

CONTENT

Unit 1: Nature of Adolescence

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 belief 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

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, requiring different counseling approaches and more time.
- They tend to be less well-informed and require more information.
- Conflicts between cultural/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.

- 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 for their future.
- There are many effective channels for reaching adolescents: through 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 services in a more efficient and effective manner.

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
- 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



DESIRABLE ADOLESCENT HEALTH STATUS

Young people between the ages of 10-19, who have survived the vulnerable period of childhood, are generally healthy.

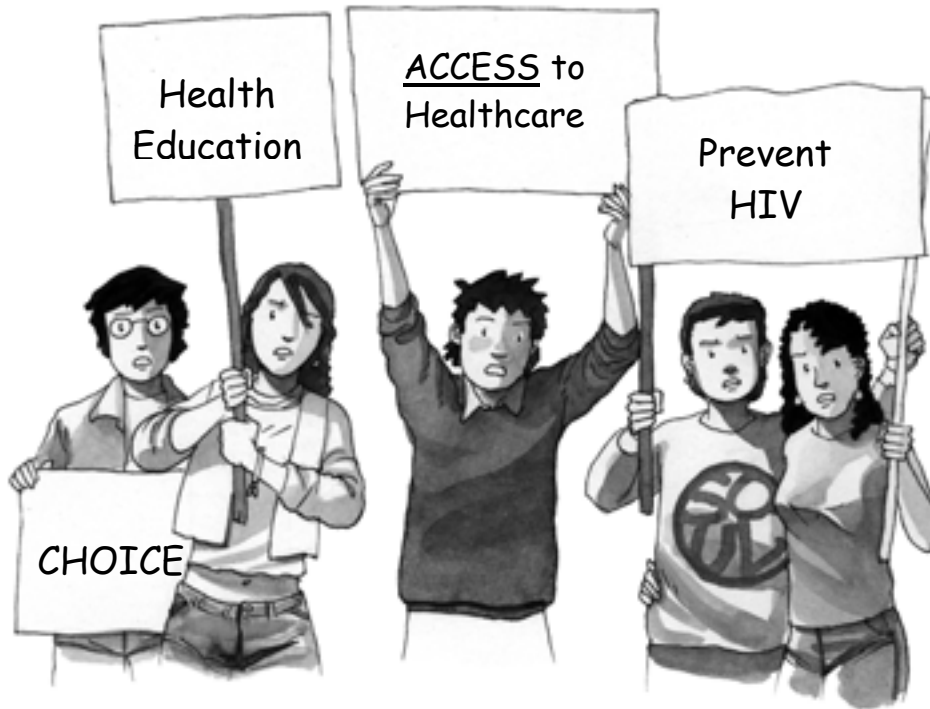
The challenge for reproductive health care providers is to help young people achieve a desired state of reproductive health which, according to the Cairo International Conference on Population and Development, “is a state of complete physical, mental, and social well-being and not merely the absence 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.

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 reproductive health 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 ones' own body.
- The right to be free of discrimination, coercion and violence in one's sexual decisions and sexual lives.

- 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.
- 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.
- There is no method for providing client feedback.

Unit 2: Adolescent Vulnerabilities, Risk-taking Behaviors, and their Consequences

VULNERABILITIES OF ADOLESCENTS

Gender issues have a marked influence on the socio-economic vulnerabilities of adolescents as well as 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 in sexual and reproductive matters.



Emotional Vulnerabilities

- Mental health problems can increase during adolescence because of hormonal and other physical changes of puberty, along with changes in adolescents' social environment.
- Adolescents often lack assertiveness and good communication skills 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 manifestation 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

- Young people's need for money often increases while they 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, 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.
- There are also many young people 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, orphans because of AIDS and other circumstances, and other neglected and/or abandoned youth.

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, invulnerability, and impulsiveness can lead to a lack of future planning and 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.

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 including 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, and social influences and pressures, including available opportunities.
- Adolescents tend to test their limits and minimize costs of risk-taking; this type of behavior is age-appropriate, but adults must assist adolescents to avoid serious consequences.

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

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 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, as rapid growth requires an increased intake of calcium.
- 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 affect 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 15-19 year-old women are untimely or unwanted. For example, 81% of pregnancies among 15-19 year olds are untimely or unwanted in Botswana, 32% in the Philippines, and 57% in Peru.
- Too-Early Childbearing: Worldwide, more than 10% of all births are to women 15-19, and in the least developed countries, teen pregnancy accounts 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.
- Young women, compared to older 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 STI infections 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

PSYCHOLOGICAL AND BEHAVIORAL CONCERNS

Certain social relationships and pressures, along with concerns of 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.

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 in 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.
 - 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 because of rapid physical and social changes and 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.

LIFE SKILLS FOR HEALTHY 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 onto 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.
 - Effectively negotiate safe sex to prevent unwanted pregnancy and STIs 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 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.

Unit 4: Communicating with the Adolescent Client

FEELINGS OF THE ADOLESCENT

Understanding the realities and mind-set of the adolescent client will foster better communication and responsiveness to her/his 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.



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 be judgmental in words or in body language that suggest disapproval of her/him being at the clinic, of her/his behavior, or of her/his 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.

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 aspects 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 assurance to 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 prevent further sexual abuse), the counselor/provider should explain why it is important and explain to whom, when, and how the information will be shared.
- **Respect:** This characteristic involves the way in which the counselor/provider relates to the adolescent, requiring recognition of the client's humanity and 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 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.
- 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 her/his 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, which **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.
- Smiling without showing tension.

- Facial expressions which show interest and concern.
- Maintaining eye contact with the client.
- Encouraging supportive gestures such as nodding one's head.

Negative nonverbal cues include:

- Not making or 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 with adolescent clients:

R = Relax the client by using facial expressions showing 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

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 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 and reflection of 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 adolescents to examine their conduct and make the changes they consider necessary. This will promote ownership of the decisions, greater self-confidence, and self-control.



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 adolescent 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.

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.
- Assist the client to 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 adolescent, 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 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 a single question 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?”, “What’s your family like?”

- Ask in-depth questions in response to a previous question and to solicit more information.

Example: “Can you explain that better?”

- Avoid biased questions that lead the client to respond in a pre-determined way.

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 incriminating 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.

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 or may signify 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.
 - *If the adolescent cannot or will not talk*, the counselor should propose another meeting.

- **Crying:** The counselor should 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’s 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.
 - *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.



COMMUNICATING AND COUNSELING ABOUT SEXUALITY WITH ADOLESCENTS

Communicating and counseling with 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 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 consequences, advantages, and disadvantages of options.
- Assisting the client to make an informed decision.
- 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/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.

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 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 to not 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 it is necessary to do so.
 - If possible, accompany the adolescent to the referral appointment.

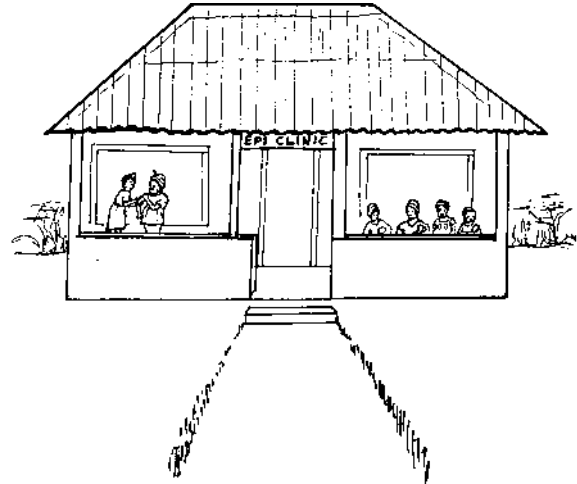
Note: *Sexual abuse will be covered in detail in Unit 11.*

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

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 STIs 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.

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—onset, duration, 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.
- 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.

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.

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. 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 use drugs.

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 STIs 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.
- Physical attraction—to men or women, to both, or to neither.
- The number of sexual partners s/he has had.

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.

If a pelvic exam is necessary, then the following techniques can reduce any 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, 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 examination.
- Protect her/his physical privacy as much as possible. Allow her/him to keep on her/his clothes except for what must be removed. Make sure to cover the parts of her/his body that are exposed. Never leave any part of the body exposed when not being examined.
- Reassure the adolescent 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 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.

Traditionally, young women have come to the clinic for prenatal care or contraception, thus presenting an opportunity to also prevent and treat STIs. You 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.

These statistics document the extent of unprotected sexual activity among youth and demonstrate the clear need to protect young people against both 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 sexually transmitted infections 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 sexually transmitted infections.

THE RANGE OF "SAFER SEX"

"Safer Sex" describes a range of ways that sexually active people can protect themselves from all 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, masturbating your partner or masturbating together, as long as males do not ejaculate near any opening or broken skin on their partners.

Low Risk

There are other activities that are **probably safe** such as using a latex condom for **every** act of sexual intercourse (penis in vagina, penis in rectum, penis in mouth), using a barrier (such as a 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 or hand into the vagina or anus or sharing sexual toys (rubber penis, vibrators, etc.) without cleaning them.

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 any kind of sexual intercourse without using a condom or having oral sex without a latex barrier.

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 pregnancy and STIs/HIV.

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 non-existent or inadequate.
 - 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 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.
- Spontaneous act—method not available when needed.
- Attitude of provider 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 that they have never used before—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.
- Fears that their parents will find out they are having/planning to have 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 it.
- 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.
- May desire conception. For a girl, it may be a way to keep a relationship or a boyfriend; for a boy, conception may be a way to prove manhood; or they may already 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

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 suffer consequences of retarded fetal growth.
- **Spontaneous Abortion and Still Births:** Young adolescents under the 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 of 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 status, which may encourage boys to practice unprotected sex.
- Some boys refuse to take responsibility for the pregnancy which contributes 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 of child abuse or neglect.
- Premature marriages are frequently unstable and end in divorce.

COMMON SIDE EFFECTS AND THEIR IMPACT ON CLIENTS

Most side effects from modern 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.

- 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.

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 or misconceptions are sometimes spread by health workers who may themselves be misinformed about certain methods or who have religious or cultural beliefs pertaining to contraception which they allow to impact on 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.
- **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.**



UNIT 8: STIs/HIV and Adolescents

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 an 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 STIs.
- Sexual intercourse is often unplanned and spontaneous.
- 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.
- 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 prepared to be sexually active.
- Young people often confuse sex with love and engage in sexual relations before they are ready in the name of “love.” A young person can either be pressured into having sex or 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.
- 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

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.



1. Unroll condom on erect penis.



2. Carefully remove condom after sexual act.



3. Tie a knot to avoid spilling semen.

- **Use condoms.** Condoms should be discontinued only when pregnancy is desired, or when both partners in a stable relationship know for certain that 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 communicating with their partners about sex and their sexual histories. A communicative relationship is essential to emotional and physical health.

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.

STI MANAGEMENT

A 20-year-old male comes to the clinic for treatment.

Using Etiologic Management

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 for a chlamydia test, 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.



Using Clinical Management

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, asks the patient to bring his partner(s) in for treatment, s/he counsels the patient, and gives him condoms.

Using Syndromic Management

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.

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 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.