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.
  - Fewer time-consuming minor complaints and side effects.
Satisfied clients often return for RH 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 client-provider counseling session, many different factors influence the outcome of the counseling. These factors should all 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
- 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
- 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 adolescent’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 chance to demonstrate condom use on a penis model or on a pelvic model if it is a female condom.

• Help clients learn to negotiate condom use.

• 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.

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.

• 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.

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/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

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.

**Transsexual**—Person desires to change or has changed her/his biological sex because her/his body does not correspond to her/his sexual identification. Sexual orientation varies.

**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.

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.
Unit 11: Sexual Abuse

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 wishes. 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.

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.

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.
• STIs, including HIV/AIDS.
• Unwanted pregnancy and its consequences (unsafe abortion, bad pregnancy outcomes, etc.).
• 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.
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
- 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

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

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 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.

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 personal topics with clients. Screening for sexual abuse is the next logical step in the provision of comprehensive care.
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 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.


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?"

“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. They should tell you to stop any time that they feel uncomfortable.
- It is important that the provider report what s/he observes 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 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.

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 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.
• 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.
Unit 12: Pregnancy, Birth, and Postpartum Issues

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.

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 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)

- Take her blood pressure at every visit.

- 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. 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.

- 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.

**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.
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 PREGNATAL 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. 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 adolescents 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.
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.

- 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 (tea with sugar, milk, chocolate), or have a family member or support person to give a back rub.
- Encourage walking, it will stimulate true labor or relieve false labor.

Early Labor

- Provide comfortable chairs for the adolescent and her support person(s), and provide diversions to help pass the time (playing cards, games, books, magazines, radio, TV).
- 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.
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.

- 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, take 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.

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, 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 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 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 oversensitivity 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 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 care-takers (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, 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. Discuss with the adolescent mother her contraceptive needs. Explore with her how she is coping with mothering and physical, emotional, and/or baby problems.
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, 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.

**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.
- 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.


The Adolescent and Breastfeeding
Breastfeeding is a particular challenge for adolescents. They 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 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 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 success and confidence during antenatal and postnatal periods. Provide breastfeeding guidance from the moment of delivery.
• Emphasize that breastfeeding is pleasurable and convenient.

• 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.

• Focus on body image in a positive way, e.g., breastfeeding can help her return to her pre-pregnant shape.

• Encourage foods that are high in nutrition, yet are also “social” foods.


**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 over dilute 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—it’s protein content is too high and is hard to digest, its chemical make-up can burden the baby’s kidneys, and it is inadequate in vitamins and iron.

• How to prepare, use, and store the formula.

• 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 of 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

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.
- 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.

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 reproductive health 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 improved adolescents.

2. Collect information using the assessment tool (Participant Handout 13.1) 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.
- 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?
LIST OF ACRONYMS
### List of Acronyms

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


• 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.


• Pathfinder International, FOCUS on Young Adults. 1998. Reaching young men with reproductive health programs. *In Focus*. December.


**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


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