospital routine. • Divide Px into working groups with a trainer to accompany each group. • After Px return from their visit, ask each group to present their conclusions of the facility assessment to the larger group. They should identify which areas they thought were good, which areas needed improvement, and present recommendations for improving services. • Allow 10 minutes for each group to gather their thoughts before presenting. • Reconvene the large group. • Allow each group 10-15 minutes for their presentation. The groups should compare their conclusions with those of the other groups. • Distribute extra copies of the *Assessment Tool* (Px Handout 13.1) so that Px can evaluate their own facility after the training. 

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
	ACTION PLAN (1 HOUR 40 MIN.) The trainer should: • Distribute the *Action Plan Form (Px Handout 13.2)*.  • Explain that even though Px have not completed an assessment of their own facility, they can try to complete the *Action Plan* from their experience. • Divide Px into groups made up of colleagues from their own facility or area, if possible. • Allow 1 hour for the development of *Action Plans* and allow 10-15 minutes for each presentation. **UNIT SUMMARY (5 MIN.)** The trainer should summarize the unit content. **POST-TEST AND PX EVALUATION (45 MIN.)** The trainer should: • Pass out copies of post-test *(Px Handout 13.3)* and ask Px to complete the test. Remind Px that the purpose of the test is to evaluate the training, not the participants.  

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
	• Allow 30 minutes to complete the post-test and correct when Px are finished. • Pass out copies of the *Participant Evaluation Form (Px Handout 13.4)* and ask Px to complete the form. Allow approximately 15 minutes for this, but do not rush the Px. Encourage them to be as complete as possible in forming their answers. Explain that their reactions will help improve future trainings.  • Collect the evaluation forms and thank Px for their enthusiasm and contributions to the course.

Transparency 1.1: Stages of Adolescent Development

- **Early Adolescence (10-13)**
  - Onset of puberty and rapid growth
  - Impulsive, experimental behavior
  - Beginning to think abstractly
  - Orientation moving outside of family
  - Increasing concern with image and acceptance by peers

- **Middle Adolescence (14-16)**
  - Continues physical growth and development
  - Starts to challenge rules and test limits
  - Develops more analytical skills; greater awareness of behavioral consequences
  - Strong influences of peers, especially on image, social behavior
  - Increasing interest in sex; special relationships begin with opposite sex
  - Greater willingness to assess own beliefs and consider others

- **Late Adolescence (17-19)**
  - Reaches physical and sexual maturity
  - Improved problem-solving abilities
  - Developing greater self-identification
  - Peer influence lessens
  - Reintegration into family
  - Intimate relationships more important than group relationships
  - Increased ability to make adult choices and assume adult responsibilities
  - Movement into vocational phase of life

Transparency 1.2: Changes During Adolescence

Physical and Sexual Changes During Adolescence

In Women	In Men	In Both Sexes
• Menarche • Development of breasts • Widening of hips • Appearance of pubic and underarm hair • Development of the vulva and pelvis	• Growth of the penis, scrotum and testicles • Nighttime ejaculation • Morning erection • Development of back muscles • Appearance of pubic and underarm hair	• Accelerated growth • Increased perspiration • Presence of acne • Face with characteristics of young adult • Change in tone of voice • Activation of sexual desire • Initiation of sexual activities

Psychological and Emotional Changes

- Mood swings
- Insecurities, fears, doubts
- Behavioral expressions of emotion: withdrawal, hostility, impulsiveness, non-cooperation
- Self-centeredness
- Feelings of being misunderstood and/or rejected
- Fluctuating self-esteem
- Interest in physical changes, sex, and sexuality
- Concern about sexual identity, decision-making, reputation
- Need to feel autonomous and independent

Transparency 1.3: International Policy Consensus on Adolescent Reproductive Rights

United Nations Convention on the Rights of the Child (1990)

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
   b. To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
   d. To ensure appropriate pre-natal and post-natal health care for mothers;
   e. To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents;
   f. To develop preventative health care, guidance for parents and family planning education and services.

(Article 24)

International Conference on Population and Development (ICPD) ICPD Programme of Action (1994)

Information and services should be made available to adolescents to help them understand their sexuality and protect themselves from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility. This should be combined with the education of young men to respect women's self-determination and share responsibility with women in matters of sexuality and reproduction.

(7.41)

Fourth World Conference on Women (FWCW) Platform for Action (1995)

The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.

Transparency 2.1: Health Problems of Adolescents

Psychological Problems

- Increased depression, sometimes as serious as a suicide ideation and attempts, disproportionately affect adolescents.

Nutritional Problems

- Undernourishment and overnourishment are increasing problems among adolescents.

Injuries from Accidents

- Unintentional injury is the leading cause of death among young people; interpersonal violence is increasing.

Substance Misuse

- Illicit drug use is becoming more widespread; tobacco and alcohol use patterns are established in youth and young adulthood.

Reproductive Health Problems

- Maturation Issues
  - Menstrual irregularities and hormonal imbalances often accompany the menses in the early years before regular menstruation is established. Boys experience premature ejaculation.

- Unwanted Pregnancy
  - High proportions of pregnancies among 15-19 year old women are mistimed or unwanted.

- Too-Early Childbearing
  - Worldwide, more than 10% of all births are to women 15-19, and in the least developed countries, teens account for 17%.

- Unsafe Abortion
  - Most of the estimated 1–4.4 million abortions among adolescents per year are unsafe because they are performed illegally, under hazardous conditions, and/or by unskilled practitioners.

- STI/HIV
  - Each year, more than one-half of all new HIV infections occur in young people under 25, and more than two-thirds of all reported STI infections occur among this group in developing countries.

Transparency 4.1: Types of Questions

CLOSED

Lead only to one response or brief, precise answers, often “yes” or ‘”no.”

Example:

How old are you?

Have you had sexual relations?

Have you ever taken a pregnancy test?

How many children do you have?

OPEN-ENDED

These questions permit varied responses. They are more detailed, demand reflection and permit the adolescent to express feelings or concerns.

Example:

How can I help you?

What are your friends like?

What have you heard about the pill?

IN-DEPTH

These are questions based on responses to previous questions to solicit more information. This type of question is used during the course of the conversation.

Example:

“Can you tell me what you mean when you say….”

BIASED

These questions lead the person to respond in a pre-determined way.

Example:

“Have you heard that the condom makes coitus less pleasurable?”

Transparency 7.1: Health Risks of Early Pregnancy

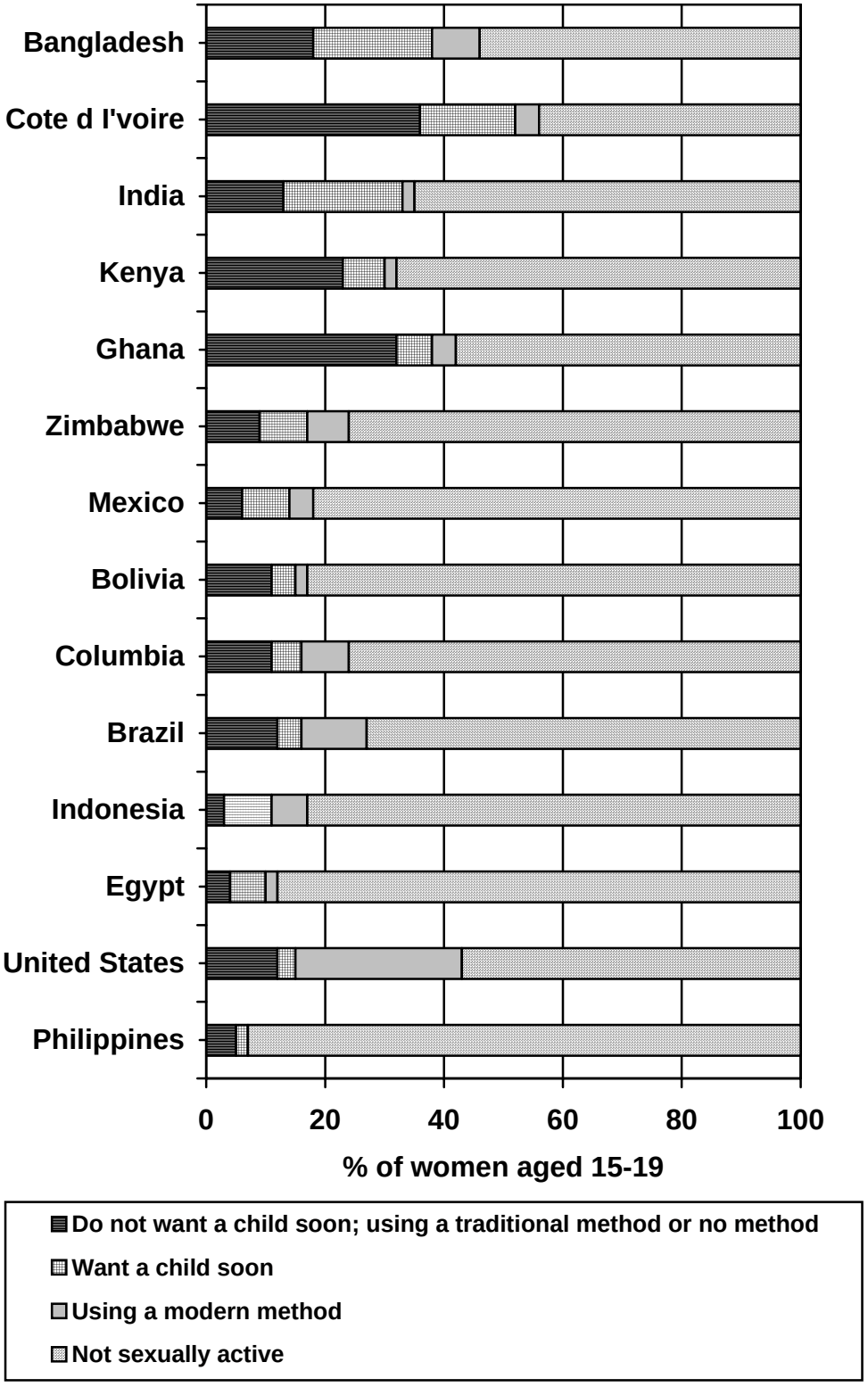
WHO estimates that the risk of dying due to pregnancy-related causes is twice as high for women ages 15-19 than for women ages 20-24. For girls ages 10-14, maternal mortality may be 5-times higher than for women in their early twenties. The health risks of early pregnancy are:

- **Obstructed delivery**
- **Cephalopelvic disproportion**
- **Pre-eclampsia**
- **Anemia**
- **Unsafe abortion**
- **Premature birth**
- **Spontaneous abortion**
- **Still birth**

Transparency 7.2: Pregnancy Outcomes by Age

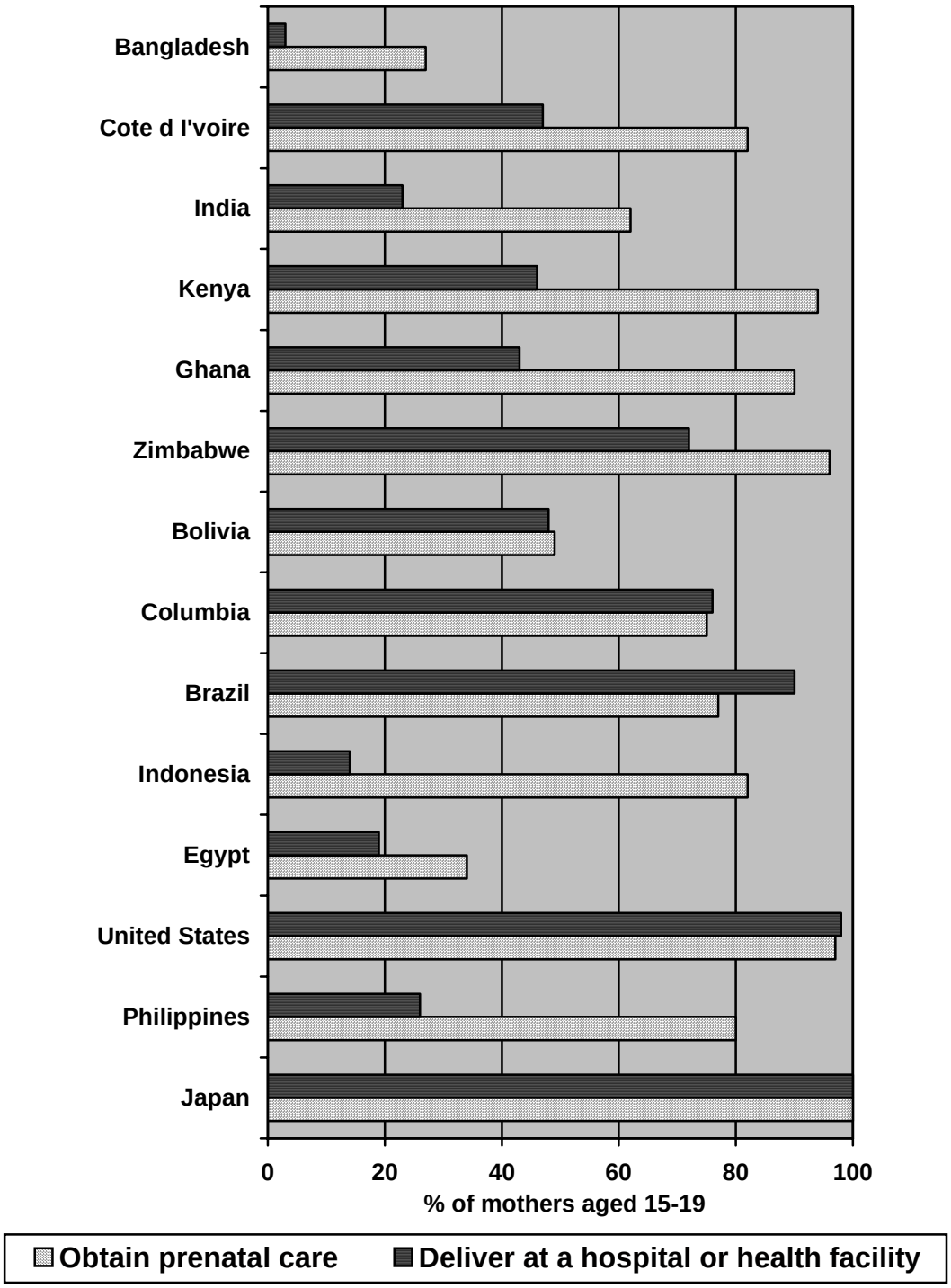
Country	Woman's Age	Maternal Deaths/1,000 Births	Average Birth Weight	% of Premature Births	Perinatal Deaths/1,000 Births

Transparency 7.3: Unmet Need for Contraception among Adolescents



Source: Alan Guttmacher Institute. 1998. *Into a new world: young women's sexual and reproductive lives*. New York: Alan Guttmacher Institute.

Transparency 12.1: Percentage of Adolescents that Receive Prenatal Care or Deliver in Hospitals/Health Facilities



Source: Alan Guttmacher Institute. 1998. *Into a new world: young women's sexual and reproductive lives*. New York: Alan Guttmacher Institute.

Transparency: 13.1: Characteristics Of Youth-Friendly Services

Provider Characteristics
• Specially trained staff
• Respect for young people
• Privacy and confidentiality honored
• Adequate time for client/provider interaction
Health Facility Characteristics
• Separate space/special times set aside
• Convenient hours
• Convenient location
• Adequate space/sufficient privacy
• Comfortable surroundings
• Peer counselors available
Program Design Characteristics
• Youth involvement in design and continuing feedback
• Drop-in clients welcomed/appointments arranged rapidly
• No overcrowding/short waiting times
• Affordable fees
• Publicity/recruitment that informs and reassures youth
• Young men and women welcomed
• Wide range of services available
• Necessary referrals available
• Educational material available onsite/to take
• Group discussions available
• Delay of pelvic exam and blood tests possible
• Alternative ways to access information, counseling and services

Trainer's Tools 0.1: Pre-Test Answer Key

Instructions: Write in "B" for the beginning (ages 10-13) or "E" for the end (ages 17-19) of adolescence.

1. Identify which of the following more commonly occur near the beginning or end of adolescence:

   E Reaches physical and sexual maturity.
   B Major concern with peer group.
   B Impulsive, experimental behavior.
   E Has developed problem-solving abilities.

Instructions: Circle all the answers that apply. Some questions have more than one correct answer.

2. Having specially trained providers serve adolescents is important because:

   a) Communicating with adolescents can require special care with regards to language, tone, and establishing trust.
   b) Effective interventions can address problems related to serious risk-taking.
   c) Life-long health habits are established in adolescence.
   d) Adolescents may ask to see a training certificate.

3. Which of the following occur more in adolescents than adults:

   a) Heart conditions.
   b) Anemia.
   c) Injuries.
   d) Low-birth weight babies.

4. Adolescents can be vulnerable to illness or health problems because:

   a) This period of rapid growth has greater nutritional requirements.
   b) Young people have less power to resist risky sexual demands.
   c) Adolescents are more susceptible to colds and flu.
   d) Adolescents can have difficulties accessing confidential health care.

5. Among the most important conditions a provider can ensure for the adolescent client are:

   a) Privacy.
   b) Popular music playing.
   c) Respect.
   d) Fun atmosphere.

6. Syndromic management of STIs is most effective in diagnosing:

   a) Genital ulcers.
   b) Urethritis.
   c) Vaginal discharge.
   d) Cervicitis.

7. The contraceptive methods that are appropriate for breast-feeding women who are more than 6 weeks postpartum are:

   a) IUD.
   b) Combined oral contraceptives.
   c) Progestin-only contraceptives (progestin-only pills, Norplant, injectables like Depo-Provera).
   d) Lactational Amenorrhea Method (LAM).

8. The major reason condoms break is:

   a) They have been washed with soap.
   b) They are too small.
   c) The vagina is not wet enough.
   d) They are used with an oil-based lubricant such as Vaseline.

9. Which of the following complications of pregnancy are more likely to occur in adolescents under the age of 15 compared with older women:

   a) Giving birth to very large babies.
   b) Premature labor.
   c) Dysfunctional labor.
   d) Spontaneous abortion.
   e) Still birth.

10. Which methods of contraception may <u>not</u> be suitable to the adolescent client:

    a) Emergency contraception.
    b) Combined oral contraceptives.
    c) Sterilization.
    d) Condoms.
    e) Injectable contraceptives.

11. WHO estimates that the risk of dying of pregnancy-related causes is:

    a) Twice as high for women ages 15-19 than for older women.
    b) Three times as high for women aged 15-19 than for older women.
    c) Four times as high for women aged 15-19 than for older women.
    d) Five times as high for women aged 15-19 than for older women.
    e) The same for women aged 15-19 than for older women.

12. Which of the following methods are appropriate for counteracting rumors and misconceptions about contraceptives:

    a) Using strong scientific facts to counteract misinformation.
    b) Giving less information so the client is not confused.
    c) Finding where the rumors came from and checking to see if there is any basis for the rumor.
    d) Not telling the client about side effects because it might make them frightened.

Instructions: Write in the correct answers

13. Name two common sources of sexual and reproductive health information for adolescents that can be inaccurate or misleading.

    Peer groups, media, friends

14. Annie is a 16 year old who has just delivered her first baby. She decided to breastfeed her baby for the first 6 months, until she goes back to school. Annie tells her mother that she will be breastfeeding the baby and will use it to prevent pregnancy. Her mother tells her that she is mistaken and that she could still become pregnant. What advice should her care provider give her to ensure that she has effective contraceptive protection?

    LAM is an effective method as long as:
    a. A woman's menses has not returned.
    b. The woman is fully or nearly fully breastfeeding her infant
    c. The infant is less than 6 months old

    If any one of the 3 criteria changes, she must start another contraceptive method immediately.

15. Two signs of anemia are?

    Pallid eyelids, tongue, gums, and nailbeds; feeling weak or tired; dizziness; shortness of breath; fast heartbeat; fainting

16. Which methods protect adolescents against STIs and pregnancy?

    Condoms (male or female)

17. What should the adolescent do if she is taking combined oral contraceptives and she forgets to take a pill?

    If she misses one pill, the client should take it as soon as she remembers. Take the next one at the regular time. If she misses two pills, the client should take two pills as soon as she remembers. She should take two pills the next day and use a backup method for the next week. The client should finish the packet normally.

Instructions: Write "T" for true and "F" for false.

18. **T** International policies agreed to by a majority of the world's countries calls for reproductive health information and services to be available to adolescents.

19. **F** Rape only happens to females.

20. **F** STIs cannot be transmitted through oral sex.

Trainer's Tool 1.1: Barriers to Information and Services for Youth

My name is Abena. I am sixteen years old. I live 5 km from here and normally sell small snacks on the roadside to earn money for my mother and younger siblings. It was not easy for me to have the time to go to the clinic.

I went because I have a boyfriend and I don't want to become pregnant. Some of the girls that I sell with have become pregnant and I see how hard their lives are with a small child and no husband. I had heard that you could take some pills to prevent pregnancy so I wanted to find out if it was true.

I went to the clinic early in the morning because I needed to get back so I could sell something before the day ended. When I arrived there were several women waiting outside with small children. They kept looking at me and whispering. One of the older women asked me why I was there since the clinic only served women who were older with children and a husband. She told me this was no place for a "small girl" like myself. ***(Tear the sign)***

The staff was late to arrive. I sat there for over an hour waiting for the front doors of the clinic to open. ***(Tear the sign)***

Once I was inside I wondered how I could talk with the nurse. I finally got up enough courage to speak to the woman behind the table with a sign saying "Reception". When I approached, her face became hard. She asked me why I was here and that I should be in school. When I explained that I wanted to talk with a nurse, she questioned me. I was too embarrassed to tell her why I was here. She then told me that the morning hours were for prenatal and maternal and child health services only and that I would have to come back later in the day. When I asked her what time, she just shrugged her shoulders and ignored me ***(Tear the remaining piece of the sign in half and discard it.)***

(Hold the medium sized sign in front of you so everyone can see it.)

I came back at 2:00 pm. I hadn't eaten anything and had nowhere to go while I waited, so I had sat down under a tree for the last 4 hours. It was very hot out and I was hungry and thirsty. When I asked the receptionist if I could see the nurse, she told me that the nurses had taken a break for lunch. They would be back in an hour. The receptionist was very unfriendly and I could tell she didn't think I should be there.
(Tear the sign)

After an hour, the nurses came back. I was told that I could go in and speak with one of them. She instructed me to the exam area. When I went to the exam room, the nurse looked angry. She asked me why I was here. I told her that I didn't want to be pregnant and I had heard there were some pills to take. She told me that if I didn't want to become pregnant then I shouldn't have sex. I should be in school or helping out at home not running around with boys.
(Tear the sign)

I explained that I wasn't running around with boys and that I only had one boyfriend. The way she was looking at me, I could tell that she thought I was loose. She told me that before I could use the pill, I would need to have an exam and that she didn't have time today. I would have to come back on Friday. ***(Tear the remainder of the sign in half and discard it)***

(Hold the small sign in front of you so everyone can see it)

On the way home, I questioned whether I should return. I didn't want to become pregnant, but I also felt like the nurse thought I was a bad person and I wasn't sure I could lose another day of work. I decided I would go one last time. Friday finally came. This time I arrived later at the clinic. After I entered, I went to the receptionist. It was the same person as last time. She asked me why I was here. When I told her I was here for an exam and to get the pill, she said in a very loud voice "you are here for family planning." I could feel the eyes of the other women in the waiting room staring at my back. I was so embarrassed. ***(Tear the sign)***

The receptionist told me to go back to the exam room. When the nurse came she told me to undress. She didn't give me anything to cover up with. I was a bit frightened looking at the equipment. She told me to put my feet in the stirrups. I didn't know what she was going to do. The next thing I knew she was putting something cold and hard in my vagina. I felt very panicked. Just then, there was a quick knock on the door and then this other nurse entered. She started to ask questions about another patient. The whole time the two nurses were talking, the door was ajar. I wanted to die of shame. ***(Tear the sign)***

After the exam, the nurse gave me a packet of pills and told me to take one a day at the same time of day. She mentioned something called "side effects" but I didn't understand what she meant. She told me to come back when I have two or three pills left. I left and started taking these pills every morning. It isn't easy, sometimes I feel nausea and I don't know if I can keep taking them. I don't know how I am going to get back to the clinic and the thought of seeing the nurse again makes me think that perhaps I should just forget about taking these pills and pray to God that I don't get pregnant. ***(Tear the remaining sign in half and discard it)***

Trainer's Tool 3.1: List of Statements to Practice Assertiveness

"If you don't run away with me now, I'm going to think you don't love me."

"There's nothing wrong with spending the night together."

"I'll leave you if you don't sleep with me."

"If you were really as macho as you say you are, you'd take a girl to bed."

"Try some drugs; they won't hurt you."

"Don't worry. Even though we're not using a condom, nothing will happen."

"I'll give you this money if you do what I say."

"Didn't you hear what I said? Virginity produces cancer."

"If all the other girls do it [coitus], I don't know why you don't."

Source: Vereau, D. 1998. *Improving interpersonal communications skills for counseling adolescents on sexual reproductive health*. Lima, Peru: Pathfinder International.

Trainer's Tool 6.1: Sexual Safety Questionnaire Answer Key

Instructions: Indicate whether you think the statement is true or false and explain your reasoning.

1. **Young people are more vulnerable to STIs than older adults.**
   Answer: TRUE. Young people have less access to relevant information, even when they are sexually active. They may be more reluctant to seek treatment, and services are more likely to be unavailable or inaccessible to them. Young adults often lack social or economic power, which may force them to resort to selling sex, which in turn leaves them at risk of infection, exploitation, and abuse.

2. **People increase their risk of HIV infection 10 times if they do NOT use a condom when having intercourse with a person who's HIV status they do not know.**
   Answer: TRUE. Assuming that condoms are 90% effective, medical researchers calculate that people reduce their chance of becoming infected with HIV 10 times with the use of condoms. However, condoms can be more or less effective than this rate.

3. **In heterosexual intercourse with an HIV partner, young women are at greater physiological risk of becoming infected than young men.**
   Answer: TRUE. The female reproductive tract remains immature until at least 18 years of age. The walls of the vagina, cervix, and uterus are thin and easily ruptured, penetrated, and infected. Cervical mucus output is frequently inadequate in very young women, and lack of lubrication can increase the likelihood of infection. Studies show that the concentration of HIV is higher in semen than in vaginal secretions, and that abrasions or cuts occur more often in the vagina than on the penis. Semen remains in the vagina for a long time, increasing the risk of infection.

4. **A major reason condoms break is because they have been used incorrectly with an oil-based lubricant.**
   Answer: TRUE. Commonly used oil-based lubricants, such as vaseline, break down the latex of condoms and make breakage more likely. Only water-based lubricants or contraceptive cream should be used with condoms.

5. **People without any symptoms of illness may carry and transmit HIV to a sex partner.**
   Answer: TRUE. The average incubation time for HIV, from infection to diagnosis of full-blown AIDS, is now 8 years. During much of this time a person may have no symptoms. Yet, very soon after infection a person can infect others. In the weeks and even months following infection, a test for HIV may remain negative because the test measures the presence of antibodies that may not have been formed yet.

6. **People who have had one sexually transmitted disease are at higher risk of contracting a second STI, including AIDS.**
   Answer: TRUE. There is increasing evidence that people who have had one STI are at higher than average risk for getting a second infection. This may be related to

lifestyle and the fact that many STIs such as herpes, syphilis, and genital warts create open sores in the genital area that provide easy access for other infections.

7. **A dab of lubricant on the tip of the penis or inside the condom greatly increases the sensation for the male.**
   Answer: TRUE. Most men prefer the sensation of lubricated condoms to that of dry condoms and report that adding a dab of water-based lubricant before rolling on the condom increases the sensation even more.

8. **Anal intercourse puts a person at risk for HIV infection only when it occurs between males.**
   Answer: FALSE. Anal intercourse does not only occur in men. Some heterosexual couples also have anal intercourse, and since the membranes of the rectum are thin, they are particularly vulnerable to injury whether the partner is male or female. Blood vessels close to the surface provide easy access to the blood stream. Many experts believe that anal intercourse is too dangerous and should be avoided completely. Others recommend correct and consistent use of condoms.

9. **As a result of the AIDS epidemic, the number of unmarried people having intercourse has decreased significantly over the past five years.**
   Answer: FALSE. The percentage of unmarried women who have had intercourse has risen yearly in almost every country.

10. **For the majority of women, outercourse that includes stimulation of the clitoris leads to orgasm more frequently than intercourse.**
    Answer: TRUE. Many women need direct stimulation of the clitoris to have orgasm. Many who do not experience orgasm during intercourse do so during masturbation.

11. **Sexual abstinence is the only 100% sure way to prevent pregnancy and sexually transmitted disease.**
    Answer: TRUE. Studies of couples using condoms to prevent pregnancy produce failure rates from 1% to 22%. Some STIs such as human papilloma virus (HPV) may be transmitted despite condom use. However, CONDOMS DO WORK! In a 1987-1991 study of couples in which one partner had HIV, all 123 couples who correctly used condoms every time in four years prevented transmission of HIV. In 122 couples who did not use condoms every time, 12 partners became infected. Another study in 1993 showed similar results.

12. **STIs cannot be transmitted through oral sex.**
    Answer: FALSE. If you engage in unprotected oral sex, you are at risk for gonorrhea, syphilis, chancroid, herpes simplex virus (HSV), human papilloma virus (HPV), cytomegalovirus (CMV), and HIV.

13. **Using powders or herbs to dry out the vagina to increase male sexual pleasure can increase a woman's risk of contracting an STI.**
    Answer: TRUE. Without adequate lubrication, scrapes and small cuts in the vagina are more likely to occur during intercourse, allowing for easier entry of bacteria or viruses into the woman's blood stream.

Trainer's Tool 6.2. Answer Key to Risk Game

Conduct	Rating for Risk
1. Vaginal sex with a stranger without protection	HR
2. Dry kissing	NR
3. French kissing	LR
4. Body to body rubbing with clothes on	NR
5. Body to body rubbing with clothes off	LR
6. Erotic massage	NR
7. Sex with several partners without protection	HR
8. Oral sex with an acquaintance using a condom	LR
9. Anal sex using a condom	MR
10. Mutual masturbation to the point of orgasm (on me, not in me)	NR
11. Anal sex without a condom	HR
12. Vaginal sex using spermicide	HR
13. Hugging	NR
14. Introducing an injured finger into the anus or vagina	MR
15. Sharing a hot bath with a partner	NR
16. Rubbing penis between the thighs of partner	LR
17. Solo masturbation	NR
18. Masturbating partner and making contact with semen and/or vaginal fluid	LR
19. Telephone sex	NR
20. Occasional sexual intercourse with an acquaintance using a condom	LR
21. Sexual relations using oral contraceptives	HR
22. Sharing sexual toys without cleaning them	MR
23. Having oral sex without a latex barrier	MR

Trainer's Tool 7.1: Demographic Data

Country	Population Ages 10-24 (millions) 2000	Average Age at First Marriage (all women)	Total Fertility Rate (TFR)	% of Adult Population Ages 15-49 Infected with HIV, 1997	% Single, Sexually Active (females)	% Giving Birth by Age 20	% Illiterate		% Using Modern Contraception Methods (females)	
							M	F	SINGLE	MARRIED
NORTH AFRICA										
Egypt	22.1	19	3.3	0.1	-	29	26	44	-	18
WESTERN AFRICA										
Ghana	6.6	19	4.5	2.4	8	49	-	-	23	13
Nigeria	36.7	17	6.0	4.1	10.2	54	-	-	13	1
EASTERN AFRICA										
Ethiopia	20.1	18	6.7	9.3	-	-	47	62	-	-
Kenya	11.1	20	4.7	11.6	8	46	8	11	20	24
Mozambique	6.2	17	5.6	14.2	11	65	33	67	5	1
Tanzania	11.2	18	5.6	9.4	11.9	52	-	-	12	4
Uganda	7.3	18	6.9	9.5	3.6	66	24	34	22	4
Zambia	3.3	18	6.1	19.1	9.5	63	22	27	13	9
MIDDLE AFRICA										
Cameroon	4.9	18	5.2	4.9	13.5	54	-	-	20	3
SOUTHERN AFRICA										
Botswana	0.6	25	4.1	25.1	26	55	11	5	35	-
South Africa	12.4	26	2.9	12.9	-	-	15[a]	15[a]	-	64
WESTERN ASIA										
Azerbaijan	2.2	24	1.9	*	-	-	-	-	-	-
SOUTH ASIA										
Bangladesh	46.5	14	3.3	*	-	63	58	71	-	28
India	300.2	20	3.3	0.8	-	49	20	44	-	-
SOUTHEAST ASIA										
Viet Nam	25.3	21	2.5	0.2	-	19	7	7	-	15
EAST ASIA										
China	317.1	22	1.8	0.1	-	8	3	8	-	-

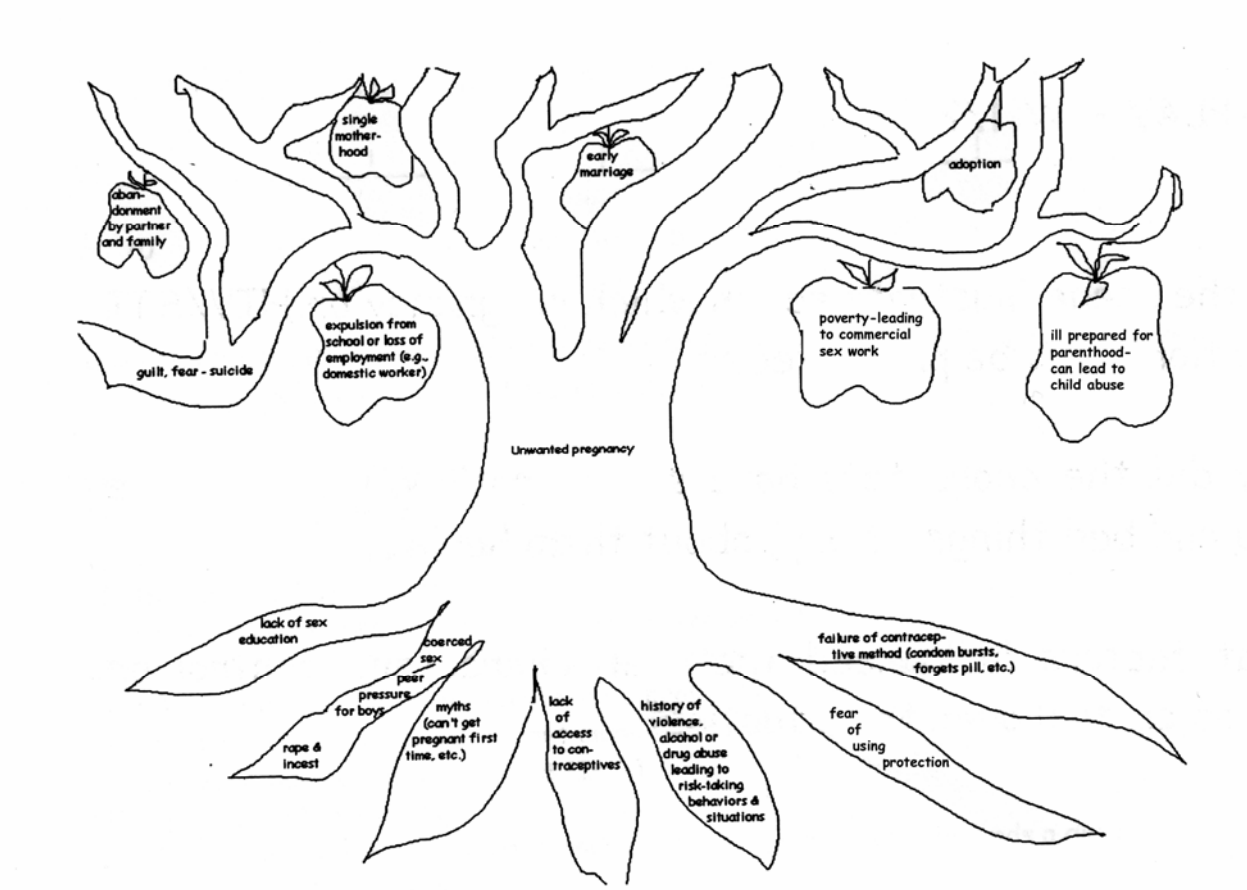
NORTH AMERICA										
United States	57.7	25	2.1	0.8	-	19	-	-	-	-
CENTRAL AMERICA										
Costa Rica	1.2	22	3.2	0.6	-	-	3	2	38	30
CARIBBEAN										
Haiti	2.9	21	4.7	5.2	5.4	32	47	43	10	8
SOUTH AMERICA										
Bolivia	2.6	21	4.2	0.1	10**	36	3	7	-	10
Brazil	50.9	21	2.4	0.6	8.8	32	15	9	61	47
Ecuador	4.0	20	3.3	0.3	6**	53	3	3	-	19
Peru	8.1	21	3.4	0.6	2.2	32	3	5	33	31
NORTHERN EUROPE										
United Kingdom	11.1	26	1.7	0.1	-	-	-	-	50	-
WESTERN EUROPE										
Netherlands	2.8	27	1.6	0.2	-	-	3	3	-	-
EASTERN EUROPE										
Poland	9.5	22	1.4	0.1	-	-	-	-	-	-
SOUTHERN EUROPE										
Italy	9.2	26	1.2	0.3	-	-	*	*	-	-
OCEANIA										
Fiji	0.3	23	3.3	0.1	-	-	2	2	-	-

[a]Among 18-24-year-olds
*Number rounds to zero
**Data are based on single teens who have ever had intercourse rather than those reporting intercourse in the last 4 weeks.

Source: Population Reference Bureau, MEASURE *Communication*. 2000. *The World's Youth 2000*. Washington, DC: MEASURE *Communication*.

Trainer's Tool 7.2:
Mind Mapping: Consequences of Unwanted Pregnancy

Label the tree roots with the reasons that adolescents don't use protection (i.e. the causes of unwanted pregnancy). The tree trunk should be labeled "unwanted pregnancy", and the fruit should be the consequences of unwanted pregnancy for the mother, father, and child. Have Px think of as many long-term consequences of unwanted pregnancy as they can. For example, early pregnancy can lead to the woman dropping out of school. As a result, the woman will then have diminished economic opportunities, which can lead to poverty and possibly result in her becoming a commercial sex worker to support her family.



Source: de Bruyn, M. and N. France. 2001. *Gender or sex: Who cares. Skills building resource pack on gender and reproductive health for adolescents and youth workers with a special emphasis on violence, HIV/STIs, and unwanted pregnancy.* Chapel Hill, NC: IPAS.

Trainer's Tool 10.1: Fishbowl Exercise

Instructions: Write each of the client descriptions on separate pieces of paper.

Client 1: You are an 18-year-old woman. You are only attracted to women. Your family has made it clear that when you finish secondary school at the end of the year, you should think about getting married. You go to the counselor/provider for advice. You want to know if s/he can give you some type of medicine that will make you attracted to men instead of women.

Client 2: You are a 15-year-old male. You often dress up in women's clothing and imitate female behavior. Because of this habit, you are ridiculed by your community and your family is ashamed of you. You see nothing wrong with dressing as a woman and intend to continue this behavior. Your parents have sent you to see the counselor/provider because they think you just need to be straightened out.

Client 3: You are a 16-year-old heterosexual male. However, in order to make money, you exchange sexual favors (including anal intercourse) with men for money. You have heard that HIV is only spread through sex, and since you only have sex (vaginal intercourse) with your girlfriend, you are not worried about catching the virus. Some of the older boys tease you about being "gay," and you are concerned that having sexual relations with men will make you gay.

Client 4: You are a 17-year-old male and have recently been having dreams that involve you kissing or caressing another man. You have a girlfriend whom you are sexually attracted to, so you don't understand why you are having these dreams.

Client 5: You are a 14-year-old female. As long as you can remember, you have felt as if you really should have been born a boy. You enjoy doing tasks that are seen as male activities, and all of your friends are young men. You realize that you are different from other girls in your community. You cannot relate to them and are not interested in any of the same things as them. Your family has been pressuring you to act more like a young woman, especially as you become more physically mature. You want to please your family, but you wish you could live life as a boy.

Trainer's Tool 11.1: Sexual Abuse Truth or Myth

1. _____**Truth** __**X**__**Myth** **Rape happens only to females.**

   It can also be perpetuated by females against males and by males against males.

2. _____**Truth** __**X**__**Myth** **Sexual abuse only means rape.**

   Sexual abuse includes all forms of sexual coercion (emotional, physical, and economic) against a child or adolescent. It may or may not include rape. Any type of unwanted sexual contact is considered sexual abuse.

3. __**X**__**Truth** _____**Myth** **Someone who sexually violates another can also be a loving person.**

   People who are sexually violent can be loving and caring when they are not being violent.

4. _____**Truth** __**X**__**Myth** **Rape is an act of uncontrollable sexual desire.**

   Rape is about control and power, not desire. It can sometimes be an angry response to a situation, such as expecting sex and not having that expectation met.

5. _____**Truth** __**X**__**Myth** **Sexual abuse happens only in lower socio-economic groups.**

   Sexual abuse occurs in rural, urban, and suburban areas and among all ethnic, racial, and socio-economic groups.

6. _____**Truth** __**X**__**Myth** **Once someone realizes that s/he is being sexually violated, it is easy to leave the relationship.**

   By the time a person realizes that s/he is being sexually violated, s/he may already feel committed to the relationship and find it hard to leave.

7. _____**Truth** __**X**__**Myth** **Most rapes are committed by strangers.**

   In 84% of all rapes, the perpetrator knows the victim. Perpetrators can include a parent, partner, ex-partner, boyfriend, family member, another person in the home, teacher, neighbor, acquaintance, or more rarely, a stranger.

8. _____**Truth** __**X**__**Myth** **Someone can change another person's sexually violent behavior by changing some of his/her own behaviors.**

   The only behavior you can change is your own. You can do specific things that put you in less risky situations, but you can't control how someone else will act.

9. __**X**__**Truth** _____**Myth** **It is rape if someone puts his/her fingers inside a woman's vagina against her will.**

   Though rape laws vary from country to country, rape is commonly defined as the use of physical and/or emotional coercion—or threats to use coercion—in order to forcibly penetrate a child, adolescent, or adult vaginally, orally, or anally.

10. __**X**__**Truth** _____**Myth** **An adolescent is less likely to be sexually violated if her/his parents know her/his date (boyfriend or girlfriend).**

It lessens the anonymity and lets the date know that someone cares about who their child is with.

11. __**X**__**Truth** _____**Myth** **People who are sexually abused as children or adolescents are more likely to become sexual abusers as adults.**

Studies show that people who are sexually abused as children are more likely to become abusers themselves unless they receive psychological support to help them deal with the abuse that they experienced.

12. __**X**__**Truth** _____**Myth** **Rape can occur within marriage.**

Marital rape is when one spouse forces the other to have sex either by physical or emotional coercion. We discussed marital rape; can anyone define other types of rape? Acquaintance rape, stranger rape, gang rape.

13. _____**Truth** __**X**__**Myth** **Women asked to be raped when they wear revealing clothing or act flirtatious.***

No one asks to be raped. A woman has the right to wear whatever she pleases, and a man has the responsibility to respect that. Dressing attractively and flirting are an invitation for attention and/or admiration, but they are NOT an invitation for rape. Only a rapist is responsible for rape.

14. __**X**__**Truth** _____**Myth** **Alcohol can contribute to sexual assault.***

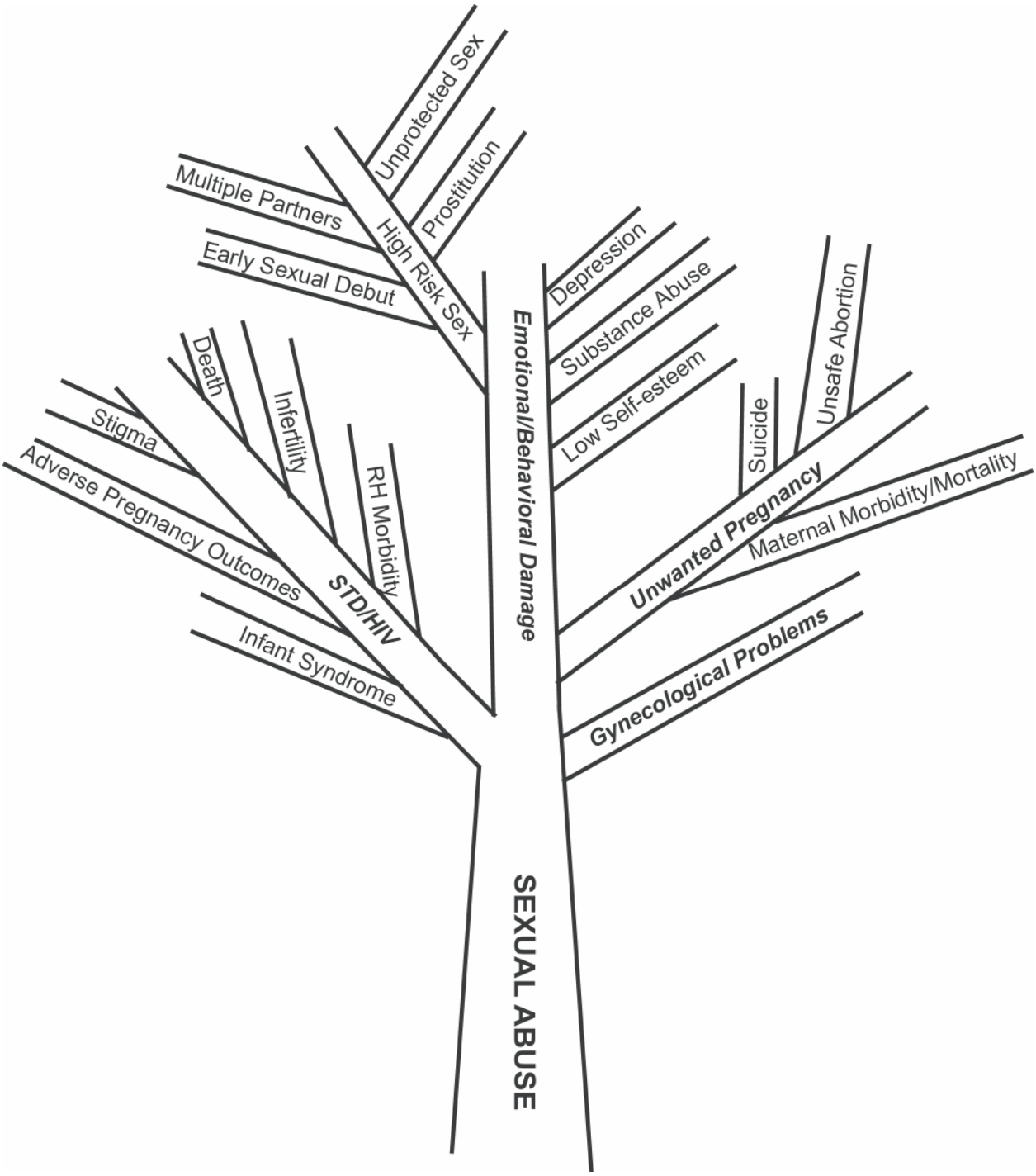
Drinking effects communications, reasoning skills, and self-control. For the attacker, alcohol might reduce inhibitions and lead to acts of violence that would not have happened if he or she was not drinking. Alcohol might also diminish a person's ability to correctly interpret verbal and/or nonverbal cues from a partner about consent for sexual activity. For the victim, alcohol might inhibit his or her ability to fight off an attacker or to act on early warning signs of a high-risk situation.

15. _____**Truth** __**X**__**Myth** **If a young woman did not fight back, she was not really assaulted.**

Young women in rape or sexual abuse situations are legitimately afraid either of being injured further or that the abuser/attacker will harm them in some other way. Terror often prevents a young woman from fighting back.

***Source:** EngenderHealth and Planned Parenthood Association of South Africa. 2001. *Men as partners: a program for supplementing the training of life skills educators, second edition*. New York: EngenderHealth.

Trainer's Tool 11.2: Consequences of Sexual Abuse



Trainer's Tool 11.3A: List of Barriers to Screening

Time constraints.

Lack of training about the issue.

Provider feels there is nothing s/he can do to help.

The clinic is not the place to address sexual abuse.

There are more important health issues to be addressed.

Belief that women won't want to talk about their experiences.

Belief that sexual abuse is a private or shameful issue.

Provider believes that sexual abuse does not occur with her/his patients.

Belief that sexual abuse is so prevalent that it is seen as a normal part of life.

There are no services for survivors of sexual abuse in the community/country, so why bother to screen for sexual abuse?

Belief that screening for sexual abuse is not the provider's responsibility.

Trainer's Tool 11.3B: Responses to the Barriers

Time constraints.

Developing a standardized screening tool and referral program can make dealing with sexual abuse a time-efficient process.

Already RH/FP clinics are seeing survivors of sexual violence. Sexual abuse has been linked to repeat visits and increased use of services, and it can be the cause of chronic or repeat RH problems. Addressing sexual abuse early on can prevent repeat visits in the future, thereby saving time.

Lack of training about the issue.

It is possible for a provider who is knowledgeable on the subject to conduct a training within their clinic for all staff on the issue of screening and referral. The key to responding to sexual abuse is commitment to the issue.

Provider feels there is nothing s/he can do to help.

While you may not be able to solve the problem, you can help by detecting the problem, providing an opportunity for the client to talk, helping the client identify a safe place where s/he can stay temporarily, and, if services exist, setting up a referral process.

The clinic is not the place to address sexual abuse.

Screening for sexual abuse is the next logical next step in the provision of comprehensive care. Adolescents are already coming for other RH/FP services. Often the clinic is the only place where sexual abuse can be addressed, especially if there are no referral services in the community.

There are more important health issues to be addressed.

Research shows that sexual abuse and its medical consequences are just as—or even more—prevalent than many common conditions for which providers routinely screen. It also has significant consequences for the client's future RH.

Belief that young men/women won’t want to talk about their experiences.

Research and clinical experience show that this is not the case. Many young men/women are hoping that someone will ask. Many providers are surprised to see how readily clients will talk about the issue when they begin asking their clients direct questions about sexual abuse.

Belief that sexual abuse is a private or shameful issue.

Staff already discuss sensitive and personal topics with clients.

Provider believes that sexual abuse does not occur with his/her patients.

Sexual abuse happens in all societies regardless of ethnicity, class, or whether the person is from a rural or urban area.

Belief that sexual abuse is so prevalent that it is seen as a normal part of life.

Health programs need to provide training that includes empirical evidence to help providers recognize that sexual abuse is a serious problem with tangible health consequences.

There are no services for survivors of sexual abuse in my community/country, so why bother to screen for sexual abuse?

This is a serious and legitimate concern. There is a need for health programs to investigate the resources in their community and build links with those services. Also screening for sexual abuse serves the purpose of recognizing sexual abuse as a RH problem. The first step is to create community awareness on the issue. Some health programs have started their own programs to deal with sexual abuse in communities where services are lacking.

Belief that screening for sexual abuse is not the provider's responsibility.

Sexual abuse is an RH issue and, therefore, screening for sexual abuse is the provider's responsibility. If left untreated, sexual abuse can often lead to more complicated RH problems later on. The provider is often the only one who has the opportunity to screen for sexual abuse and therefore should make sure that screening for sexual abuse is part of every RH visit.

Source: IPPF. 2000. The link between gender-based violence and sexual and reproductive health. *BASTA!* New York: IPPF.

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
BCG	Bacille Calmette-Guerin (tuberculosis vaccine)
BP	Blood Pressure
BV	Bacterial Vaginosis
CBT	Competency Based Training
CMV	Cytomegalovirus
COC	Combined Oral Contraceptives
CPD	Cephalopelvic Disproportion
DMPA	Depot-Medroxyprogesterone Acetate
DPT	Diptheria Pertussis Tetanus
FGM	Female Genital Mutilation
FP	Family Planning
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSV	Herpes Simplex Virus
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IUD	Intrauterine Device
OPV	Oral Polio Vaccine
PID	Pelvic Inflammatory Disease
PX	Participants
RH	Reproductive Health
RTI	Reproductive Tract Infection
STI	Sexually Transmitted Infection
TB	Tuberculosis
TV	Trichomonas Vaginalis
WHO	World Health Organization
YFS	Youth Friendly Services

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