MODULE 16: REPRODUCTIVE HEALTH SERVICES FOR ADOLESCENTS

Participant’s Manual

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Pathfinder International
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Participant Handout 0.1: Defining Participant's Expectations of the Course

1. What do you hope to accomplish during this course?

2. Do you anticipate any difficulties during this course?

3. While you attend this training, what will you be missing at home? For example, having a young baby at home or a sick family member.

4. While you attend the training, what will you be missing at work? For example, there is no one to cover your position or certain work will not be completed.

5. How do you think this training will help you at work?
Participant Handout 0.2: Suggestions for Effective Feedback

DO

- Ask a question when you have one.
- Feel free to share an example.
- Request an example if a point is not clear.
- Search for ways in which you can apply a general principle or idea to your work.
- Think of ways you can pass on ideas to your subordinates and co-workers.
- Be skeptical—don't automatically accept everything you hear.
- Participate in the discussion.

DON'T

- Try to develop an extreme problem just to prove the trainer doesn't have all the answers. (The trainer doesn't.)
- Close your mind by saying, "This is all fine in theory, but..."
- Assume that all topics covered will be equally relevant to your needs.
- Take extensive notes; the handouts will satisfy most of your needs.
- Sleep during class time.
- Discuss personal problems.
<table>
<thead>
<tr>
<th>Time</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 am – 10:30 am</td>
<td>Opening and Pre-test (1 hr, 45 min.)</td>
<td>Opening and Pre-test (1 hr, 45 min.)</td>
<td>Introduction and Test (1 hr, 45 min.)</td>
<td>“Where Are We?”</td>
<td>“Where Are We?”</td>
<td>“Where Are We?”</td>
</tr>
<tr>
<td>10:30 am – 11:00 am</td>
<td>Break</td>
<td>Break</td>
<td>Unit 4 continued</td>
<td>Unit 8 continued</td>
<td>Unit 8 continued</td>
<td>Unit 8 continued</td>
</tr>
<tr>
<td>11:00 am – 12:00 pm</td>
<td>Unit 1: Nature of Adolescence (2 hrs, 45 min.)</td>
<td>Unit 4 continued</td>
<td>Unit 7 continued</td>
<td>Contraceptive Options (3 hrs, 45 min.)</td>
<td>Unit 11 continued</td>
<td>Unit 11 continued</td>
</tr>
<tr>
<td>12:00 pm – 1:30 pm</td>
<td>Lunch</td>
<td>Lunch</td>
<td>Unit 7 continued</td>
<td>Lunch</td>
<td>Lunch</td>
<td>Lunch</td>
</tr>
<tr>
<td>1:30 pm – 3:30 pm</td>
<td>Unit 2: Adolescent Vulnerabilities and Risk-taking (55 min.)</td>
<td>Unit 4 continued</td>
<td>Unit 7 continued</td>
<td>Unit 9 continued</td>
<td>Unit 9 continued</td>
<td>Unit 9 continued</td>
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<tr>
<td>3:30 pm – 6:00 pm</td>
<td>Unit 3: Adolescent Behavior (1 hr, 55 min.) Reflections</td>
<td>Unit 4 continued</td>
<td>Unit 7 continued</td>
<td>Unit 9 continued, Sexual Identity and Orientation (1 hr, 10 min) Reflections</td>
<td>Unit 12 continued</td>
<td>Unit 12 continued</td>
</tr>
</tbody>
</table>

**Notes:**
- The schedule above reflects 9-hour days to accommodate approximately 40 hours of training time. Alternatively, this training can be done in 6 and half days with the facility assessment being conducted on the last day.
- Day 1, Day 2, Day 3, Day 4, Day 5, Day 6 refer to different days of the training schedule.
- “Where Are We?” refers to different units of the training.
- “Assessment” indicates the time for assessment activities.
- “Reflections” indicates the time for reflection activities.
- “Break” indicates the time for breaks.
- “Contraceptive Options” indicates the time for contraceptive options.
- “Unit 1: Nature of Adolescence” indicates the time for the first unit.
- “Unit 2: Adolescent Vulnerabilities and Risk-taking” indicates the time for the second unit.
- “Unit 3: Adolescent Behavior” indicates the time for the third unit.
- “Unit 4 continued” indicates the continuation of the fourth unit.
- “Unit 7 continued” indicates the continuation of the seventh unit.
- “Unit 9 continued” indicates the continuation of the ninth unit.
- “Unit 11 continued” indicates the continuation of the eleventh unit.
- “Unit 12 continued” indicates the continuation of the twelfth unit.
- “Unit 13 continued” indicates the continuation of the thirteenth unit.
- “Lunch” indicates the time for lunch.

*The schedule above reflects 9-hour days to accommodate approximately 40 hours of training time. Alternatively, this training can be done in 6 and half days with the facility assessment being conducted on the last day.*
Participant Handout 0.4: Where Are We? and Reflections

Where Are We?

Starting each day with "Where are We?" is our opportunity to share insights, clarify issues, resolve problems, and review the previous days' material we need to remember so that each of us can get the most out of the course and each day's experiences.

Reflections

After a full day of activities, we need to take time to look over what we have done and examine what it means to us individually.

The "Reflections" activity is an opportunity for the trainers and Px to share feedback on the training activities and to identify areas that need reinforcement or further discussion. Therefore, each day, selected Px (housekeeping team) will solicit feedback from the other Px during breaks or lunch and then at the end of the day will meet with the trainers to discuss how the day of training went.

For the first session of "Reflections," the housekeeping team should ask other Px the following questions and share the responses with the trainers:

- What did I like about today and why?
- What did I not like about today and why?
- What did I learn and experience today that I will be able to use?

The housekeeping team is free to vary the exercise to make it more interesting and less repetitive.
Participant Handout 0.5: Reproductive Health Services for Adolescents Pre-Test

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

1. Identify which of the following more commonly occur near the beginning or end of adolescence:
   ___ Reaches physical and sexual maturity.
   ___ Major concern with peer group.
   ___ Impulsive, experimental behavior.
   ___ Has developed problem-solving abilities.

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

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

3. Which of the following occur more in adolescents than adults:
   a) Heart conditions.
   b) Anemia.
   c) Injuries.
   d) Low-birth weight babies.

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

5. Among the most important conditions a provider can ensure for the adolescent client are:
   a) Privacy.
   b) Popular music playing.
   c) Confidentiality.
   d) Respect.

6. Syndromic management of STIs is most effective in diagnosing:
   a) Genital ulcers.
   b) Urethritis.
   c) Vaginal discharge.
   d) Cervicitis.
7. The contraceptive methods that are appropriate for breast-feeding women who are more than 6 weeks postpartum are:
   a) IUD.
   b) Combined oral contraceptives
   c) Progestin-only contraceptives (progestin-only pills, Norplant, injectables like Depo-Provera).
   d) Lactational Amenorrhea Method (LAM).

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

9. Which of the following complications of pregnancy are more likely to occur in adolescents under the age of 15 compared with older women:
   a) Giving birth to very large babies.
   b) Premature labor.
   c) Dysfunctional labor.
   d) Spontaneous abortion.
   e) Still birth.

10. Which methods of contraception may not be suitable to the adolescent client:
   a) Emergency contraception.
   b) Combined oral contraceptives.
   c) Sterilization.
   d) Condoms.
   e) Injectable contraceptives.

11. WHO estimates that the risk of dying of pregnancy-related causes is:
   a) Twice as high for women aged 15-19 than for older women.
   b) Three times as high for women aged 15-19 than for older women.
   c) Four times as high for women aged 15-19 than for older women.
   d) Five times as high for women aged 15-19 than for older women.
   e) The same for women aged 15-19 than for older women.

12. Which of the following methods are appropriate for counteracting rumors and misconceptions about contraceptives:
   a) Using strong scientific facts to counteract misinformation.
   b) Giving less information so the client is not confused.
   c) Finding where the rumors came from and checking to see if there is any basis for the rumor.
   d) Not telling the client about side effects because it might make them frightened.
Instructions: Write in the correct answers

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

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

15. Two signs of anemia are:

16. Which methods protect adolescents against STIs?

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

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

18. ____International policies agreed to by a majority of the world's countries calls for reproductive health information and services to be available to adolescents.

19. ____Rape only happens to females.

20. ____STIs cannot be transmitted through oral sex.
Participant Handout 1.1: Adolescent Reproductive Rights

- The right to good reproductive health.
- The right to decide freely and responsibly on all aspects of one's sexuality.
- The right to information and education about sexual and reproductive health so that good decisions can be made about relationships and having children.
- The right to own, control, and protect one's own body.
- The right to be free of discrimination, coercion and violence in one's sexual decisions and sexual life.
- 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:
  - Contraceptive information, counseling and services.
  - Prenatal, postnatal, and delivery care.
  - Healthcare for infants.
  - Prevention and treatment of STIs.
  - Safe abortion services, where legal, 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.

Participant Handout 3.1: Gender Role Case Studies

1. Aunt Rekha wants to give a doll as a present to her young nephew. She believes that dolls will help teach little boys about taking care of someone and how to be loving. Her husband thinks it is a bad idea and will only teach their nephew to be a sissy.*

2. Esther and David, the older children, are both attending school when a family crisis occurs. Their parents must leave home for several days and need one of the older children to take time off from school to take care of the younger two children and to tend to the household chores. Esther thinks David should be selected because she faces a critical week in school preparing for and taking an important examination. David thinks Esther should be selected because taking care of children and tending the house is female work—and that she would be better at it in any case.

3. Sonia and Ron know each other and have become friendlier but have never gone out on a date. Sonia learns of a movie she really wants to see and decides to ask Ron to go with her. Although Ron is interested in going out with Sonia, he decides to turn her down because he believes he should have been the one to do the asking.*

4. Jose and Maria have been going out for a year. Their relationship is good—and even their parents approve! But lately Jose has been putting pressure on Maria to become more sexually involved than she wants. She believes she should be able to say “no” and not harm the relationship, but he thinks it’s her place as a woman to please him.*

5. Since his father’s death, Kweku has been thinking about giving up his studies so he can get a job to help support his mother and younger brothers and sisters. However, Kweku’s mother feels that he should stay in school so that when he finishes next year he will be eligible for a better, higher paying job.

Participant Handout 3.2: Decision-Making/Predicting Consequences

List three likely consequences for each of the following decisions. Then circle the **best possible** consequence and put a line through the **worst possible** consequence for each:

1. Amina decides to steal a skirt from a store.

2. Kojo is late for his curfew and decides to ride home with a friend who doesn’t have his driver’s license.

3. Maria decides to spray paint graffiti all over a store because the owner was rude to her friends.

4. Raj decides to go to a party where there will be alcohol and no adults.

5. Charlene decides to inhale cleaning fluid just to go along with new friends.

6. Daniel and Lucy have several drinks and decide to go to his bedroom.

7. Pamela has decided to run away to a big city.

8. Kareem decides to drop out of school in the middle of his senior year.

9. Tomas decides to take an after-school job even though his grades are not very good and he’s been told he has to improve.

Participant Handout 4.1: Small Group Discussion Topics

Confidentiality Issues

A. Discuss and present different creative procedures that will permit the adolescent to believe his/her concerns will remain confidential. Two case studies should support these presentations, emphasizing the procedures to follow and approaches to take to obtain the adolescent’s trust.

B. Discuss and present appropriate ways to inform the adolescent that the information provided will not be kept confidential when the counselor believes it is absolutely necessary to discuss the case with others. Develop this process in the following two case studies: 1) an adolescent who has a STI and refuses treatment and 2) an adolescent who is involved in a situation of abuse against another adolescent. Weigh the consequences for the adolescents in each case.

C. Analyze what occurs in the country with regard to confidentiality in light of existing norms and laws. Discuss the main obstacles (if any exist) to privacy in counseling sessions and how these issues have been addressed.

Participant Handout 4.2: Clarifying Sexual Values

Please read the following statements and answer them honestly. Move under the sign (agree or disagree) that corresponds to your answer, as the trainer reads the statements aloud, one by one.

1. Men by nature have a greater need to satisfy their sexual desires than do women.
2. Only excessive masturbation is harmful.
3. A woman should be a virgin at the time of her marriage.
4. In an intimate relationship, the woman sets the limits on sexual contact.
5. Parents should accept their homosexual son rather than try to re-orient his sexual preference.
6. The main function of sex is reproduction.
7. If an adolescent requests contraceptives, s/he should receive them.
8. Adolescent girls are much more likely to link sex with "being in love."
9. Family planning should be available for married people only.
10. Adolescents shouldn't be given contraceptives without their parents' permission.
11. Adolescents shouldn't be given contraceptives because it will encourage sexual activity.
12. Health care providers should be the main source of sexual information for adolescents.
13. Using family planning methods is not a good idea before the wife has had her first child.
14. Parents should not allow their daughters as much sexual freedom as they allow their sons.
15. A child should be given sex education at school.
16. Adolescents who contract STIs have had many sexual partners.

Participant Handout 4.3: 
Lines to Practice the Clarification Technique

Note: The words in boldface are the ones the counselor must ask the adolescent to define. *Example:* What do you mean by “he makes love to me?”

1. “My parents would **kill** me if they know I have **relations** with Pedro.”

2. "**I don’t want to know anything** about contraceptives.”

3. “They say our relationship is **light**…that doesn’t bother me.”

4. “I like a girl but they tell me she’s a **teaser**.”

5. “Girls **don’t pay attention to me.**”

6. “I’ve come for help, I’m **so alone**!”

7. “My boyfriend **makes love to me** and I don’t like it to be so **sticky sweet.**”

8. “**Sometimes** I use a condom, but other times I don’t.”

9. “Yes, I have sex, but **nothing has ever happened** that I can’t handle.”

Participant Handout 5.1: Reproductive History Form
Participant Handout 6.1: Sexual Safety Questionnaire

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

1. Young people are more vulnerable to STIs than older adults.

2. People increase their risk of HIV infection 10 times if they do NOT use a condom when having intercourse with a person whose HIV status they do not know.

3. Having heterosexual intercourse with an HIV+ partner puts young women at greater physiological risk of becoming infected than young men.

4. A major reason condoms break is because they have been used incorrectly with an oil-based lubricant.

5. People without any symptoms of illness may carry and transmit HIV to a sex partner.

6. People who have had one sexually transmitted disease are at higher risk of contracting a second STI, including HIV.

7. A dab of lubricant on the tip of the penis or inside the condom greatly increases the sensation for the male.
Participant Handout 6.1: Sexual Safety Questionnaire (cont'd.)

8. Anal intercourse puts a person at risk for HIV infection only when it occurs between males.

9. As a result of the AIDS epidemic, the number of unmarried people having intercourse has decreased significantly over the past five years.

10. For the majority of women, "outercourse" that includes stimulation of the clitoris leads to orgasm more frequently than intercourse.

11. Sexual abstinence is the only 100% sure way to prevent pregnancy and sexually transmitted disease.

12. STIs can not be transmitted through oral sex.

13. Using powders or herbs to dry out the vagina to increase male sexual pleasure can increase a woman's risk of contracting an STI.
Participant Handout 6.2: Talking About Condoms

If your partner says:

"I don’t like using condoms. It doesn’t feel as good."
You can say:
"I’ll feel more relaxed and if I’m more relaxed I can make it feel better for you."

"We have never used a condom before."
I don’t want to take any more risks."

"Using condoms is not pleasant."
"Unplanned pregnancy is more unpleasant. Getting AIDS is more unpleasant."

"Putting it on interrupts everything."
"Not if I help put it on."

"Don’t you trust me?"
"I trust you are telling the truth. But with some STIs, there are no symptoms. Let’s be safe and use condoms."

"I know I do not have a STI."
"I want to use them to prevent pregnancy."

"I don’t have a condom."
"I do."

"I will pull out in time. I will practice withdrawal."
"Women can still become pregnant or get STIs from pre-ejaculation fluid."

"I thought you said condoms were for casual partners."
"I decided to face facts. I like having sex with you and I want to stay healthy and happy."

"Condoms are not romantic."
"What is more romantic than making love and protecting each other’s health at the same time?"

"But I love you."
"Then you will help me protect myself."
Participant Handout 6.2: Talking About Condoms (cont’d.)

"I guess you don’t really love me.
"I do, but I do not want to risk my life to prove it."

"We’re not using a condom, and that’s it."
"OK. Let’s do something else."

"Just this once without it."
"It only takes once to get pregnant. It only takes once to get a sexually transmitted infection. It only takes once to get HIV."

# Participant Handout 7.1: Adolescent Contraception

<table>
<thead>
<tr>
<th>Contraceptive Method Effectiveness</th>
<th>Safety, Appropriateness, and Special Considerations for the Adolescent Client</th>
<th>Counseling Issues</th>
</tr>
</thead>
</table>
| Low-Dose Combined Oral Contraceptives  
*Typical Use Effectiveness:* 6-8 pregnancies per 100 women in first year of use.  
*Correct and Consistent Use:* 0.1 pregnancies per 100 women in the first year of use | [Table cell content] | [Table cell content] |
<table>
<thead>
<tr>
<th>Contraceptive Method Effectiveness</th>
<th>Safety, Appropriateness, and Special Considerations for the Adolescent Client</th>
<th>Counseling Issues</th>
</tr>
</thead>
</table>
| **Depo-Provera (DMPA) Injectable Contraceptive**  
*Typical Use Effectiveness:* 0.3 pregnancies per 100 women in first year of use.  
*Correct and Consistent Use:* 0.3 pregnancies per 100 women in the first year of use. | | |
<table>
<thead>
<tr>
<th>Contraceptive Method Effectiveness</th>
<th>Safety, Appropriateness, and Special Considerations for the Adolescent Client</th>
<th>Counseling Issues</th>
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</thead>
<tbody>
<tr>
<td>Norplant Implants</td>
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<td><em>Typical Use Effectiveness:</em></td>
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<td>0.1 pregnancies per 100 women in</td>
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<td>the first year of use. Over 5</td>
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<td>years, 1.6 pregnancies per 100</td>
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<td>women.</td>
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<tr>
<td><em>Correct and Consistent Use:</em></td>
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<td>0.1 pregnancies per 100 women in</td>
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<td>the first year of use. Over 5</td>
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<td>years, 1.6 pregnancies per 100</td>
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<td>women.</td>
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<td>Contraceptive Method Effectiveness</td>
<td>Safety, Appropriateness, and Special Considerations for the Adolescent Client</td>
<td>Counseling Issues</td>
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<tr>
<td><strong>IUDs (TCu 380A)</strong>&lt;br&gt;Typical Use Effectiveness: 0.8 pregnancies per 100 women in the first year of use.&lt;br&gt;Correct and Consistent Use: 0.6 pregnancies per 100 women in the first year of use.</td>
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<tr>
<td>Contraceptive Method Effectiveness</td>
<td>Safety, Appropriateness, and Special Considerations for the Adolescent Client</td>
<td>Counseling Issues</td>
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<td>Condoms</td>
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<tr>
<td><em>Typical Use Effectiveness:</em> 14 pregnancies per 100 women in the first year of use.</td>
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<tr>
<td><em>Correct and Consistent Use:</em> 3 pregnancies per 100 women in the first year of use. Adolescents who use condoms correctly every time can reduce their risk of STIs to a very low level.</td>
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<tr>
<td>Contraceptive Method Effectiveness</td>
<td>Safety, Appropriateness, and Special Considerations for the Adolescent Client</td>
<td>Counseling Issues</td>
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<td><strong>Female Barrier Methods</strong></td>
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<tr>
<td>Typical Use Effectiveness:</td>
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<td>Spermicides: 26 pregnancies per 100 women in the first year of use.</td>
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<td>Diaphragm: 20 per 100 women.</td>
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<td>Cervical cap for women who have not had children: 20 per 100 women.</td>
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<td>Cervical cap for women who have children: 40 per 100 women.</td>
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<tr>
<td>Female condom: 21 per 100 women.</td>
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<tr>
<td>Correct and Consistent Use:</td>
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<tr>
<td>Spermicides: 6 per 100 women.</td>
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<tr>
<td>Diaphragm: 6 per 100 women.</td>
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<tr>
<td>Cervical cap for women who have not had children: 9 per 100 women.</td>
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<tr>
<td>Cervical cap for women who have children: 26 per 100 women.</td>
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<tr>
<td>Female Condom: 5 per 100 women.</td>
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<tr>
<td>Contraceptive Method Effectiveness</td>
<td>Safety, Appropriateness, and Special Considerations for the Adolescent Client</td>
<td>Counseling Issues</td>
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<tr>
<td><strong>Lactational Amenorrhea Method (LAM)</strong>&lt;br&gt; <em>Typical Use Effectiveness:</em> 2 pregnancies per 100 women in the first 6 months after childbirth.&lt;br&gt; <em>Correct and Consistent Use:</em> 0.5 pregnancies per 100 women in the first 6 months after childbirth.</td>
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<tr>
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<tr>
<td><strong>Male Sterilization</strong>&lt;br&gt;<strong>Vasectomy Sterilization:</strong>&lt;br&gt;Typical Use Effectiveness: 0.15 pregnancies caused per 100 men in the first year after the procedure. <strong>Correct and Consistent Use:</strong> 0.1 pregnancies per 100 women. Correct use means using condoms or another effective family planning method consistently for the first 20 ejaculations or for 3 months after the procedure.</td>
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<tr>
<td>Contraceptive Method Effectiveness</td>
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<tr>
<td><strong>Female Sterilization</strong>&lt;br&gt;<strong>Typical Use Effectiveness:</strong>&lt;br&gt;In the first year after the procedure: 0.5 pregnancies per 100 women (1 in every 200 women). Within 10 years after the procedure 1.8 pregnancies per 100 women (1 in every 55 women). Effectiveness depends partly on how the tubes are blocked, but all pregnancy rates are low.&lt;br&gt;&lt;br&gt;<strong>Correct and Consistent Use:</strong> In the first year after the procedure: 0.5 pregnancies per 100 women (1 in every 200 women). Within 10 years after the procedure 1.8 pregnancies per 100 women (1 in every 55 women).</td>
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<tr>
<td><strong>Emergency Contraceptive Pills (ECPs)</strong>&lt;br&gt;The LNG-only regimen reduces the risk of pregnancy by about 85% after a single act of intercourse.&lt;br&gt;The Yuzpe regimen reduces the risk by about 74%.</td>
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<td><strong>Abstinence</strong>&lt;br&gt;Effectiveness rates are not available.</td>
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### Participant Handout 7.2: Selection Guidelines for Contraceptive Methods

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<tr>
<th>Contraceptive Method Effectiveness</th>
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</table>
| **Low-Dose Combined Oral Contraceptives (COCs)**<br>Typical Use Effectiveness: 6-8 pregnancies per 100 women in first year of use.<br>Correct and Consistent Use: 0.1 pregnancies per 100 women in the first year of use. | Yes, low-dose COCs are appropriate and safe for adolescents. Many adolescents choose a COC because of low failure rate, the relief from dysmenorrhea, and the ease of using a method that is not directly related to intercourse. COCs may be used in sexually active adolescents before onset of menses. Selection of a particular COC depends on cost, availability, and the needs of the client. Some pills are more estrogen dominant and others are more progestin dominant. A COC with more progestin is helpful in adolescent clients with dysmenorrhea, hypermenorrhea, previous breakthrough bleeding, and/or dysfunctional uterine bleeding. A client with previous nausea or vomiting on COCs may benefit from using a very low-dose estrogen pill with 20 mcg ethinyl estradiol. COCs may be beneficial for adolescents who have Premenstrual Syndrome (PMS), endometriosis, acne, or for adolescents with hypoestrogenism due to eating disorders and excessive exercise. Failure rates are higher for adolescents than for all other ages. Failure to take... | The most important counseling issue with adolescents is to make sure they understand the necessity of taking pills correctly.  
- Show the client the pill packet and explain how to take the pills. The client should:  
  - Take the first pill on the first day of her period or on any of the next four days.  
  - Take one pill every day, at the same time of day.  
  - After finishing one packet, take the first pill in the next packet on the next day if the client has a 28-day packet. If the client has a 21-day packet, she should wait seven days and then begin the next packet.  
- Explain to the client that if she forgets to take her pills, she may become pregnant. If she forgets to take her pills, she should do the following:  
  - If she misses one pill, the client should take it as soon as she remembers. Take the next one at the regular time.  
  - If she misses two pills, the client should take two pills as soon as she remembers. She should take two pills the next day, and use a backup method for the next week. The client should finish the packet normally.  
  - If she misses more than two pills, the client should throw away the packet, and start a new one, and use a back-up method for the next week. |
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</table>
| pills regularly is often due to lack of knowledge or confusion about pill taking. Providers should encourage condom use in addition to COCs for STI/HIV protection. Help adolescents figure out where to keep pills and how to remember to take them at the same time daily by linking pill taking to a routine activity such as brushing teeth. COCs are available in 21-day or 28-day packages. Most adolescents do better using the 28-day pill because it is easier to remember taking a pill every day rather than stopping for 7 days. Discuss when to start taking the pill carefully with adolescents so that you both are clear about when she began taking the pills. This will make it easier to determine later whether the pills are being taken correctly. | • Review possible side effects. Side effects, especially breakthrough bleeding, are common in the first few cycles. Occasionally, women may experience nausea, weight gain, breast tenderness, headaches, unexpected bleeding or spotting, depression, or dizziness. These side effects usually settle over time. Encourage the adolescent to persevere and return if the side effects remain troublesome. | • Review the reasons why she should return to the care provider:  
  - Chest pain or shortness of breath.  
  - Severe headaches (with blurred vision).  
  - Swelling or severe pain in one leg.  
• Tell the client to return anytime she has a problem and in time for re-supply.  
• Have the client repeat this information. |
| Yes, POPs are appropriate and safe for adolescents. But, POPs must be taken daily at approximately the same time every day to be effective in preventing pregnancy because the progestin levels in the blood peak about 2 hours after they are taken and then rapidly decline. If a client is 3 hours late taking the pill, she should use a back-up form of contraception. POPs may not be the best choice for adolescents who cannot remember to take POPs at the same time. | • Show the client the pill packet and explain how to take the pills. She should:  
  - Take the first pill on the first day of her period or on any of the next four days.  
  - Take one pill every day, at the same time of day.  
  - Take the pills non-stop, from one packet to another.  
  - Do not miss a day.  
• Explain what the client should do if she misses taking one POP:  
  - Take it as soon as she remembers. |
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</table>
| Correct and Consistent Use: 0.5 pregnancies per 100 women in the first year of use. | time every day. POPs are a choice for adolescents who cannot tolerate the estrogen in COCs or have a medical contraindication to the use of COCs. If a client is switching from a COC to a POP, they should start taking the POP at the end of the active 21 COC tablets. Because POPs do not protect against STIs/HIV, providers should encourage condom use in addition to POPs. | - Continue taking the next pill at the usual time and use a back up method for the next 7 days.  
- Then continue taking the pills as usual.  
- Explain what the client should do if she misses 2 or more POPs. She should:  
  - Take 2 pills as soon as she remembers.  
  - Take 2 pills on the next day.  
  - Use a backup method for the next 7 days.  
  - Then continue taking the pills as usual.  
- Review possible side effects. Women not breastfeeding may have a change in menstrual periods. Most breastfeeding women have no side effects. Occasionally, women may experience breast tenderness or headaches.  
- Review the reasons why she should return to the care provider:  
  - If she thinks she might be pregnant.  
  - If she has abdominal pain, breast tenderness, or fainting.  
- Tell the client to return anytime she has any worries or a problem and in time for resupply.  
- Have the client repeat this information. |
| Depo-Provera (DMPA) Injectable Contraceptive  
Typical Use Effectiveness: 0.3 pregnancies per 100 women in first year of use. | Yes, DMPA is safe and appropriate for adolescents. It is a good method for adolescents who have difficulty remembering when to take oral contraceptives. Since it may be difficult | - Show the client the vial of DMPA.  
- Explain the use of DMPA.  
  - DMPA is given by injection every three months. The client should never be more than two weeks |
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</table>
| **Correct and Consistent Use:** 0.3 pregnancies per 100 women in the first year of use. | for adolescents to remember to return at regular intervals it may be helpful to use a reminder system that encourages clients to return 12 weeks after the previous injection. This allows for a 2 week "grace period" where the injection can still be given up to 14 weeks without fear of pregnancy. DMPA does not protect against STIs/HIV; therefore providers should encourage condom use as well. | late for her repeat injection. If the client knows that she may not be able to come at the appointed time, she may come up to four weeks early.  
- The injection will take effect immediately if it is given between day one and day seven of her menstrual cycle.  
- If the injection is given after day seven of her cycle, a back-up method should be used for 24 hours.  
  - Review possible side effects. Most women initially experience irregular spotting or prolonged light to moderate bleeding. Later bleeding is likely to be lighter, less frequent, or stop altogether. Some women also experience weight gain or headaches.  
  - Review the reasons why she should return to the care provider:  
    - Heavy vaginal bleeding.  
    - Excessive weight gain.  
    - Headaches.  
  - Tell the client to return anytime she has a problem and in time for her next injection.  
  - Have the client repeat this information. |
| **Norplant Implants**  
*Effectiveness:* 0.1 pregnancies per 100 women in the first year of use. Over 5 years, 1.6 | Yes, Norplant is safe and appropriate for adolescents. The main reason for discontinuation of Norplant is menstrual problems, especially irregular bleeding. Counseling is essential because adolescents must be prepared for | • Show the client the Norplant rods.  
• Explain how Norplant works and how it is used. When the Norplant rods are inserted the client should:  
  - Keep the insertion area dry for 4 days. She can |
### Contraceptive Method Effectiveness

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</table>
| pregnancies per 100 women. | incorrect bleeding and must make plans about how they and their partner will react to the irregular bleeding. Although the overall days of bleeding may increase, the total blood loss is often less and rarely results in anemia. After removal of Norplant, fertility returns rapidly. Studies done on Norplant use by adolescents found side effects similar to those of older women and similar continuation rates. Continuation rates for adolescents using Norplant were higher than those for adolescents using Pills or DMPA. Adolescents who select this method are most likely to want 3-5 years of contraceptive protection, have often experienced failure of other methods, can tolerate a small surgical procedure, and have access to services. Adolescents may be concerned about the Norplant rods being visible under the skin. They are afraid others may see them and know they are sexually active. Programs must ensure that adolescents have access to services to remove Norplant whenever an adolescent needs or wants removal. Norplant does not protect against STIs/HIV, therefore providers should encourage condom use as well. | take the gauze off after 2 days and the adhesive bandage after 5 days.  
- Her arm may be sore for a few days. There might be some bruising or swelling.  
- Return to the clinic if she has any concerns.  
- If possible, give the client a card that tells her the date of Norplant insertion, where to go if she has questions or problems and when she should have Norplant removed.  
- Give advice on common side effects such as weight gain, skin disorders, and changes in menstrual bleeding including spotting, bleeding between periods, or amenorrhea. Explain that some of these are common and not harmful.  
- Describe symptoms of serious problems that require medical attention. Explain that she should return to the clinic if she thinks she might be pregnant, has severe pain in her lower abdomen, infection at the insertion site, very heavy menstrual bleeding (twice as much or twice as long as usual), very bad headaches that start or become worse after she begins using Norplant, or if skin or eyes become unusually yellow.  
- It is especially important for adolescents that there are facilities where subdermal implants can be removed whenever the client requests. |
| **IUDs (TCu 380A)** | Yes, IUDs are appropriate for | • Show the client the IUD and explain how it is |

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*Pregnancies per 100 women.*

Correct and Consistent Use: 0.1 pregnancies per 100 women in the first year of use. Over 5 years, 1.6 pregnancies per 100 women.
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<tr>
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<tbody>
<tr>
<td><strong>Typical Use Effectiveness:</strong> 0.8 pregnancies per 100 women in the first year of use.</td>
<td>Adolescents in stable, mutually monogamous relationships. Women under the age of 20 who have not given birth appear to have greater risks for expulsions and painful menses. Careful screening for STIs before insertion is important. Where STI incidence is high among adolescents other contraceptives that have a protective effect against STIs may be a better option.</td>
<td>Inserted.</td>
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<tr>
<td><strong>Correct and Consistent Use:</strong> 0.6 pregnancies per 100 women in the first year of use.</td>
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<td>- Explain to the client how to check for the strings.</td>
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<tr>
<td><strong>Condoms</strong> <strong>Typical Use Effectiveness:</strong> 14 pregnancies per 100 women in the first year of use.</td>
<td>Yes, condoms are safe and appropriate for adolescents. Because they are available without a prescription and provide protection against STIs/HIV, they are a good method for adolescents. Behavior change towards</td>
<td>- Review possible side effects. Side effects of IUD use may include: cramping and some pain during and immediately after insertion, heavier and longer menstrual flow for the first few months, increased vaginal discharge, and possible infection. Heavier and longer bleeding is normal and expected, especially in the first few months. Bleeding usually decreases during the first and second years of IUD use.</td>
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<tr>
<td><strong>Correct and Consistent</strong></td>
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<td>- Explain the warning signs of potential complications:</td>
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<td>- Abnormal bleeding.</td>
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<td>- Abnormal discharge.</td>
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<td>- Pain (abdominal or pain with intercourse).</td>
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<td>- Fever.</td>
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<td>- Strings missing, shorter, or longer.</td>
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<td>- Tell the client to return any time she has a problem.</td>
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<td>- Remind her that the IUD can stay in for up to 10 years.</td>
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<td>- Have the client repeat this information.</td>
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<td></td>
<td>- Show the client the condom and explain how to use it. She should:</td>
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<td>- Open the package carefully so the condom doesn’t tear.</td>
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<td>- Not unroll the condom before putting it on.</td>
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<td>- Place the unrolled condom on the tip of the hard</td>
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<tr>
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<tr>
<td>Use: 3 pregnancies per 100 women in the first year of use. Adolescents who use condoms correctly every time can reduce their risk of STIs to a very low level.</td>
<td>condom use among adolescents requires skill development and practice in learning how to use condoms correctly, empowering female adolescents, overcoming cultural barriers, and peer support. Adolescent girls frequently are not assertive about the use of condoms when their partner rejects the idea. Providers should give adolescents ideas about how to negotiate condom use. Cultural barriers and the realistic extent of possible change need to be understood. Condoms provide significant protection against STIs/HIV. Condoms may be lubricated or unlubricated. In most areas of the world lubricated condoms are preferred by most adolescents.</td>
<td>penis.</td>
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<td>- Hold the tip of the condom with the thumb and forefinger.</td>
<td>- Unroll the condom until it covers the penis.</td>
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<tr>
<td></td>
<td>- Unroll the condom until it covers the penis.</td>
<td>- Leave enough space at the tip of the condom for the semen.</td>
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<td>- After ejaculation, hold the rim of the condom and pull the penis out of the vagina before it becomes soft.</td>
<td>- After ejaculation, hold the rim of the condom and pull the penis out of the vagina before it becomes soft.</td>
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<td>Hold the tip of the condom with the thumb and forefinger.</td>
<td>- Explain about the care of condoms.</td>
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<td>Unroll the condom until it covers the penis.</td>
<td>- Don't apply oil-based lubricants (like baby oil, cooking oil, petroleum jelly/Vaseline, or cold cream) because they can destroy the condom. It is safe to use contraceptive foam or jelly, clean water, saliva, or water-based lubricants.</td>
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<td>Leave enough space at the tip of the condom for the semen.</td>
<td>- Store condoms in a cool, dry place. Don't carry them near the body because heat can destroy them.</td>
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<td>After ejaculation, hold the rim of the condom and pull the penis out of the vagina before it becomes soft.</td>
<td>- Use each condom only once.</td>
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<td>- Don't use a condom if the package is broken or if the condom is dry or sticky or the color has changed.</td>
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<td>- Take care to dispose of used condoms properly.</td>
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<td>- Review possible side effects. Most men and women have no side effects. Occasionally men or women can be allergic to condoms or spermicides. If itching, burning, or swelling develop, the client(s) should return to the clinic to discuss another method.</td>
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<td>- Tell the client to return to the clinic:</td>
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</table>
| **Female Barrier Methods**        | **Typical Use Effectiveness:** Spermicides 26 pregnancies per 100 women in the first year of use. Diaphragm: 20 per 100. Cervical cap for women who have not had children: 20 per 100. Cervical cap for women who have children: 40 per 100. Female condom: 21 per 100 women. **Correct and Consistent Use:** Spermicides 6 per 100. Diaphragm: 6 per 100. Cervical cap for women who have not had children: 9 per 100. Cervical cap for women who have children: 26 per 100. Female Condom: 5 per 100 women. | **Any time there is a problem.**  
**In time for re-supply.**  
**If either partner is unhappy with the method.**  
**If either partner thinks she or he may have been exposed to an STI.**  
**Have the client repeat the instructions.** |
|                                  | Female barrier methods are appropriate methods for adolescents, but they do require a high level of motivation for correct and consistent use. Use is related to intercourse and some adolescents find this inconvenient or feel it interferes with sexual pleasure. Supplies may be difficult to keep private. Barrier methods provide some protection against STIs. The female condom is highly effective for protection against STIs/HIV. **It should be noted that research has shown that spermicides facilitate HIV transmission and therefore should not be promoted in high HIV prevalence countries or if the young woman is at risk.** | **Show the client the vaginal method and explain how to use it.**  
**If she chooses a diaphragm or cervical cap, arrange for proper fitting and placement by a specially trained provider.**  
**Give her plenty of spermicides and plan for a return visit for more.**  
**Encourage her to come back to the clinic any time she has questions.**  
**Explain how to use the method (all vaginal methods must be used each time each time she has intercourse).** |
| **Spermicides**                   | **Inserting any spermicide:**  
- Insert the spermicide in the vagina before each act of intercourse.  
- Don't douche for at least 6 hours after intercourse. |
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<tr>
<td>Insert any time less than one hour before sex (if using foam, shake the foam before filling applicator).</td>
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<tr>
<td>Squeeze foam or cream from the can or tube into a plastic applicator.</td>
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<td>Insert the applicator deep into the vagina and push the plunger.</td>
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<tr>
<td>Tablets, Suppositories, Film</td>
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<tr>
<td>Less than one hour but more than 10 minutes before sex, insert the tablet, suppository or film deep into the vagina with the applicator of fingers.</td>
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<tr>
<td>Film must be folded in half and inserted with dry fingers near the cervix, or else the film will stick to the finger and not the cervix.</td>
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<tr>
<td>Diaphragm</td>
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<td>Inserting:</td>
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<tr>
<td>Hold the diaphragm with the dome down (spermicide in the dome).</td>
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<td>Squeeze about a tablespoon of spermicidal cream or jelly into the cup of the diaphragm and around the rim.</td>
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<td>Press opposite sides of the rim together so that the diaphragm folds and insert the folded diaphragm into the vagina. Push the diaphragm downward and back along the back wall of the vagina as far as it...</td>
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| **Lactational Amenorrhea Method (LAM)**<br><br>**Typical Use Effectiveness:** 2 pregnancies per 100 women in the first 6 months after childbirth.<br><br>**Correct and Consistent Use:** 0.5 pregnancies per | Yes, LAM is appropriate for any young woman who is under 6 months postpartum, fully or nearly fully breastfeeding, and amenorrheic. This method may be difficult for adolescents unless they have a stable lifestyle that is conducive to frequent breastfeeding. The LAM method does not provide | twisted.  
- Guide the penis into the female condom to be sure the penis does not enter the vagina outside of the condom’s sheath.  
- Remove and insert a new female condom if:  
  - The condom rips or tears during insertion or tears during use.  
  - The outer ring is pushed inside.  
  - The penis enters outside the pouch.  
  - The condom bunches inside the vagina.  
  - You have sex again.  

Removing the female condom:  
- Remove the female condom lying down to avoid spillage.  
- Throw the female condom away. Do not reuse it.  

- Ask the client these 3 important questions:  
  - Have your menses returned?  
  - Are you regularly giving the baby much other food besides breast milk or allowing long periods without breastfeeding, either day or night?  
  - Is your baby more than 6 months old?  
- If the answer to all of these questions is “no,” then the client can use LAM. Her chance of pregnancy is |
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<tr>
<td>100 women in the first 6 months after childbirth.</td>
<td>protection against STIs/HIV; therefore providers should encourage condom use as well.</td>
<td>only 1% to 2% but she can also choose a complimentary form of family planning at any time. It is important to remember that if the answer to any of the questions is “yes,” then she is at risk of getting pregnant and needs another method of family planning if she doesn’t want to become pregnant.</td>
</tr>
</tbody>
</table>

- Breastfeeding is most effective if the client does the following:
  - Breastfeeds on demand, day and night.
  - Feeds from both breasts.
  - Avoids intervals of more than four hours between any daytime feeds and more than six hours between any nighttime feeds.
  - Breastfeeds fully or nearly fully for about six months.
  - When introducing supplemental feeds, breastfeeds first and then give the feed.
  - Doesn’t use pacifiers, nipples, or bottles.
  - Expresses breastmilk if separated from the baby.
  - Tries to eat healthy foods and drink plenty of water.
  - Continues breastfeeding as long as possible (2 years or beyond).
- It isn’t necessary to give the baby water or teas. However, if the baby seems thirsty she should drink more water.

- The client must stop using LAM as her only form of contraception if:
  - Her baby reaches 6 months of age.
  - She is having menstrual bleeding.
<table>
<thead>
<tr>
<th><strong>Contraceptive Method Effectiveness</strong></th>
<th><strong>Safety, Appropriateness, and Special Considerations for the Adolescent Client</strong></th>
<th><strong>Counseling Issues</strong></th>
</tr>
</thead>
</table>
| **Male Sterilization** <br> **Vasectomy Sterilization:**<br> *Typical Use Effectiveness:* 0.15 pregnancies caused per 100 men in the first year after the procedure.<br> **Correct and Consistent Use.** Correct use means using condoms or another effective family planning method consistently for the first 20 ejaculations or for 3 months after the procedure. | While there is no medical reason to deny sterilization, it is generally not recommended for people at the beginning of their childbearing years. However, there may be mitigating circumstances, such as HIV or the presence of some genetic diseases, where youth may wish to discuss sterilization. Low parity and young age are risk factors for regret. Vasectomy does not provide protection against STIs/HIV. | - She begins giving the baby supplemental foods.  
- Discuss the client's decision to be sterilized. How long has he considered it? Has he discussed it with his wife or partner? How would he feel if circumstances change in his life such as divorce or death of a child or spouse? Does he understand that the method is permanent?  
- Give the client instructions before the procedure. He should:  
  - Eat a light breakfast the morning of the procedure.  
  - Bathe the day of the surgery and wear clean clothes.  
  - Empty bowels the morning of surgery and urinate just before the procedure.  
  - Ask someone to accompany client home after the procedure.  
- Give the client instructions after the procedure. He should:  
  - Rest for a day or two.  
  - Not lift anything heavy or do heavy work for one week after the procedure.  
  - Take all of the medicine given at the clinic.  
  - Keep the incision clean and dry.  
  - May bathe after 24 hours.  
  - May notice bruising in the area of the stitches, this is normal.  
  - The stitches will dissolve and don't have to be removed (Note: These instructions must be modified if non-absorbable sutures are used or no sutures at all). |
<table>
<thead>
<tr>
<th>Contraceptive Method Effectiveness</th>
<th>Safety, Appropriateness, and Special Considerations for the Adolescent Client</th>
<th>Counseling Issues</th>
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<tr>
<td>Female Sterilization</td>
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<tr>
<td>Typical Use Effectiveness:</td>
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</table>
| In the first year after the procedure: 0.5 pregnancies per 100 women (1 in every 200 women). Within 10 years after the procedure: 1.8 pregnancies per 100 women (1 in every 55 women). Effectiveness depends partly on how the tubes are blocked, but all pregnancy rates are low. | Avoid intercourse for 2-3 days and then use condoms for 20 ejaculations.  
- Review possible side effects. Return immediately to the doctor or clinic if there is fever, bleeding, or pus from the incision, dizziness, excessive scrotal pain which persists or gets worse, or excessive swelling of the scrotum.  
Note: If semen analysis is available, offer to have sperm analyzed after 15-20 ejaculations. |
| Correct and Consistent Use:      | While there is no medical reason to deny sterilization, it is generally not recommended for people at the beginning of their childbearing years. However, there may be mitigating circumstances, such as HIV or the presence of some genetic diseases, where youth may wish to discuss sterilization. Low parity and young age are risk factors for regret. Sterilization does not provide protection against STIs/HIV. | Discuss the client's decision to be sterilized. How long has she considered it? Has she discussed it with her husband or partner? How would she feel if circumstances change in her life, such as divorce or death of a child or spouse? Does she understand that the method is permanent? |
|                                  |                                                                             | Give the client instructions before the procedure. She should:  
- Not eat or drink anything after midnight the night before the surgery.  
- Bathe the day of surgery and wear clean clothes.  
- Ask someone to bring her home after the procedure.  
- Ask a friend or family member to care for her children, if applicable.  
- Not wear jewelry, nail polish, or hairpins. |
|                                  |                                                                             | Give the client instructions after the procedure. She should:  
- Rest for a day or two.  
- Not lift anything heavy or do heavy work for one week after the procedure. |
<table>
<thead>
<tr>
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<th>Counseling Issues</th>
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<td>women (1 in every 55 women).</td>
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<tr>
<td>Emergency Contraceptive Pills (ECPs)</td>
<td>Emergency contraceptive pills should be available to adolescents who have unprotected sex. The earlier ECPs are taken after unprotected sex, the greater the chances are that they will be effective. ECPs can be provided in advance to adolescents, but they should be counseled that ECPs are for emergency use only. ECPs do not provide protection against STIs/HIV.</td>
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<td></td>
<td>Keep the incision clean and dry.</td>
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<td></td>
<td>May bathe after 24 hours.</td>
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<td></td>
<td>Expect to feel a little pain in the lower abdomen.</td>
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<td></td>
<td>May notice bruising or discoloration in the area of the procedure, this is normal.</td>
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<td></td>
<td>Return to the clinic in one week to have the stitches removed (Note: The instructions should be modified where absorbable sutures are used).</td>
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<td></td>
<td>Review possible side effects. Return immediately to the clinic if client experiences fever, bleeding, pus from the incision, or abdominal pain that doesn't go away or gets worse.</td>
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<td></td>
<td>Show the client the pills and explain how to use them. She should:</td>
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<td>Swallow the first dose as soon as convenient, but no later than 120 hours after having unprotected sex.</td>
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<td>Swallow the second dose 12 hours after the first dose. Important: if more than 120 hours have passed since client had unprotected sex do not use ECPs.</td>
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<td></td>
<td>If client vomits within two hours of taking a dose, she should take two tablets as soon as possible. If the vomiting occurs after the first dose, client will still need to take a second dose 12 hours later (provider can give client extra pills). To reduce nausea, take the tablets after eating or before bed.</td>
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<td></td>
<td>Instruct the client not to take any extra emergency contraceptive pills unless vomiting occurs. More pills</td>
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<tr>
<td>Contraceptive Method Effectiveness</td>
<td>Safety, Appropriateness, and Special Considerations for the Adolescent Client</td>
<td>Counseling Issues</td>
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<td></td>
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<td>will not decrease the risk of pregnancy further.</td>
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<tr>
<td>[ ] Abstinence</td>
<td>Abstinence is appropriate for young people who have not yet begun sexual activity, as well as those who are already sexually experienced. There may be emotional or social advantages to delaying sexual intercourse until youth are older, more mature, or married. Abstinence provides protection.</td>
<td>• Important: If more than 120 hours have passed since client had unprotected sex, do not use ECPs.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Review possible side effects. ECPs often cause temporary side effects such as nausea and vomiting. Sometimes they can cause headaches, dizziness, cramping, or breast tenderness. These side effects generally do not last more than 24 hours.</td>
</tr>
<tr>
<td></td>
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<td>• Review what to expect after using ECPs. Women will not see any immediate signs showing whether the ECPs worked. The menstrual period should come on time (or a few days early or late). Tell the client that if her period is more than a week later than expected, or if she has any cause for concern, she should return to the clinic.</td>
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<tr>
<td></td>
<td></td>
<td>• Instruct the client to return to the clinic when she has her period if she wishes to use a contraceptive method to prevent future pregnancies.</td>
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<td>• Have the client repeat this information.</td>
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<td></td>
<td>• Pregnancy will not occur if close contact between the penis and vagina does not take place. The risk of some (but not all) STIs, including HIV, is avoided if youth do not engage in vaginal, anal, or oral sex. Intimate skin to skin genital contact may transmit some STIs, including herpes, genital warts and syphilis.</td>
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<td>• Discuss ways to handle peer and partner pressure.</td>
</tr>
<tr>
<td>Contraceptive Method Effectiveness</td>
<td>Safety, Appropriateness, and Special Considerations for the Adolescent Client</td>
<td>Counseling Issues</td>
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<tr>
<td></td>
<td>against some, but not all, STIs.</td>
<td>to engage in sexual activity.</td>
</tr>
</tbody>
</table>
Participant Handout 7.3: Immediate and Underlying Causes of Misconceptions and Rumors

Dr. X went to work in a clinic in a small town. As an obstetrician-gynecologist, she was very interested in adolescent reproductive health. Dr. X was pleased to discover that her town had one of the highest pill-acceptance rates among adolescent women in the province. But when she talked to the midwives and nurses, she discovered that they were extremely busy delivering babies of teenage.

Dr. X decided to check the records of some of the young women who came to the clinic. She found that many of the adolescent clients who had accepted family planning, and had been given COCs, were the same clients who were coming to the clinic for prenatal visits.

Dr. X decided to investigate the reason for this. She compiled a list of COC acceptors who had become pregnant while on the method. Then she asked several village health workers to interview these young women to find out how they had been taking their pills. The village health workers reported that some of the young women had taken the pill only after sleeping with their boyfriends or husbands.

Dr. X asked the village health workers to hold a series of health-education classes about the contraceptive pills. The village health workers did this. They explained that the pills did not work unless taken every day. They also explained that it was necessary to have a certain level of hormones circulating in the blood to prevent pregnancy. The health workers also explained what to do when one or two pills were missed.

Over the next several months, Dr. X monitored pregnancy rates and found no change! She was very frustrated!

One day while she was making a prenatal examination of a pregnant pill acceptor with pre-eclampsia, she asked the young woman how she had taken her pills. The young woman said that she had taken them only after having sex with her boyfriend. Dr. X asked why she had taken them that way. The young woman said that she didn't sleep with her boyfriend every day, so why did she need pills every day? Dr. X asked her how she thought the pills worked. The woman said she didn't know, but she supposed they killed the man's "seed."

Dr. X explained that pills don't kill the "seed," they only prevent eggs from developing in a woman's ovaries. The young woman said she didn't understand about eggs being in her ovaries; it was the first time she had heard anything like that--all she knew was that she was pregnant, although she had taken the pill.
Dr. X began to suspect that the young woman did not have the medically correct idea about contraception. She asked the young woman how she thought conception occurred. The young woman said, "The woman is the vessel and the man plants the seed." Dr. X asked what the woman's role was. The young woman said, "She is merely the place for planting."

Dr. X then realized the underlying reason for the village adolescents' confusion and their subsequent failure to take the pills properly. They believed that they could become pregnant any time "the man's seed was planted" and that the pills worked only by killing the seed.

Dr. X began conducting classes for the health workers on counseling adolescent clients on the anatomy and physiology of reproduction. She also included information for them on how to counteract rumors and misinformation.
### Participant Handout 7.4A: Rumors and Misinformation about COCs

<table>
<thead>
<tr>
<th>Rumor or Misinformation</th>
<th>Facts &amp; Realities: Information to Combat Rumors</th>
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</thead>
<tbody>
<tr>
<td><strong>I only need to take the Pill when I sleep with my boyfriend or husband.</strong></td>
<td>A young woman must take her pills every day in order not to become pregnant. (The provider can use an analogy: ask her if someone can be a grandmother and a grandfather at the same time. When she says &quot;no,&quot; tell her that pills are like that, too—it is either/or.) Either she takes them every day and she will not become pregnant, or she only takes them sometimes and may become pregnant. Pills only protect against pregnancy if she takes them every day. If she misses one pill, she should take two as soon as she remembers.</td>
</tr>
<tr>
<td><strong>I am still protected from pregnancy when I stop taking the Pill if I have been using it long enough.</strong></td>
<td>A young woman is only protected for as long as she actually takes the pill every day. (Reinforce this by using an analogy or personal example.)</td>
</tr>
<tr>
<td><strong>Pills make you weak.</strong></td>
<td>Sometimes adolescents feel weak for other reasons, but they are also taking the Pill, so they think it is the Pill that causes the weakness. If a young woman feels weak, she should keep taking her pills every day and go to see a doctor. Pills do not make an adolescent weak. A doctor should be seen to try to find out what else is causing weakness in a young woman. If an adolescent is feeling &quot;weak&quot;, a pregnancy would almost certainly make her feel much worse than taking the Pill.</td>
</tr>
<tr>
<td><strong>The Pill will build up in your body. Pill residues settle in the uterus so that the adolescent has to have her uterus cleaned every year in order to prevent the formation of a lump.</strong></td>
<td>It is not possible for pills to accumulate in the body. Pills are swallowed and dissolved in a young woman's body just like other medicines and food. The substances in the Pill are absorbed by the digestive system and circulated throughout the body by the blood. (Demonstrate how a pill dissolves in a glass of water.)</td>
</tr>
<tr>
<td>Rumor or Misinformation</td>
<td>Facts &amp; Realities: Information to Combat Rumors</td>
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</tr>
<tr>
<td>The Pill is dangerous and causes cancer.</td>
<td>Numerous studies have disproved this rumor. The Pill has been used safely by millions of adolescent women for over 30 years and been tested more than any other drug. In fact, studies show that the Pill can protect women from some forms of cancer, such as those of the ovary, endometrium, and breast.</td>
</tr>
<tr>
<td>The Pill causes abnormal or deformed babies.</td>
<td>There is NO medical evidence that the Pill causes abnormal or deformed babies. There have always been incidences of abnormalities and birth defects, long before the Pill was invented. Birth defects are usually caused by genetic (e.g., Down Syndrome) or environmental factors (e.g., drugs, exposure to toxic waste and chemicals).</td>
</tr>
<tr>
<td>Taking the Pill is the same as having an abortion.</td>
<td>The Pill is taken to prevent conception, not to cause an abortion. The pill prevents ovulation so that fertilization cannot occur, preventing a pregnancy (and therefore any chance of an &quot;abortion&quot;).</td>
</tr>
<tr>
<td>The Pill causes the birth of twins or triplets.</td>
<td>The Pill has no effect on the tendency toward multiple births. The tendency to have twins usually runs in families. That is, if there have been multiple births in either the young man's or young woman's family, then the chances of having twins are greater. Multiple births may also be triggered by fertility medication or by drugs taken to induce pregnancy.</td>
</tr>
<tr>
<td>The Pill prolongs pregnancy. A young woman who took the pill before she got pregnant delivered almost two months after her expected date of delivery.</td>
<td>The pill does not prolong pregnancy in any way. An example such as this was probably a simple case of not calculating the date of conception correctly.</td>
</tr>
<tr>
<td>Rumor or Misinformation</td>
<td>Facts &amp; Realities: Information to Combat Rumors</td>
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</tr>
<tr>
<td>Women who take the Pill for several years need to stop the Pill to give the body a &quot;rest period.&quot;</td>
<td>A &quot;rest period&quot; from taking Pills is <strong>not</strong> necessary and a young woman may use COCs for as many years as she wants to prevent a pregnancy. A rest period would not be beneficial and would disrupt the young woman's preferred and successful method of contraception.</td>
</tr>
<tr>
<td>The Pill can't be used following an abortion.</td>
<td>COCs are <strong>appropriate for use immediately post-abortion</strong> (spontaneous or induced), in either the first or second trimester, and should be initiated within the first seven days postabortion, or anytime the provider can be reasonably sure that the client is not pregnant. Ovulation returns almost immediately postabortion: within two weeks for first-trimester abortion and within four weeks for second-trimester abortion. Within six weeks after an abortion, 75% of women have ovulated. Immediate use of COCs postabortion does <strong>not</strong> affect return to fertility following discontinuation of COCs.</td>
</tr>
<tr>
<td>The Pill causes infertility or makes it more difficult for a young woman to become pregnant once she stops using it.</td>
<td>Studies have clearly shown that the Pill does not cause infertility or decrease a young woman’s chances of becoming pregnant once she stops taking it.</td>
</tr>
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</table>
### Participant Handout 7.4B: Rumors and Misinformation about IUDs

<table>
<thead>
<tr>
<th>Rumor or Misinformation</th>
<th>Facts &amp; Realities: Information to Combat Rumors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The thread of the IUD can trap the penis during intercourse.</strong></td>
<td>The strings of the IUD are soft and flexible, cling to the walls of the vagina, and are rarely felt during intercourse. If the string is felt, it can be cut very short, (leaving just enough string to be able to grasp with a forceps). The IUD cannot trap the penis, because it is located within the uterine cavity and the penis is positioned in the vagina during intercourse. The string is too short to wrap around the penis and cannot cause injury to it. (For greater reassurance, use a pelvic model to show how an IUD is inserted or demonstrate with your fingers how it would be impossible for the IUD to trap the penis.)</td>
</tr>
<tr>
<td><strong>A young woman who has an IUD cannot do heavy work.</strong></td>
<td>Using an IUD should not stop a young woman from carrying out her regular activities in any way. There is no correlation between the performance of chores or tasks and the use of an IUD.</td>
</tr>
<tr>
<td><strong>The IUD might travel inside a young woman's body to her heart or her brain.</strong></td>
<td>There is no passage from the uterus to the other organs of the body. The IUD is placed inside the uterus and unless it is accidentally expelled, stays there until it is removed by a trained health care provider. If the IUD is accidentally expelled, it comes out of the vagina, which is the only passage to the uterus. (Teach the client to feel the string, especially after menstruation, to confirm that it is in place.)</td>
</tr>
<tr>
<td><strong>The IUD causes ectopic pregnancy.</strong></td>
<td>There is no evidence that the use of an IUD increases the risk of an ectopic pregnancy. One study (Vessey, et. al., 1979) showed the risk of ectopic pregnancy to be the same for all women (with or without an IUD) at 1.2 cases per 1,000 women per year.</td>
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<tr>
<td>Rumor or Misinformation</td>
<td>Facts &amp; Realities: Information to Combat Rumors</td>
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<tr>
<td>A young woman who was using an IUD became pregnant. The IUD became embedded in the baby’s forehead.</td>
<td>The baby is very well-protected by the sac filled with amniotic fluid inside the mother’s womb. <strong>If a young woman gets pregnant with an IUD in place, the health provider should remove the IUD immediately due to the risk of infection.</strong> If for some reason the IUD is left in place during a pregnancy, it is usually expelled with the placenta or with the baby at birth.</td>
</tr>
<tr>
<td>The IUD rots in the uterus after prolonged use.</td>
<td>Once in place, if there are no problems, the IUD can remain in the uterus up to 10 years. The IUD is made up of materials that cannot deteriorate or &quot;rot.&quot; Rather, it simply loses its effectiveness as a contraceptive after 10 years.</td>
</tr>
<tr>
<td>An IUD can't be inserted until 12 weeks postpartum.</td>
<td>If health-care providers are specially trained, the IUD can be inserted immediately after the delivery of the placenta or immediately following a Cesarean section, or up to 48 hours following delivery. Expulsion rates for postpartum insertion vary greatly, depending on the type of IUD and the provider’s technique. Current information indicates that expulsion rates may be higher during the period from 10 minutes to 48 hours after delivery, as compared with the first 10-minute period. To minimize the risk of expulsion, only properly trained providers should insert IUDs immediate postpartum. Use of an inserter for IUD insertion tends to reduce the expulsion rate. After the 48 hour postpartum period, a Copper T may be safely inserted at four or more weeks postpartum.</td>
</tr>
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<td>The withdrawal technique for Copper T insertion helps minimize perforations for inserting IUDs four to six weeks postpartum. Other types of IUDs may have different perforation rates.</td>
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### Participant Handout 7.4B: Rumors and Misinformation about IUDs (cont.)

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<tr>
<th>Rumor or Misinformation</th>
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| An IUD can't be inserted until 12 weeks postpartum (cont.). | Given the relative lack of information on the other IUDs at four to six weeks, it is advisable to wait until six weeks postpartum for the insertion of IUDs other than the Copper T. 

It has been shown that IUDs do not affect breastmilk and can be safely used by breastfeeding women postpartum. |
| An IUD can't be inserted after an abortion. | With appropriate technique, the IUD may be inserted immediately postabortion (spontaneous or induced) **if the uterus is not infected**, or during the first seven days postabortion (or anytime you can be reasonably sure the client is not pregnant). 

Expulsion rates vary greatly, depending both on IUD type and on provider technique. To minimize the risk of expulsion, only providers with proper training and experience should insert IUDs. Clients must be carefully counseled to detect expulsions. 

Postabortion IUD insertion after 16 weeks' gestation requires special training of the provider for correct fundal placement. If this is not possible, insertion should be delayed for six weeks postabortion. |
<table>
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<tr>
<th>Rumor or Misinformation</th>
<th>Facts &amp; Realities: Information to Combat Rumors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using a condom is like taking a shower with a raincoat on.</td>
<td>Many couples are not bothered by condoms. Types of condoms vary widely and a couple should choose a brand that will suit them best and give them the most pleasure.</td>
</tr>
<tr>
<td>If a condom slips off during sexual intercourse, it might get lost inside the young woman's body.</td>
<td>A condom cannot get lost inside the young woman's body, because it cannot pass through the cervix. If the condom is put on properly, it will not slip off. The condom should be rolled down to the base of the erect penis. (If it comes off accidentally, instruct the client to pull it out carefully with a finger, taking care not to spill any semen which may lead to an unwanted pregnancy.)</td>
</tr>
<tr>
<td>There is too much danger of condoms breaking or tearing during intercourse.</td>
<td>Condoms are made of thin but very strong latex rubber and they undergo extensive laboratory tests for strength. (Demonstrate how strong the condom is by blowing it up like a balloon or pulling it over your hand and wrist.) Condoms are meant to be used only once. There is less chance that a condom will break or tear if it is stored away from heat and placed on the erect penis leaving enough space at the tip for the ejaculate. A condom is more likely to break if the vagina is very dry, or if the condom is old (past the expiration date).</td>
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## Participant Handout 7.4D: Rumors and Misinformation about DMPA

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<tr>
<th>Rumor or Misinformation</th>
<th>Facts &amp; Realities: Information to Combat Rumors</th>
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<tr>
<td>A young woman who uses DMPA will never again be able to get pregnant.</td>
<td>Sometimes there is a delay of six to twelve months after the last injection for a young woman's fertility to return to normal. In a study in Thailand, almost 70% of former DMPA users conceived within the first 12 months following discontinuation and 90% conceived within 24 months, a percentage comparable to pregnancy rates for the general population.</td>
</tr>
<tr>
<td>Injectable contraceptives cause cancer.</td>
<td>Research has clearly proven that DMPA does not cause cancer. In fact, it has been shown to protect against ovarian cancer.</td>
</tr>
<tr>
<td>DMPA causes nausea.</td>
<td>Nausea is not common with injectables. In fact, many women on injectable contraceptives find that their appetite becomes stronger.</td>
</tr>
<tr>
<td>A young woman will not have enough breastmilk if she uses DMPA while breastfeeding.</td>
<td>Studies have shown that the amount of breastmilk does not decrease when breastfeeding women are using DMPA. DMPA also has no effect on the composition of breastmilk, the initiation or duration of breastfeeding, or the growth and development of the infant.</td>
</tr>
<tr>
<td>DMPA stops menstrual bleeding (amenorrhea) and that is bad for a young woman's health.</td>
<td>Amenorrhea is an expected result of using DMPA, because adolescent women using DMPA do not ovulate. This kind of amenorrhea is not harmful. It helps prevent anemia and frees adolescent women from the discomfort and inconvenience of monthly bleeding.</td>
</tr>
<tr>
<td>Rumor or Misinformation</td>
<td>Facts &amp; Realities: Information to Combat Rumors</td>
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<tr>
<td>Young women need to stop using DMPA and have a &quot;rest&quot; after several injections.</td>
<td>There is no cumulative effect of DMPA and there is no limit to the number of years that DMPA can be used without the need to give the body a &quot;rest.&quot; The time needed to clear the drug from the body is the same for multiple injections as for one.</td>
</tr>
</tbody>
</table>
## Participant Handout 7.4D:
Rumors and Misinformation about DMPA (cont.)

<table>
<thead>
<tr>
<th>Rumor or Misinformation</th>
<th>Facts &amp; Realities: Information to Combat Rumors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DMPA causes abnormal or deformed babies.</strong></td>
<td>There is no evidence that DMPA causes any abnormalities in infants. Studies done on infants who were exposed to DMPA while in the womb showed no increase in birth defects. These infants were followed until they were teenagers, and the research found that their long-term physical and intellectual development was normal.</td>
</tr>
<tr>
<td><strong>DMPA causes abortion.</strong></td>
<td>DMPA prevents ovulation. If no egg is released, no fertilization takes place; hence, no pregnancy and no abortion.</td>
</tr>
<tr>
<td><strong>DMPA causes amenorrhea, resulting in pregnancy or a tumor.</strong></td>
<td>Amenorrhea is one of the signs of pregnancy, but not all amenorrhea means that a young woman is pregnant. The amenorrhea experienced with DMPA use is due to the thinning of the endometrium and is not harmful in anyway. Amenorrhea sometimes is a sign of a tumor or cancer of the endometrium or ovary. However, DMPA amenorrhea is not only &quot;normal,&quot; but there is evidence that DMPA may actually help prevent endometrial and ovarian tumors.</td>
</tr>
<tr>
<td><strong>DMPA causes irregular bleeding, resulting in anemia.</strong></td>
<td>During the first three to six months of DMPA use, irregular bleeding may be experienced in the form of spotting or minimal bleeding. This usually stops within a few months of continuous use of DMPA and rarely results in anemia.</td>
</tr>
<tr>
<td><strong>DMPA causes masculine characteristics in females, such as facial hair.</strong></td>
<td>Studies have shown that the use of DMPA will not cause any masculinizing effect, such as facial hair.</td>
</tr>
<tr>
<td>Rumor or Misinformation</td>
<td>Facts &amp; Realities: Information to Combat Rumors</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>DMPA will result in retained menses, causing blood toxicity.</td>
<td>No menses lining is formed with DMPA use, since it results in an atrophic endometrium, so there is nothing to &quot;retain&quot; or cause a problem.</td>
</tr>
<tr>
<td>DMPA will result in a decrease in libido.</td>
<td>DMPA sometimes has a slight effect on a young woman's libido. However, the sense of security against the risk of pregnancy may increase the libido of the young woman.</td>
</tr>
<tr>
<td>DMPA is still in the &quot;developmental stage&quot; and adolescents shouldn't be experimented on.</td>
<td>DMPA was developed in the 1960s. Since then, it has been approved as a long-acting contraceptive method and is now marketed in more than 90 countries. To date, over 30 million women have used DMPA, over 100,000 have used it for more than 10 years, and between eight and nine million women currently rely on DMPA for contraceptive protection, without problems.</td>
</tr>
</tbody>
</table>
Participant Handout 9.1: Role Plays and CBT Skills Assessment Checklists for ARH Counseling

Purpose of Role Play Exercise:
To provide an opportunity for the participant to practice her/his skills in the process and content of counseling, before working with actual clients.

Instructions:

1. Every participant should be involved in the role-play exercise, either as a player or as an observer.

2. **Players** should meet for 10 minutes before the role play to assign roles, decide and agree on the message or main point the role play is to make, who is going to play what role, what each player is going to say, etc.

3. **Observers** are requested to use the *CBT Skills Assessment Checklists* to record their observations of the counseling process as well as the information given about contraceptive methods and protection against HIV/STIs. The form is an aid to assess skills in a systematic and objective manner and to facilitate concise discussion and feedback following the role plays. Note whether the provider applies the steps in GATHER (as appropriate to the role play). Does the provider address the problem adequately? Does s/he address the "client's" concerns? Is the information given correct and complete? What is the client's behavior? How does the "provider" behave? What non-verbal messages are communicated by the client or provider?

4. While players are preparing, observers are requested to familiarize themselves with the *CBT Skills Assessment Checklists*.

5. Suggested time limits (may be changed by trainer to meet the time available):

<table>
<thead>
<tr>
<th>Instructions:</th>
<th>5 minutes</th>
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<tbody>
<tr>
<td>Player preparation time:</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Role play presentation:</td>
<td>5-10 minutes</td>
</tr>
<tr>
<td>Feedback and analysis:</td>
<td>15-30 minutes</td>
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</tbody>
</table>
# CBT Skills Assessment Checklist for ARH Counseling

<table>
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<tr>
<td></td>
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</table>

## GENERAL COUNSELING

Provider ensures that discussion cannot be overheard.  
Provider assures confidentiality.  
Provider uses visual aids.  

## Provider's Nonverbal Communication

**Friendly/welcoming/smiling/respectful?**

**Non-judgmental/receptive?**

**Listens attentively/nods head to encourage and acknowledge client's responses?**

**Appears patient and comfortable?**

## Provider's Verbal Communication

**Phrases questions clearly and appropriately? Uses non-technical terms?**

**Listens to client's responses closely?**

**Answers client's questions?**

**Doesn't interrupt?**

**Uses language the client can understand?**

## GATHER Process and Content

**G**reets the client in a friendly and respectful manner?  
- Welcomes the client and registers her/him.  
- Provides privacy (both auditory and visual).  
- Determines the purpose of the visit.  
- Assures the client that all information discussed will be confidential.

**A**sked client about her/himself?  
- Client's needs and concerns.  
- Reproductive goals.  
- What, if any, method of contraception s/he has used in the past.  
- Her/his risk of HIV/STI and precautions taken.  
- How well does client communicate with partner.

**T**ells client about safer sex and methods of protection?  
- Discusses safer sex techniques including abstinence.  
- Tells about all methods available.
### CBT Skills Assessment Checklist for ARH Counseling

<table>
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<tr>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Discusses dual protection—emphasizes that only the condom protects against both pregnancy and STI/HIV.</td>
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<tr>
<td>Asks which method interests client.</td>
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<tr>
<td>Asks what client knows about the method.</td>
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<tr>
<td>Corrects myths/rumors/incorrect information.</td>
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<tr>
<td>Describes how method works and its effectiveness.</td>
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<tr>
<td>Explains that besides the method chosen, a condom also must be used for every act of intercourse to protect against STI/HIV.</td>
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<tr>
<td>Uses A/V aids during counseling.</td>
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<tr>
<td>Describes benefits and risks.</td>
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<tr>
<td>Describes potential side effects.</td>
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<tr>
<td>Answers client's questions clearly.</td>
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<tr>
<td>Helps client to reach an informed decision?</td>
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<td></td>
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<tr>
<td>Asks if anything is not understood.</td>
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<tr>
<td>Repeats information if necessary.</td>
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<tr>
<td>Asks &quot;what method do you want?&quot;</td>
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<tr>
<td>Explains any tests or procedures that will be performed.</td>
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<tr>
<td>Examines the client.</td>
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<tr>
<td>Screens the client for any medical precautions to the use of the method.</td>
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<td></td>
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<tr>
<td>Explains how to use method?</td>
<td></td>
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</tr>
<tr>
<td>Explains clearly what client has to do to use chosen method(s) successfully.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instructions to client are complete and clear.</td>
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<tr>
<td>Asks client to repeat back instructions.</td>
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<tr>
<td>Reminds client of potential minor side effects.</td>
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<td></td>
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<tr>
<td>Reminds client of danger signs.</td>
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<tr>
<td>Explains to client what to do if problems.</td>
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<td></td>
</tr>
<tr>
<td>Demonstrates how to use condoms.</td>
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</tr>
<tr>
<td>Explains to the client how and when s/he can get re-supplies of the method(s) including condoms.</td>
<td></td>
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<tr>
<td>Return or follow-up visit</td>
<td></td>
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<tr>
<td>Asks the client if s/he is still using dual protection (contraceptive method and condoms or condoms alone).</td>
<td></td>
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</tr>
<tr>
<td>If s/he has stopped using dual protection, discusses the problem and other options.</td>
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</tr>
<tr>
<td>Asks about any problems or side effects s/he is experiencing.</td>
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<tr>
<td>Makes sure s/he is practicing dual protection correctly.</td>
<td></td>
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</tbody>
</table>

Comments

_________________________________________________________

_________________________________________________________________

Pathfinder International

Adolescent Curriculum
# CBT Skills Assessment Checklist for Condom Counseling

<table>
<thead>
<tr>
<th>TASK/ACTIVITY</th>
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<tbody>
<tr>
<td><strong>INITIAL INTERVIEW</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>See ARH Counseling Checklist.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>METHOD-SPECIFIC COUNSELING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Assures necessary privacy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Obtains necessary biographical data (name, address, age, etc.).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. If client chooses condoms:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Asks what client knows about condoms, if s/he has ever used in the past, and what was her/his experience.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Corrects any myth, rumors or incorrect information.</td>
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</tr>
<tr>
<td>4. Provides basic facts about condoms:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- How they work and their effectiveness.</td>
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</tr>
<tr>
<td>- Repeats advantages of using condoms, alone or with another method.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Asks if client or partner has any allergies to latex.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Counsels on talking with partner about the use of condoms.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Where to obtain/cost.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Asks if client has any questions and responds to these.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Provides specific instructions on how to use condoms correctly:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Use at every act of intercourse.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Do not &quot;test&quot; condoms by blowing up or unrolling.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Put on when penis is erect.</td>
<td></td>
<td></td>
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<tr>
<td>- Put on before penis is near or introduced into vagina.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Demonstrates how to put on condom correctly by using a model, banana, or two fingers:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Cautions client not to unroll condom before putting it on.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Shows how to place the rim of the condom on the penis and how to unroll up to the base of the penis.</td>
<td></td>
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</tr>
<tr>
<td>- Instructs on how to leave half-inch space at tip of condom for semen and to make sure space is not filled with air, as it may burst.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Shows how to expel air by pinching tip of condom as it is put on.</td>
<td></td>
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</tbody>
</table>
# CBT Skills Assessment Checklist for Condom Counseling

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<tbody>
<tr>
<td><strong>METHOD-SPECIFIC COUNSELING (continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. (continued)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cautions about tearing accidentally with fingernails or rings.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Counsels client on what to do if condom breaks during intercourse:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• See doctor or clinic where woman can be assessed for emergency contraception, if available.</td>
<td></td>
<td></td>
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<tr>
<td>8. Has client practice putting on condom, using the model/banana/fingers.</td>
<td></td>
<td></td>
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<tr>
<td>• Corrects any technique errors.</td>
<td></td>
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</tr>
<tr>
<td>9. Counsels client on how to remove penis from vagina with condom intact and no spillage of semen:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hold on to rim of condom while withdrawing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Be careful not to let semen spill into vagina when penis is flaccid.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Discusses use of lubricants and what not to use:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• No oil-based products, including mineral/vegetable/cooking oil, petroleum jelly, baby-oil, margarine/butter, etc.</td>
<td></td>
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</tr>
<tr>
<td>• Advises client how to dispose of condoms—by flushing, burning, or burying.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Repeats major condom messages to client:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Be sure to have condom before you need it.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Use condom with every act of intercourse.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Do not use a condom more than once.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Do not rely on condom if package is damaged, torn, outdated, dry, brittle, or sticky.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Discusses how to negotiate condom use with partner.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Encourages client to return at any time for advice, more condoms, or when s/he wants to use another method.</td>
<td></td>
<td></td>
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</tbody>
</table>
CBT Skills Assessment Checklist for Condom Counseling

Comments:  


# CBT Skills Assessment Checklist for COC Counseling

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<tr>
<td><strong>INITIAL INTERVIEW</strong></td>
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<tr>
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<tr>
<td><strong>METHOD-SPECIFIC COUNSELING</strong></td>
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<td></td>
</tr>
<tr>
<td>1. Assures necessary privacy.</td>
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</tr>
<tr>
<td>2. Obtains necessary biographical data (name, address, age, etc.).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. If client chooses COCs:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Asks her what she knows about COCs. Corrects any myths, rumors, or misinformation she may express.</td>
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<td></td>
</tr>
<tr>
<td>• Asks if she has used COCs in the past. What was her experience?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Gives client a package of COCs to look at and handle.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Explains advantages of the COC, including non-contraceptive benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Briefly explains how COCs work and the importance of taking it every day.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Explains potential common side effects of the COC. Stresses that she may experience some (or possibly none) of these and that they can all be managed:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- amenorrhea/very scanty periods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- spotting or breakthrough bleeding (BTB)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- nausea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- headaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- breast tenderness/fullness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- mood changes/depression</td>
<td></td>
<td></td>
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<tr>
<td>- weight gain or weight loss</td>
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</tr>
<tr>
<td>• Reassures client that most side effects are not serious and will decrease or stop after about 3 months of use.</td>
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<tr>
<td>• Responds to any questions or concerns the client may have.</td>
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</tr>
<tr>
<td>• Explains that provider will ask her some questions and perform a minimal physical examination to be sure that the COC is medically appropriate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Do you think you are pregnant?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Have you had any bleeding between periods?</td>
<td></td>
<td></td>
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<tr>
<td>• Bleeding after intercourse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Any bleeding heavier than usual over the past 3 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• What is your age?</td>
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<tbody>
<tr>
<td><strong>METHOD-SPECIFIC COUNSELING (continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. (continued)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Do you smoke cigarettes or use other tobacco products?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Do you have high blood pressure?</td>
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<tr>
<td>- Do you have diabetes?</td>
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<tr>
<td>- Have you ever had a blood clot in your legs or lungs?</td>
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<tr>
<td>- Have you ever had a stroke?</td>
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<tr>
<td>- Have you ever been told you have heart disease?</td>
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<td></td>
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<tr>
<td>- Do you have severe chest pains and unusual shortness of breath?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Do you think you have heart disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Do you have breast cancer now or have you been diagnosed in the past?</td>
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<tr>
<td>- To your knowledge, do you have any liver disease now?</td>
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<tr>
<td>- Have you ever been told you have a tumor of the liver?</td>
<td></td>
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<tr>
<td>- Do you have frequent and severe headaches with blurred vision or temporary loss of vision?</td>
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<tr>
<td>- Are you breastfeeding a child less than 6 months old at present?</td>
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</tr>
<tr>
<td>- Are you <strong>fully or almost fully</strong> breastfeeding (no solid food supplements or liquids)?</td>
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<td></td>
</tr>
<tr>
<td>- Have you had a menstrual period since your delivery? (Bleeding in the first 56 days following delivery is not considered a menstrual period.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Have you ever had a severe pelvic infection with chills, fever, pain in your womb area, and a vaginal discharge?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Do you have any of these symptoms now?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reassures client of confidentiality and uses judgment concerning the necessity of asking the following questions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Do you or your partner have other sex partners?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- What medicines do you regularly take?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Are you taking any medicines for seizures/convulsions? Tuberculosis (Rifampin)? Other medications?</td>
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<td></td>
</tr>
</tbody>
</table>
## CBT Skills Assessment Checklist for COC Counseling

<table>
<thead>
<tr>
<th>TASK/ACTIVITY</th>
<th>CASES</th>
<th>COMMENTS</th>
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</thead>
<tbody>
<tr>
<td><strong>METHOD-SPECIFIC COUNSELING (continued)</strong></td>
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</tr>
<tr>
<td>5. If COC is appropriate, gives the following client instructions:</td>
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<tr>
<td>* Start the pill on the first day of your next menstrual period (or on the fifth day of your menstrual period, or use local guidelines for this instruction). If client starts COCs after day five of her cycle, she should use a backup method for the first seven days.*</td>
<td></td>
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</tr>
<tr>
<td>Explains to the client that if she forgets to take her pills, she may become pregnant. If she forgets to take her pills, she should do the following:</td>
<td></td>
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<tr>
<td>* If she misses one pill, the client should take it as soon as she remembers. Take the next one at the regular time.*</td>
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<tr>
<td>* If she misses two pills, the client should take two pills as soon as she remembers. She should take two pills the next day, and use a backup method for the next week. The client should finish the packet normally.*</td>
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</tr>
<tr>
<td>* If she misses more than two pills, the client should throw away the packet, and start a new one, and use a backup method for the next week.*</td>
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<tr>
<td>Cautions client that she may feel queasy or nauseated if she takes two pills in one day, but taking two pills reduces her chances of becoming pregnant.</td>
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<tr>
<td>6. Explains other situations in which a back-up method is needed:</td>
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<tr>
<td>* <strong>Diarrhea/vomiting:</strong> Start using a back-up method on the first day of diarrhea or vomiting, and use it for at least 7 days after the diarrhea/vomiting is over. Meanwhile, continue to take your pills as usual.*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* If she is taking certain medications used in the treatment of tuberculosis and seizures (rifampin, phenytoin, carbamazepine).*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Explains that COCs do not protect against STI/HIV and that condoms should be used properly each time she has intercourse to prevent STI/HIV transmission.</td>
<td></td>
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<tr>
<td>8. Shows client how to use a condom if she has not previously used one.</td>
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</tr>
<tr>
<td><strong>METHOD-SPECIFIC COUNSELING (continued)</strong></td>
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</tr>
<tr>
<td>9. Stresses the importance of informing other providers who may care for her that she is using the COC.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Asks client to repeat back in her own words instructions for when to start the COC, which pill she will begin with, how she will take the second and subsequent pills, and what she will do if she misses a pill or pills.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Explains in a non-alarming way the early pill warning signs, stressing the rarity of these:</td>
<td></td>
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</tr>
<tr>
<td>• Severe, constant pain in belly, chest, or legs and very bad headaches that start or become worse after she begins to take COCs.</td>
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<tr>
<td>• Brief loss of vision, sees flashing lights or zigzag lines (with or without bad headaches)</td>
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<tr>
<td>• Jaundice (skin and eyes look yellow)</td>
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<tr>
<td>12. Asks client a few questions to ensure that she understands and remembers key instructions.</td>
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<tr>
<td>13. Prescribes or provides client with as many COC packets as program guidelines allow.</td>
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<tr>
<td>• Provides client with at least a three-month supply of condoms and explains where s/he can obtain a re-supply.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reassures client that she may change the pills or try another method if she does not like these COCs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Reassures client that provider is available to see her if she has any problems or questions or needs advice.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Plans for a return visit and gives client a definite return date.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Asks client to bring her pill packets with her on the return visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Documents/records the visit according to local clinic guidelines.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>RETURN VISIT COUNSELING</strong></td>
<td></td>
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</tr>
<tr>
<td>17. Asks client if she is satisfied with the COC.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Asks if she is having any problems or experiencing any side effects.</td>
<td></td>
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<tr>
<td>19. Asks client how she is taking the COCs, and to demonstrate with the package she is using.</td>
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</tbody>
</table>
## CBT Skills Assessment Checklist for COC Counseling

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<tbody>
<tr>
<td>RETURN VISIT COUNSELING (continued)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Repeats the history checklist.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Briefly reviews key messages/instructions concerning missed pills, use of back-up method, and danger signs.</td>
<td></td>
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</tr>
<tr>
<td>22. Asks client to repeat these instructions back.</td>
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<td></td>
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</tbody>
</table>
| 23. If the client is satisfied with the COC, is tolerating the COC well, is not experiencing any serious side effects, and no precautions exist, then the provider:  
  • Prescribes/provides client with as many COC packets as program guidelines allow.  
  • Provides her with a sufficient supply of condoms and tells her where she can obtain a re-supply. | | |
| 24. If client wants to discontinue the COC, helps her make an informed choice of another method. | | |
| 25. Encourages client to see a provider at any time if she has questions or problems. | | |

Comments: __________________________________________________________
_____________________________________________________________________
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# CBT Skills Assessment Checklist for POPs

<table>
<thead>
<tr>
<th>TASK/ACTIVITY</th>
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<tbody>
<tr>
<td>INITIAL INTERVIEW</td>
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<td></td>
</tr>
<tr>
<td>See ARH Counseling Checklist.</td>
<td></td>
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<tr>
<td>METHOD-SPECIFIC COUNSELING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Assures necessary privacy.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. Obtains necessary biographical data (name, address, age, etc.).</td>
<td></td>
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<tr>
<td>3. If the client chooses POPs:</td>
<td></td>
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<tr>
<td>- Asks her what she knows about POPs. Corrects myths, rumors or misinformation she may express.</td>
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<tr>
<td>- Asks if she has used POPs in the past. What was her experience?</td>
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<tr>
<td>- Gives her a package of POPs to look at and handle.</td>
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<tr>
<td>- Explains advantages of the POP, including non-contraceptive benefits.</td>
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<tr>
<td>- Briefly explains how the POP works and the importance of taking it <strong>at the same time every day</strong>.</td>
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<tr>
<td>- Explains that she should continue to the next packet of pills <strong>without any rest</strong>.</td>
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<tr>
<td>- Explains that she should take her pills even when she does not have sex.</td>
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<tr>
<td>- Explains that she may have her menses at any time before the end of the packet. Reminds her that absent menses is also normal with POPs.</td>
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<tr>
<td>4. Explains what to do if she misses taking one POP:</td>
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<tr>
<td>- If she is breastfeeding and using POPs for extra protection, she is still protected if she misses a pill as long as her menses have not returned.</td>
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<td></td>
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<tr>
<td>- Take it as soon as she remembers.</td>
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<tr>
<td>- Continue taking pills at the usual time.</td>
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<tr>
<td>- If her menses have returned, she should use a back-up method for the next 2 days, regardless of if she is breastfeeding.</td>
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<tr>
<td>Explains what the client should do if she misses taking 2 or more POPs:</td>
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<td></td>
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<tr>
<td>- Take 2 pills as soon as she remembers.</td>
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<td></td>
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<tr>
<td>- Take 2 pills on the next day.</td>
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<tr>
<td>- Immediately start using a backup method since there is an increased chance of becoming pregnant.</td>
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<tr>
<td>- If menses do not occur within 4-6 weeks, come to the clinic.</td>
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</table>
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<tbody>
<tr>
<td><strong>METHOD-SPECIFIC COUNSELING (continued)</strong></td>
<td></td>
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</tr>
<tr>
<td>5. Asks client to repeat back in her own words</td>
<td></td>
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<tr>
<td>instructions on when to start POPs, when to take</td>
<td></td>
<td></td>
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<tr>
<td>them and when to use a backup method.</td>
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<tr>
<td>6. Explains potential common side effects of the</td>
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<td></td>
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<tr>
<td>POPs that she may experience some (or possibly none)</td>
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<td></td>
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<tr>
<td>of these, and that they can all be managed:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Amenorrhea/very scanty periods</td>
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<td></td>
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<tr>
<td>• Spotting or breakthrough bleeding (BTB)</td>
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<td></td>
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<tr>
<td>7. Explains other situations when backup is needed:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diarrhea and vomiting</td>
<td></td>
<td></td>
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<tr>
<td>• If she is taking certain medications used in the</td>
<td></td>
<td></td>
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<tr>
<td>treatment of TB and seizures (rifampin, phenytoin,</td>
<td></td>
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<tr>
<td>carbamazepine)</td>
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<tr>
<td>8. Explains that POPs do not protect against STI/HIV</td>
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<tr>
<td>and that condoms should be used properly each</td>
<td></td>
<td></td>
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<tr>
<td>time she has intercourse to prevent STI/HIV</td>
<td></td>
<td></td>
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<tr>
<td>transmission.</td>
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<tr>
<td>9. Shows client how to use a condom if she has not</td>
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<tr>
<td>previously used one.</td>
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<tr>
<td>10. Explains in a non-alarming way the signs that</td>
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<tr>
<td>warn a woman that she should seek medical attention:</td>
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<tr>
<td>• Extremely heavy bleeding (twice as long or twice</td>
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<tr>
<td>as much as is usual for her)</td>
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<td></td>
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<tr>
<td>• Any very bad headaches that start or become</td>
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<td></td>
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<tr>
<td>worse after taking POPs</td>
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<td></td>
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<tr>
<td>• Skin or eyes become unusually yellow</td>
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<td></td>
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<tr>
<td>• She thinks she might be pregnant</td>
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<tr>
<td><strong>CLIENT SCREENING</strong></td>
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<td></td>
</tr>
<tr>
<td>11. Screens client for POP precautions. Asks all</td>
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<tr>
<td>the questions on the checklist and records</td>
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<td></td>
</tr>
<tr>
<td>responses.</td>
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</tr>
<tr>
<td>• Do you have or have you ever had breast cancer?</td>
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<tr>
<td>• Do you have jaundice, severe cirrhosis of the</td>
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<tr>
<td>liver, a liver infection, or tumor? (Are her eyes</td>
<td></td>
<td></td>
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<tr>
<td>or skin unusually yellow?)</td>
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<tr>
<td>• Are you breastfeeding a baby less than 6 weeks</td>
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<tr>
<td>old?</td>
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<tr>
<td>• Are you taking medicine for seizures? Taking</td>
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<tr>
<td>rifampin (rifampicin) or griseofulvin?</td>
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<td></td>
</tr>
<tr>
<td>• Do you think you are pregnant?</td>
<td></td>
<td></td>
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<tr>
<td>12. Reassures client of confidentiality and uses</td>
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<tr>
<td>good judgment concerning the necessity of asking</td>
<td></td>
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<tr>
<td>the following question: “Do you or your partner</td>
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<tr>
<td>have other sex partners?”</td>
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<tbody>
<tr>
<td><strong>CLIENT SCREENING (continued)</strong></td>
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<tr>
<td>13. Manages or refers for follow-up any positive findings.</td>
<td></td>
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<tr>
<td>14. Prescribes or provides client with as many POP packets as program guidelines allow.</td>
<td></td>
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<tr>
<td>15. Provides client with at least a three-month supply of condoms and explains where s/he can obtain a re-supply.</td>
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</tr>
<tr>
<td>16. Reassures client that she may change the pills or try another method if she does not like these POPs.</td>
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<td>17. Reassures client that provider is available to see her if she has any problems or questions or needs advice.</td>
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<td>18. Plans for a return visit, gives client a definite return date, and asks client to bring her pill packets on the return visit.</td>
<td></td>
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<tr>
<td>19. Documents/records the visit according to local clinic guidelines.</td>
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<tr>
<td><strong>RETURN VISIT COUNSELING</strong></td>
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<td></td>
</tr>
<tr>
<td>20. Asks the client if she is satisfied with POPs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Asks if she is having any problems taking POPs or experiencing any side effects.</td>
<td></td>
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</tr>
<tr>
<td>22. Asks client how she is taking POPs and to demonstrate, using a POP packet.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Repeats the history checklist. If history suggests client has developed a precaution, does an appropriate examination to rule out or verify.</td>
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</tr>
<tr>
<td>24. Briefly reviews instructions concerning missed pills, back-up, and warning signs.</td>
<td></td>
<td></td>
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<tr>
<td>25. If the client is satisfied with the POP, is tolerating the POP well, is not experiencing any serious side effects, and no precautions exist:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prescribes/provides client with as many POP packets as program guidelines allow.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provides her with a sufficient supply of condoms and tells her where she can obtain a re-supply.</td>
<td></td>
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<tr>
<td>26. If client wants to discontinue POPs, or she is no longer breastfeeding, helps her make an informed choice of another method.</td>
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<tr>
<td>27. Encourages her to return to the clinic any time she has questions or problems.</td>
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</tbody>
</table>
CBT Skills Assessment Checklist for POPs

Comments: ____________________________________________________________
_________________________________________________________________
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# CBT Skills Assessment Checklist for DMPA Counseling

## INITIAL INTERVIEW

See ARH Counseling Checklist.

### METHOD-SPECIFIC COUNSELING

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<tr>
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<td>1</td>
<td>2</td>
</tr>
<tr>
<td>1. Assures necessary privacy.</td>
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<tr>
<td>2. Obtains necessary biographical data (name, address, age, etc.).</td>
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<tr>
<td>3. If the client has chosen DMPA:</td>
<td></td>
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<tr>
<td>- Asks what she knows about DMPA. Corrects any myths/rumors or misinformation.</td>
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<tr>
<td>- Explains how DMPA works and its effectiveness in preventing pregnancy.</td>
<td></td>
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<tr>
<td>- Explains the potential side effects of DMPA.</td>
<td></td>
<td></td>
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<tr>
<td>- changes in menstrual periods (irregular/spotting/no periods)</td>
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<tr>
<td>- possible delay in return to fertility of on average four months</td>
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<tr>
<td>- she may gain weight</td>
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<tr>
<td>- she may feel some depression</td>
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<tr>
<td>- Explores with client how irregular or increased bleeding may affect her daily life, and if a delay in return to fertility is important to her.</td>
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<tr>
<td>- Explains what to expect regarding injection, frequency of return visits.</td>
<td></td>
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</tr>
<tr>
<td>- Explains that COCs do not protect against STI/HIV and that condoms should be used properly each time she has intercourse to prevent STI/HIV transmission.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Shows client how to use a condom if she has not previously used one.</td>
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<td></td>
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<tr>
<td>- Asks client if she has any questions and responds to them.</td>
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<td></td>
</tr>
<tr>
<td>4. Screens client for precautions using DMPA Screening Checklist.</td>
<td></td>
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</tr>
<tr>
<td>- Asks all questions on history checklist.</td>
<td></td>
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<tr>
<td>- Checks weight and blood pressure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Records findings.</td>
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<td></td>
</tr>
<tr>
<td>5. Repeats important instructions to client:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- DMPA injections take effect immediately if given between day 1-7 of menstrual cycle. Otherwise, <strong>client must use back-up method or abstain from intercourse for 24 hours following first injection.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Return for next injection in three months. Client may be up to 2 weeks late in returning and will still be protected from pregnancy. However, it is better for client to return on time.</td>
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</tbody>
</table>
# CBT Skills Assessment Checklist for DMPA Counseling

## METHOD-SPECIFIC COUNSELING (continued)

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<tr>
<th>TASK/ACTIVITY</th>
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</thead>
<tbody>
<tr>
<td>5. (continued)</td>
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<tr>
<td>- Reminds client of menstrual changes she may experience and possibility of weight gain.</td>
<td></td>
<td></td>
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<tr>
<td>- Reminds client to inform other health care providers she is on DMPA.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Reassures client she may return at any time if she has questions or concerns.</td>
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<td></td>
</tr>
<tr>
<td>6. Discusses with client returning immediately if she has any of the following problems:</td>
<td></td>
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<tr>
<td>- Heavy vaginal bleeding</td>
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<tr>
<td>- Excessive weight gain</td>
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<tr>
<td>- Headaches</td>
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<tr>
<td>- Severe abdominal pain</td>
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<tr>
<td>7. Asks client to repeat important instructions.</td>
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<tr>
<td>8. Gives client DMPA card with next appointment (time and date).</td>
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<tr>
<td>9. Gives client supply of condoms and tells her where she can get a re-supply.</td>
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<tr>
<td>10. Documents/records the visit according to local clinic guidelines.</td>
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## RETURN VISIT

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<thead>
<tr>
<th>TASK/ACTIVITY</th>
<th>CASES</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>11. Asks if there are any problems or complaints.</td>
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<tr>
<td>12. Repeats the history checklist.</td>
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<tr>
<td>13. If client has developed any precautions, or wants to discontinue DMPA, helps her to make an informed choice of another method.</td>
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<tr>
<td>14. If client is more than one month late, checks for pregnancy.</td>
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<tr>
<td>15. If client is satisfied with DMPA method, no precautions exist, and she wishes to continue, gives DMPA injection.</td>
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Comments: ____________________________________________________________
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## CBT Skills Assessment Checklist for ECP Counseling

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<thead>
<tr>
<th>TASK/ACTIVITY</th>
<th>CASES</th>
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</thead>
<tbody>
<tr>
<td><strong>INITIAL INTERVIEW</strong></td>
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</tr>
<tr>
<td>See ARH Counseling Checklist.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>METHOD-SPECIFIC COUNSELING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Assures necessary privacy.</td>
<td></td>
<td></td>
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<tr>
<td>2. Obtains necessary biographical data (name, address, age, etc.).</td>
<td></td>
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</tr>
<tr>
<td>3. Asks client what makes her think that she needs ECPs.</td>
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<tr>
<td>4. Takes a brief medical history, which includes information on dates of unprotected sex and last menstrual period.</td>
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<tr>
<td>5. Tells the client about ECPs, including how they work, their effectiveness, and the possible side-effects.</td>
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<tr>
<td>6. Allows client to ask questions.</td>
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<tr>
<td>7. Explains the correct use of ECPs.</td>
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<tr>
<td>8. Shows client the ECP tablets.</td>
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<tr>
<td>9. Asks the client to summarize the instructions.</td>
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<tr>
<td>10. Gives client correct number of ECP tablets.</td>
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<tr>
<td>11. Explains how to manage possible ECPs side-effects:</td>
<td></td>
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<tr>
<td>• Nausea: Reminds client that it is a common side-effect. Suggests taking pill(s) with food or vaginal placement of second dose.</td>
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<tr>
<td>• Vomiting: Reassures client that side-effect can occur. Suggests taking pill(s) with food or milk at bedtime, or vaginal placement of second dose. Advises client to repeat the dose if it is vomited within two hours.</td>
<td></td>
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<tr>
<td>• Breast tenderness, headaches, or dizziness: Reminds client the side-effects are common and will not last long. Offers aspirin or ibuprofen for discomfort.</td>
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<tr>
<td>• Irregular bleeding or spotting: Reassures client that this is a common side effect and should not last long.</td>
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<tr>
<td>12. Tells client to return or report to a clinic or hospital if she has any concerns or questions.</td>
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<tr>
<td>13. Tells client her menstrual period may be a few days early or late, but most likely will be on time.</td>
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</table>
### CBT Skills Assessment Checklist for ECP Counseling

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>METHOD-SPECIFIC COUNSELING (continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. (continued) Reminds client to return for a pregnancy test if her menses are more than a week late.</td>
<td></td>
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<tr>
<td>14. Reminds client that ECPs are not suitable as a regular method of contraception. Asks client if she would like to discuss other methods she can use in the future.</td>
<td></td>
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<tr>
<td>15. Provides contraceptive information and services or schedules an appointment for another visit to discuss ongoing contraceptive use. Provides referral services and/or STI/HIV prevention information as needed.</td>
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<tr>
<td>16. Gives client a supply of condoms and tells her where she can get a re-supply.</td>
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<tr>
<td>17. Demonstrates a non-judgmental attitude and respect for client throughout ECP service provision.</td>
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Comments: 
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# CBT Skills Assessment Checklist for IUDs Counseling

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<thead>
<tr>
<th>TASK/ACTIVITY</th>
<th>CASES</th>
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<tbody>
<tr>
<td><strong>INITIAL INTERVIEW</strong> (Client Reception Area)</td>
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<td></td>
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<tr>
<td>See ARH Counseling Checklist.</td>
<td></td>
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</tr>
<tr>
<td><strong>METHOD COUNSELING</strong> (Counseling Area)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Assures necessary privacy.</td>
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<tr>
<td>2. Obtains biographic information (name, address, etc.).</td>
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<tr>
<td>3. If the client chooses IUDs:</td>
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<tr>
<td>• Asks her what she knows about IUDs. Corrects any myths, rumors or misinformation she may express.</td>
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<tr>
<td>• Shows her a sample IUD and where and how it is used.</td>
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<tr>
<td>• Discusses the advantages and disadvantages of the IUD.</td>
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<tr>
<td>• Explains how the IUD works and its effectiveness.</td>
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<tr>
<td>• Explains possible side effects.</td>
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<tr>
<td>• Explains benign nature of the most common side effects.</td>
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<tr>
<td>• Discusses client needs, concerns, and fears in a thorough and sympathetic manner.</td>
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<tr>
<td>4. Screens client carefully to make sure there is no medical condition that would be a problem (completes Client Screening Checklist).</td>
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<tr>
<td>5. Reviews potential side effects and makes sure that they are fully understood.</td>
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<tr>
<td><strong>PRE-INSERTION COUNSELING</strong> (Exam/Procedure Area)</td>
<td></td>
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<tr>
<td>6. Reviews Client Screening Checklist to determine if the client is an appropriate candidate for the IUD and if she has any problems that should be monitored while the IUD is in place.</td>
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<tr>
<td>7. Informs client about required physical and pelvic exams.</td>
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<tr>
<td>8. Checks that client is within seven (7) days of last menstrual period.</td>
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<tr>
<td>9. Rules out pregnancy if beyond day 7. (Refers if non-medical counselor.)</td>
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<tr>
<td>10. Describes the insertion process and what the woman should expect during and afterwards.</td>
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<tr>
<td>11. Explains that the IUD does not protect against STI/HIV and that condoms should be properly used each time she has intercourse.</td>
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<tr>
<td>TASK/ACTIVITY</td>
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<td>COMMENTS</td>
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</tr>
<tr>
<td><strong>PRE-INSERTION COUNSELING (continued)</strong></td>
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<tr>
<td>12. Demonstrate how to use a condom, if she has never used one before.</td>
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<tr>
<td><strong>POST-INSERTION COUNSELING</strong></td>
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<tr>
<td>13. Completes client record.</td>
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<tr>
<td>14. Teaches client when and how to check for strings.</td>
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<tr>
<td>15. Discusses what to do if the client experiences any side effects or problems.</td>
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<tr>
<td>16. Explains the warning signs of potential complications:</td>
<td></td>
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<tr>
<td>- Abnormal bleeding</td>
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<tr>
<td>- Abnormal discharge</td>
<td></td>
<td></td>
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<tr>
<td>- Pain (abdominal or pain with intercourse)</td>
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<tr>
<td>- Fever</td>
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<tr>
<td>- Strings missing, shorter or longer</td>
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<tr>
<td>17. Reminds client of effective life of IUD just provided to her (check IUD package insert for life of that particular IUD).</td>
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<tr>
<td>18. Gives client a supply of condoms and tells her where she can obtain a re-supply.</td>
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<tr>
<td>19. Assures client she can return to the same clinic at any time to receive advice, medical attention, and, if desired, to the IUD removed.</td>
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<tr>
<td>20. Asks client to repeat instructions.</td>
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<tr>
<td><strong>REMOVAL COUNSELING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pre-Removal Counseling</strong> (Client Reception Area)</td>
<td></td>
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<tr>
<td>22. Greets client in a friendly and respectful manner.</td>
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<tr>
<td>23. Establishes purpose of visit.</td>
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<tr>
<td>25. Asks client about her present reproductive goals (does she want to continue spacing or limiting births).</td>
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<tr>
<td>26. Describes the removal process and what she should expect during removal and afterwards.</td>
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</table>
### CBT Skills Assessment Checklist for IUDs Counseling

<table>
<thead>
<tr>
<th>TASK/ACTIVITY</th>
<th>CASES</th>
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<tbody>
<tr>
<td><strong>POST-REMOVAL COUNSELING (continued)</strong></td>
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<tr>
<td>27. Discusses what to do if client experiences any problems (e.g. prolonged bleeding or abdominal or pelvic pain).</td>
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<tr>
<td>28. Asks client to repeat instructions.</td>
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<tr>
<td>29. Answers any questions.</td>
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<tr>
<td>30. Reviews general and method-specific information about family planning methods if client wants to continue spacing or limiting births.</td>
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<tr>
<td>31. Assists client in obtaining new contraceptive method or provides temporary method (barrier) until method of choice can be started.</td>
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Comments: ____________________________________________________________________
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## CBT Skills Assessment Checklist for LAM Counseling

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<tr>
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<tbody>
<tr>
<td><strong>INITIAL INTERVIEW</strong></td>
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<tr>
<td>See ARH Counseling Checklist.</td>
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<td></td>
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<tr>
<td><strong>METHOD-SPECIFIC COUNSELING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Assures necessary privacy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Obtains biographic information (name, address, etc.).</td>
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<td></td>
</tr>
<tr>
<td>3. If client has chosen LAM:</td>
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<tr>
<td>• Asks her what she knows about breastfeeding as a contraceptive method.</td>
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<tr>
<td>• Corrects any myths/rumors/misinformation she may have.</td>
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<tr>
<td>• Asks if she has used breastfeeding in the past for child spacing purposes.</td>
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<tr>
<td>• Asks what her experience was.</td>
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<tr>
<td>• Repeats advantages of breastfeeding for baby and mother.</td>
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<tr>
<td>• Asks if she has any questions and answers these.</td>
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<tr>
<td><strong>Immediate Postpartum Period</strong></td>
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<tr>
<td>4. Counsels client on optimal breastfeeding practices, including:</td>
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<tr>
<td>• Breastfeeding immediately after delivery to provide colostrum to infant.</td>
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<tr>
<td>• Breastfeeding on demand, day and night.</td>
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<tr>
<td>• Breastfeeding on both breasts.</td>
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<tr>
<td>•Avoiding intervals of more than four hours between any two daytime feeds and more than six hours between any two nighttime feeds.</td>
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<tr>
<td>• Breastfeeding exclusively for the first six months.</td>
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<tr>
<td>• When supplements are introduced, feeding from breast first and then giving supplement.</td>
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<tr>
<td>• Avoiding use of pacifiers/bottles/nipples.</td>
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<tr>
<td>• Breastfeeding even when mother or baby is ill.</td>
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<tr>
<td>• Encouraging her to maintain sound diet.</td>
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<tr>
<td>• If separated from baby, expressing and correctly storing milk.</td>
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<tr>
<td>• Breastfeeding as long as possible.</td>
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<tr>
<td>TASK/ACTIVITY</td>
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<td>COMMENTS</td>
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<tr>
<td><strong>METHOD-SPECIFIC COUNSELING (continued)</strong></td>
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<tr>
<td>5. Discusses when to introduce an additional method of contraception. Stresses that when any one of the following conditions occur, client is at risk for pregnancy:</td>
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<tr>
<td>• When she has a menstrual period.</td>
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<tr>
<td>• When her baby reaches six months of age.</td>
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<tr>
<td>• When she starts to give regular supplementary feedings.</td>
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<tr>
<td>6. Explains that LAM will not protect her from STI/HIV and instructs her to use condoms when she has sexual intercourse.</td>
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<tr>
<td>7. Demonstrates how to use a condom if she has never used one before.</td>
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<tr>
<td>8. Asks client if she has questions and respond to these.</td>
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<tr>
<td>9. Asks client to repeat the three LAM conditions and the most important optimal breastfeeding practices. Corrects any misunderstandings.</td>
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<tr>
<td>10. Gives client a supply of condoms and tells her where she can get a re-supply.</td>
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<tr>
<td>11. Reassures client that provider is available to see her if she has any problems, questions or needs advice.</td>
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<tr>
<td><strong>Postpartum Visit</strong></td>
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<tr>
<td>12. If client is postpartum:</td>
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<tr>
<td>• Asks if client is having any breastfeeding difficulties/problems and advises/treats as appropriate.</td>
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<tr>
<td>13. Takes a history. Asks client:</td>
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</table>
| • Have you had a menstrual period since the birth of your baby?  
  **Note:** Spotting in the first 56 days is not considered menses.  
• Is your baby more than six months old?  
• Has your baby regularly started taking solid foods or liquids (more than sips of water/ritual foods)? | | |
### CBT Skills Assessment Checklist for LAM Counseling

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<tr>
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<tbody>
<tr>
<td><strong>METHOD-SPECIFIC COUNSELING (continued)</strong></td>
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<tr>
<td>14. If answer to all three questions is “no,” discusses and teaches client the three conditions under which LAM provides effective contraceptive protection:</td>
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<tr>
<td>• No menstrual period.</td>
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<tr>
<td>• Baby is less than six months old.</td>
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<tr>
<td>• She is fully or nearly fully breastfeeding.</td>
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<tr>
<td><strong>RETURN VISIT COUNSELING</strong></td>
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<tr>
<td>15. Asks if any problems or complaints and deals with these as appropriate.</td>
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<td></td>
</tr>
<tr>
<td>16. Repeats optimal breastfeeding practices.</td>
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<tr>
<td>17. Discusses other FP methods complementary to breastfeeding.</td>
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<tr>
<td>18. Gives return appointment for checkup and eventual adoption of another FP method.</td>
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Comments: ______________________________________________________________________
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Participant Handout 9.2: Role Plays for ARH Counseling

Role Play #1:
A 19 year-old woman comes to the clinic because she had unprotected sex last night and she is worried about becoming pregnant. How will the clinician respond?

Role Play #2:
A 16 year-old lactating woman, with a three month-old baby wants to postpone her next pregnancy. Her sister uses COCs and likes that method very much. She says she wants to use COCs. How will the clinician respond?

Role Play #3:
A young couple accompanied by the husband's mother, comes to see the clinician. They have been married 3 months. The wife is 17 years old. The mother-in-law insists that they should have a child as soon as possible in order to try for a son. The wife wants to postpone pregnancy for at least 2 years. How will the clinician respond?

Role Play #4:
A 16 year-old man comes to the clinic because he has noticed an ulcer on his penis. How will the clinician respond?

Role Play #5:
A 15 year-old, unmarried woman comes to see the clinician. She explains that she and her boyfriend are having sexual relations and she is worried about becoming pregnant before she is married. How will the clinician respond?

Role Play #6:
A 17 year-old man comes for counseling. He has a girlfriend and all his friends are pressuring him to have intercourse with her. He wants to wait until he is older to have sex because he is afraid of getting her pregnant and having to drop out of school to support a child. However, he has strong sexual feelings for his girlfriend and doesn't know what to do. How will the counselor/clinician respond?
Participant Handout 9.3: Counseling Cue Cards

Combined Oral Contraceptives (COCs)

What Are They?
COCs are tablets containing the hormones estrogen and progestin. A woman takes one tablet daily to prevent pregnancy.

How Effective Are They?
If 100 young women used COCs for one year, typically eight of them would become pregnant. If taken consistently every day, COCs are highly effective (one pregnancy among 1,000 young women). There is a higher failure rate for adolescents than all other ages, since adolescents have trouble remembering to take pills regularly.

How Do COCs Work?
COCs work by preventing the release of the egg from the ovary. Without an egg to be fertilized, a woman cannot become pregnant.

Advantages
♦ Are safe, effective, and easy to use.
♦ Can be used before the onset of menses.
♦ May lead to lighter, regular periods with less cramping.
♦ Can become pregnant again after stopping the pill.
♦ Don't interfere with sex.
♦ May be beneficial for adolescents who have irregular or heavy periods, menstrual cramps, or acne.
♦ Decrease risk of cancer of the female reproductive organs.

Disadvantages
♦ Have some side effects.
♦ Must be taken every day.
♦ Don't protect against STIs/HIV.

Possible Side Effects
Most adolescents experience no side effects. Occasionally, a young woman may experience nausea, weight gain, breast tenderness, headaches, unexpected bleeding or spotting, depression, or dizziness.
Combined Oral Contraceptives (COCs)

CLIENT INSTRUCTIONS
Show the client the pill packet and explain the following:

How to Use the Pills
♦ Take first pill on the first day of period or any of the next four days.
♦ Take one pill every day, at the same time of day. Keep pills in an easy to remember place, such as near where you brush your teeth every night.
♦ 28-day packet: Upon finishing a packet, begin a new one the following day.
♦ 21-day packet: Upon finishing a packet, wait seven days and then begin a new one. To remember when to start up again, mark it on a calendar.

Missed Pills – What to Do
♦ Missed pills may result in pregnancy.
♦ If one pill is missed, take it as soon as you remember. Take the next pill at the regular time.
♦ If two pills are missed, take two pills immediately, then take two pills the next day and use a backup method for a week. Finish the packet normally.
♦ If more than two pills are missed, throw away the packet and start a new one, and use a backup method for the next week.

Possible Side Effects
♦ Most adolescent women experience no side effects.
♦ Occasionally, adolescents may experience side effects (explain possible side effects, see front of card).

The Pill Does Not Protect Against STIs/HIV
To protect against STIs/HIV and provide further protection against pregnancy, use a condom during every act of intercourse.

Reasons to Return to Provider
♦ Chest pain or shortness of breath
♦ Onset of severe headaches (with blurred vision)
♦ Anytime there is a problem.
♦ Either partner thinks s/he may have been exposed to a STI.
♦ A resupply of COCs or condoms is needed (never run out completely before returning).

1. Have the Client Repeat this Information Back to You.
Male Condom

What Are They?
The condom is a thin sheath worn over the erect penis when a couple is having sex.

How Effective Are They?
If 100 couples used condoms for one year, typically 12 to 15 of the young women would become pregnant. If used correctly with every act of intercourse, condoms are highly effective in protecting against pregnancy (three pregnancies among 100 couples) and most STIs (except Herpes Simplex & other genital ulcer diseases), including HIV.

How Do Condoms Work?
The condom catches the man's sperm so that it cannot enter the vagina.

Advantages
- Is safe, effective and easy to use.
- Does not require a prescription or medical examination.
- Excellent option for someone who does not need ongoing contraception.
- May prevent premature ejaculation.
- Protects against STIs/HIV.

Disadvantages
- Interrupts the sex act.
- May cause decreased sexual sensitivity.
- Requires skills to use properly and negotiate their use with a partner.
- A new condom must be used each time the couple has sex.
- A supply of condoms must be available before sex occurs.
- A condom may occasionally break or slip off during intercourse.

Possible Side Effects
Most adolescents have no side effects. Occasionally, an adolescent may have an allergic reaction, which causes itching, burning, or swelling.
Male Condom

CLIENT INSTRUCTIONS
Show the client the condom and explain/demonstrate the following:

How to Use a Condom
♦ Check the expiration date on the condom package.
♦ Open the package carefully so the condom doesn’t tear.
♦ Do not unroll the condom before putting it on.
♦ Place the unrolled condom on the tip of the hard penis.
♦ Hold the tip of the condom with the thumb and forefinger.
♦ Unroll the condom until it covers the penis.
♦ Leave enough space at the tip of the condom for the semen.
♦ After ejaculation, hold the rim of the condom and pull the penis out of the vagina before it becomes soft.
♦ Burn or bury the condom, do not flush it down the toilet.

Condom Care
♦ Do not apply oil-based lubricants (like baby oil, cooking oil, petroleum jelly/Vaseline), because they could destroy the condom. It is safe to use clean water, saliva, or water-based lubricants.
♦ Store condoms in a cool, dry place. Do not carry them near the body, because heat could destroy them.
♦ Use each condom only once.
♦ Do not use a condom from a broken package, or if the condom is dry, sticky, or the color has changed.
♦ Take care to dispose of used condoms properly.

Possible Side Effects
♦ Most adolescents experience no side effects.
♦ Occasionally, adolescents may experience side effects (explain possible side effects, see front of card).

Reasons to Return to Provider
♦ Anytime there is a problem (condom breaks or unhappy with method).
♦ A resupply is needed (never run out completely before returning).
♦ Either partner thinks s/he may have been exposed to a STI.

Have the Client Repeat this Information Back to You and
5. Demonstrate Proper Condom Use.
Female Condom

What Is It?
The female condom is a plastic pouch that covers the cervix, the vagina, and part of the external genitals. A woman uses the female condom during intercourse to prevent pregnancy.

How Effective Are They?
If 100 young women used a female condom every time they had sexual intercourse, typically 21 of them would become pregnant. The female condom also effectively prevents many STIs, including HIV, when used correctly every time an adolescent and her partner have sexual intercourse.

How Does the Female Condom Work?
The condom catches the man’s sperm so that it does not enter the vagina.

Advantages
♦ Is safe and effective.
♦ **Does not require a prescription or medical examination.**
♦ Can be inserted up to eight hours before sexual intercourse.
♦ Female controlled.
♦ **Excellent option for someone who does not need ongoing contraception.**
♦ Can be used with oil-based lubricants and transfers heat, making it very sensitive.
♦ Protects against STIs/HIV.
♦ Does not alter vaginal flora and reduces the chance of irritation or allergic reaction.

Disadvantages
♦ Costs more than the male condom.
♦ May be noisy or awkward.
♦ Sometimes negatively associated with sex workers.
♦ **Is female initiated, but requires skills to use properly and to negotiate their use with a partner.**
♦ Can be difficult to insert.
♦ Occasionally, a condom may break or slip out during intercourse.

Possible Side Effects
Most adolescents experience no side effects. Rarely, an adolescent may experience an allergic reaction or irritation.
Female Condom

CLIENT INSTRUCTIONS
Show the client the female condom and explain the following:

How to Use the Female Condom
- Check the expiration date on the condom package.
- Open the package carefully so the condom doesn’t tear.
- Find the inner ring, which is at the closed end of the condom.
- Squeeze the inner ring together.
- Put the inner ring in the vagina.
- Push up into the vagina with a finger, the outer ring stays outside the vagina.
- During sex, guide the penis through the outer ring.
- Remove condom immediately after sex, before you stand up.
- Squeeze and twist the outer ring to keep the sperm inside the pouch.
- Pull the pouch out gently.
- Burn or bury the condom, do not flush it down the toilet.

Care of Female Condoms
- Use each condom only once.
- Do not use a condom from a broken package, or if the condom is dry, sticky or the color has changed.

Possible Side Effects
- Most adolescents have no side effects.
- Very rarely, an adolescent may experience an allergic reaction or irritation.

Reasons to Return to Provider
- Anytime there is a problem (condom breaks or unhappy with method).
- A resupply of condoms is needed (never run out completely before returning).
- Either partner thinks s/he may have been exposed to a STI.

Have the Client Repeat this Information Back to You and Demonstrate Proper Condom Use.
DMPA: The Injectable Contraceptive

What Is It?
DMPA is an injection containing the hormone progestin. The injection is given every three months.

How Effective Is It?
DMPA is highly effective if the injections are given every three months. If 100 young women use DMPA regularly for one year, typically only one of them might become pregnant.

How Does DMPA work?
DMPA works by preventing the release of the egg from the ovary. Without an egg to be fertilized, a woman cannot become pregnant.

Advantages
- Is safe and effective.
- Lasts for three months.
- Periods become very light and often disappear after a year of use.
- Completely reversible, can become pregnant again after stopping DMPA, although there might be a delay of several months.
- Can be used while breastfeeding.
- Does not interfere with sex.
- May improve anemia.

Disadvantages
- Menstrual pattern will probably change.
- Increased appetite may cause weight gain.
- Typically a four-month delay in getting pregnant after stopping DMPA.
- Doesn't protect against STIs/HIV.
- May be difficult for adolescents to remember to return for next injection.

Possible Side Effects
Most adolescents experience no side effects. Occasionally, an adolescent may experience irregular spotting, prolonged light to moderate bleeding, bleeding that becomes lighter, less frequent, or stop altogether, weight gain or headaches.
DMPA: The Injectable Contraceptive

CLIENT INSTRUCTIONS
Show the client the vial of DMPA and explain the following:

How to Use DMPA
- DMPA is given by injection every three months.
- **Identify a way to remember to return in three months (e.g. write it down on a calendar).**
- Never be more than two weeks late for a repeat injection.
- If given between day one and day seven of the menstrual cycle, DMPA is effective immediately.

Missed Injection – What to Do
- If the injection is given after day seven of the cycle, a backup method should be used for 24 hours.
- If unable to come at the appointed time, it is possible to come up to four weeks early for the second injection, or up to two weeks late.

Possible Side Effects
- Most adolescent women experience no side effects.
- Occasionally, adolescents may experience side effects (explain possible side effects, see front of card).

DMPA Does Not Protect Against STIs/HIV
To protect against STIs/HIV and provide further protection against pregnancy, use a condom during every act of intercourse.

Reasons to Return to Provider
- Heavy vaginal bleeding
- Excessive weight gain
- Headaches
- Anytime there is a problem.
- Another three-month injection or a resupply of condoms is needed (never run out completely before returning).
- Either partner thinks s/he may have been exposed to a STI.

*Have the Client Repeat this Information Back to You.*
Emergency Contraception Pills (ECPs)

(Note: information is for low-dose combined pills only, not progestin pills)

What Are They?
ECPs are a hormonal method of contraception that can be used to prevent pregnancy following an act of unprotected sexual intercourse.

How Effective Are They?
If 100 young women used ECPs once, typically two of them would become pregnant.

How Do ECPs Work?
ECPs are thought to prevent ovulation and fertilization. They are not effective once the process of implantation of a fertilized ovum has begun.

Advantages
- Are safe for all adolescents and readily available.
- Reduce the risk of unwanted pregnancy and need for abortion.
- Are appropriate for use after unprotected intercourse (including rape or contraceptive failure).
- Provide a bridge to the practice of regular contraception.
- Drug exposure and side effects are of short duration.

Disadvantages
- Do not protect against STIs/HIV.
- Do not provide ongoing protection against pregnancy.
- Should be used within five days (120 hours) of unprotected intercourse as effectiveness decreases with time.
- May change the time of the adolescent’s next period.
- Are inappropriate for regular use (high cumulative pregnancy rate).

Possible Side Effects
- Most adolescents experience no side effects. Occasionally, an adolescent may experience nausea, vomiting, headaches or dizziness, cramping, and breast tenderness. Side effects generally do not last for more than 24 hours
Emergency Contraception Pills (ECPs)
(Note: information is for low-dose combined pills only, not progestin pills)

CLIENT INSTRUCTIONS
1. Show the client the ECPs and explain the following:

How to Use ECPs
♦ Swallow four tablets as soon as possible after unprotected sex. Do not delay treatment unnecessarily as effectiveness decreases over time.
♦ Swallow the second four tablets 12 hours after the first dose.
♦ Important: ECPs can be used for up to five days (120 hours) after the occurrence of unprotected sex.
♦ If vomiting occurs within one hour after either dose, repeat the dose. If vomiting is severe, putting the pills in the vagina may be effective.
♦ To reduce nausea, take the tablets after eating or before bed.
♦ Do not take any extra ECPs unless vomiting occurs. More pills will not further decrease the risk of pregnancy.

Possible Side Effects
♦ Most adolescent women experience no side effects.
♦ Occasionally, adolescents may experience side effects (explain possible side effects, see front of card).

What to Expect After Using ECPs
♦ There will not be any immediate signs showing whether the ECPs worked.
♦ The menstrual period should come on time (or a few days early or late).

Reasons to Return to Provider
♦ Period is more than a week later than expected.
♦ Any other cause for concern.

Have the Client Repeat this Information Back to You.

2. Offer contraceptive counselling, and, if she chooses, give the client a method of contraception before she leaves. Explain that condoms must also be used with the method, in order to protect against STIs/HIV.
Intrauterine Device (IUD)
(Information is for the TCu 380A IUD.)

What Is It?
An IUD is a small plastic and copper device that is inserted into the uterus to prevent pregnancy.

How Effective Is It?
If 125 young women used the IUD for one year, typically one of them would become pregnant.

How Does the IUD work?
The IUD works by preventing sperm from joining with the egg.

Advantages
Is safe, effective, and long-acting (10 years).
Easy to remove if the adolescent wants to become pregnant.
Does not interfere with sex.
Does not interfere with breastfeeding.

Disadvantages
♦ Not suitable for adolescent women with multiple sexual partners, or whose partner has other sexual partners, due to an increased risk of Pelvic Inflammatory Disease.
♦ Should be initiated with caution, only after thorough risk assessment and, if possible, lab screening, especially in high risk areas.
♦ Menstrual pattern may change.
♦ Greater risk of expulsion and painful menses for women under the age of 20 who have not given birth.
♦ Slight pain during the first few days after IUD insertion.
♦ Does not protect against STIs/HIV.

Possible Side Effects
Most adolescents experience no side effects. Occasionally, an adolescent may experience cramping, pain during and immediately after insertion, an increase in vaginal discharge, an infection, heavier and/or longer periods, which normally decrease during the first and second years.
Intrauterine Device (IUD)
(*Information is for the TCu 380A IUD*)

**CLIENT INSTRUCTIONS**
Show the client the IUD and explain the following:

**How to Use the IUD**
- The IUD is inserted once and can stay in the uterus for up to 10 years.
- Follow-up is not required after the first three to six week checkup (unless there is a problem or national guidelines specify other protocols).
- After every menstrual period, check if strings are missing, shorter, or longer.

**Possible Side Effects**
- Most adolescent women experience no side effects.
- Occasionally, adolescents may experience side effects (explain possible side effects, see front of card).

**The IUD Does Not Protect Against STIs/HIV**
To protect against STIs/HIV and provide further protection against pregnancy, use a condom during every act of intercourse.

**Reasons to Return to Provider**
- Abnormal bleeding or discharge
- Pain (abdominal or pain with intercourse)
- Fever
- Strings are missing, shorter, or longer.
- Anytime there is a problem.
- A resupply of condoms is needed (never run out completely before returning).
- Either partner thinks s/he may have been exposed to a STI.

*Have the Client Repeat this Information Back to You.*
Lactational Amenorrhea Method (LAM)

What Is It?
The Lactational Amenorrhea Method (LAM) is the use of breastfeeding as a temporary family planning method and a bridge to a longer term method. (“Lactational” means related to breastfeeding and “Amenorrhea” means not having menstrual bleeding.)

How Effective Is It?
If 100 young women use LAM in the first six months after childbirth, typically two of them would become pregnant. While breastfeeding exclusively, LAM is even more effective (one pregnancy among 200 young women).

How Does LAM Work?
LAM works by preventing ovulation, because breastfeeding changes the rate at which natural hormones are released.

Advantages
♦ Effective in preventing pregnancy for at least six months.
♦ Encourages the best breastfeeding practices that have health benefits for the mother and baby.
♦ Can be used immediately after childbirth.
♦ No need to do anything at the time of sexual intercourse.
♦ No direct cost for family planning or for feeding the baby.
♦ No supplies or procedures needed to prevent pregnancy.

Disadvantages
♦ Effectiveness after six months is not certain.
♦ Frequent breastfeeding may be difficult for some adolescent mothers.
♦ Does not provide protection against STIs/HIV.
♦ If the mother has HIV, there is some chance that breastmilk will pass HIV to the baby.

Possible Side Effects
There are no side effects associated with LAM.
Lactational Amenorrhea Method (LAM)

CLIENT INSTRUCTIONS
Explain the following to the client:

When LAM Can Be Used
- Menstrual period has not returned.
- Baby is being breastfed exclusively, or receiving very little other food besides breast milk. Baby does not go for long periods without breastfeeding, either during the day or night.
- The baby is less than six months old.
- If all the above conditions are met, then LAM can be used. A longer-term family planning method should be decided upon and started before LAM is no longer effective.

When LAM Cannot Be Used
When any one or more of the following are true:
- Baby reaches six months of age.
- Menstrual bleeding begins.
- The baby is receiving supplemental foods.

How to Make Breastfeeding Effective
- Breastfeed on demand, day and night, and feed from both breasts.
- Avoid void intervals of more than four hours between any daytime feeds and more than six hours between any nighttime feeds.
- Breastfeed exclusively or nearly exclusively for about six months.
- Do not use pacifiers, nipples, or bottles.
- Express breastmilk if separated from the baby.
- Do not give the baby other liquids. If the baby is thirsty, the mother should drink more.

LAM Does Not Protect Against STIs/HIV
To protect against STIs/HIV and provide further protection against pregnancy, use a condom for every act of intercourse.

Reasons to Return to Provider
- Anytime there is a problem.
- A resupply of condoms is needed (never run out before returning).
- Either partner thinks s/he may have been exposed to a STI.

Have the Client Repeat this Information Back to You.
Progestin Only Oral Contraceptives (POPs)

What Are They?
POPs are tablets containing only a very small amount of one hormone, a progestin. A young woman takes one tablet daily to prevent pregnancy. POPs are the best oral contraceptive for breastfeeding adolescents.

How effective are they?
POPs are very effective for breastfeeding adolescents, about 1 pregnancy per 100 young women in the first year. As commonly used, they are less effective for non-breastfeeding adolescents.

How do POPs work?
POPs work by thickening the cervical mucus, making it difficult for sperm to pass through and by preventing the release of the egg from the ovary in about half of menstrual cycles.

Advantages
- Safe.
- Can be used by nursing mothers starting 6 weeks after childbirth.
- No estrogen side effects.
- Can become pregnant again after stopping the pill.
- Doesn’t interfere with sex.
- May help prevent benign breast disease, endometrial and ovarian cancer, and pelvic inflammatory disease.

Disadvantages
- For women not breastfeeding, menstrual periods may change.
- Must be taken at the same time every day.
- Doesn’t protect against STIs/HIV.

Possible Side Effects
Amenorrhea or irregular bleeding or spotting for young women not breastfeeding. Less common side effects include headache and breast tenderness.
Progestin Only Oral Contraceptives (POPs)

CLIENT INSTRUCTIONS
Show the client the pill packet and explain the following to the client:

1. How to Use POP
   ♦ Take the first pill on the first day of period or on any of the next four days.
   ♦ Take one pill every day, at the same time of day.
   ♦ Take the pills non-stop, from one packet to another.
   ♦ Do not miss a day.

Missed Pills – What to Do
   ♦ If one pill is missed, take it as soon as you remember. Take the next pill at the regular time. Use a back up method for the next 7 days and continue taking the pills as usual.
   ♦ If two or more pills are missed, take 2 pills as soon as you remember. Take 2 pills on the next day. Use a backup method for the next 7 days and continue taking the pills as usual.

Possible Side Effects
Most adolescent women experience no side effects. Occasionally, adolescents may experience side effects (explain possible side effects, see front of card).

POPs Do Not Protect Against STIs/HIV
To protect against STIs/HIV and provide further protection against pregnancy, use a condom during every act of intercourse.

Reasons to Return to Provider
   ♦ Anytime there is a problem.
   ♦ Abdominal pain, tenderness, or fainting.
   ♦ Suspected pregnancy.
   ♦ Either partner thinks s/he may have been exposed to a STI.
   ♦ A resupply of POPs or condoms is needed (never run out completely before returning.

Have the Client Repeat this Information Back to You.
Participant Handout 11.1: Sexual Abuse Truth or Myth

Indicate whether the statement is a truth or myth.

1. _____ Truth      _____ Myth Rape happens only to females.
2. _____ Truth      _____ Myth Sexual abuse only means rape.
3. _____ Truth      _____ Myth Someone who sexually violates another can also be a loving person.
4. _____ Truth      _____ Myth Rape is an act of uncontrollable sexual desire.
5. _____ Truth      _____ Myth Sexual abuse happens only in lower socio-economic groups.
6. _____ Truth      _____ Myth Once someone realizes that s/he is being sexually violated, it is easy to leave the relationship.
7. _____ Truth      _____ Myth Most rapes are committed by strangers.
8. _____ Truth      _____ Myth Someone can change another person’s sexually violent behavior by changing some of his/her own behaviors.
9. _____ Truth      _____ Myth It is rape if someone puts his/her fingers inside a woman’s vagina against her will.
10. _____ Truth      _____ Myth An adolescent is less likely to be sexually violated if her/his parents know her/his date (boyfriend or girlfriend).
11. _____ Truth      _____ Myth People who are sexually abused as a child or adolescent are more likely to become sexual abusers as adults.
12. _____ Truth      _____ Myth Rape can occur within marriage.
13. _____ Truth      _____ Myth Women asked to be raped when they wear revealing clothing or act flirtatious. *
14. _____ Truth      _____ Myth Alcohol can contribute to sexual assault. *
15. _____ Truth      _____ Myth If a young woman did not fight back, she was not really assaulted.

Participant Handout 11.2: Roleplay

In the following situation, a holdup victim is asked questions by a lawyer.

**Lawyer:** "Mr. Smith, you were held up at gunpoint on the corner of High St. and New Road?"

**Mr. S:** "Yes."

**Lawyer:** "Did you struggle with the robber?"

**Mr. S:** "No."

**Lawyer:** "Why not?"

**Mr. S:** "He was armed."

**Lawyer:** "Then you made a conscious decision to comply with his demands rather than resist?"

**Mr. S:** "Yes."

**Lawyer:** "Did you scream? Cry out?"

**Mr. S:** "No, I was afraid."

**Lawyer:** "I see. Have you ever been held up before?"

**Mr. S:** "No."

**Lawyer:** "Have you ever GIVEN money away?"

**Mr. S:** "Yes, of course."

**Lawyer:** "And you did so willingly?"

**Mr. S:** "What are you getting at?"

**Lawyer:** "Well, let's put it like this, Mr. Smith. You've given money away in the past. In fact, you have quite a reputation for philanthropy. How can we be sure that you weren't CONTRIVING to have your money taken from you by force?"

**Mr. S:** "Listen, if I wanted - "

**Lawyer:** "Never mind. What time did this holdup take place, Mr. Smith?"
Mr. S: "About 11:00 P.M."

Lawyer: "You were out on the street at 11:00 P.M.? Doing what?"

Mr. S: "Just walking."

Lawyer: "Just walking? You know that it's dangerous being out on the street that late at night. Weren't you aware that you could have been held up?"

Mr. S: "I hadn't thought about it."

Lawyer: "What were you wearing at the time, Mr. Smith?"

Mr. S: "Let's see ... a suit. Yes, a suit."

Lawyer: "An EXPENSIVE suit?"

Mr. S: "Well - yes. I'm a successful lawyer, you know."

Lawyer: "In other-words, Mr. Smith, you were walking around the streets late at night in a suit that practically advertised the fact that you might be a good target for some easy money, isn't that so? I mean, if we didn't know better, Mr. Smith, we might even think that you were ASKING for this to happen, mightn't we?"

Participant Handout 11.3: Case Studies

Screening for Sexual Abuse

Role Play #1

A__ is a 14-year-old. She is sent to the clinic by her mother. She seems very depressed and has stopped eating. She tells you she is afraid to use the toilet facilities outside her home.

Role Play #2

S__ is a 15-year-old. She comes to the clinic complaining of genital pain. She appears extremely anxious.

Role Play #3

R__ is a 17-year-old. He has been living on the streets. He came to the clinic because he complains of sores around his anus.
## Participant Handout 11.4: Observer Roleplay Checklist

<table>
<thead>
<tr>
<th>TASK</th>
<th>PERFORMED</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
</tr>
<tr>
<td>Ensures privacy</td>
<td></td>
</tr>
<tr>
<td><strong>Nonverbal Communication</strong></td>
<td></td>
</tr>
<tr>
<td>Friendly/welcoming/smiling?</td>
<td></td>
</tr>
<tr>
<td>Non-judgmental/empathetic?</td>
<td></td>
</tr>
<tr>
<td>Listens attentively/nods head to encourage and acknowledge client's responses?</td>
<td></td>
</tr>
<tr>
<td>Allows client enough time to talk?</td>
<td></td>
</tr>
<tr>
<td><strong>Verbal Communication</strong></td>
<td></td>
</tr>
<tr>
<td>Asks in a non-threatening tone if client has ever been touched sexually against her/his will?</td>
<td></td>
</tr>
<tr>
<td>Phrases questions clearly and appropriately? Uses non-technical terms?</td>
<td></td>
</tr>
<tr>
<td>Listens to client's responses closely?</td>
<td></td>
</tr>
<tr>
<td>Answers client's questions?</td>
<td></td>
</tr>
<tr>
<td>Uses language the client can understand?</td>
<td></td>
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<tr>
<td>Reassures client that action will only be taken with the client's permission (within the limits of the law).</td>
<td></td>
</tr>
<tr>
<td><strong>If Client Reveals Sexual Abuse:</strong></td>
<td></td>
</tr>
<tr>
<td>Asks whether the abuse is still going on?</td>
<td></td>
</tr>
<tr>
<td>Asks if client still has contact with the perpetrator?</td>
<td></td>
</tr>
<tr>
<td>Asks the age of the perpetrator and the relationship to the client?</td>
<td></td>
</tr>
<tr>
<td>Asks about the nature of the abuse?</td>
<td></td>
</tr>
<tr>
<td>Asks if client is aware of laws related to sexual abuse?</td>
<td></td>
</tr>
<tr>
<td>Asks if client wants to report the abuse to the authorities?</td>
<td></td>
</tr>
</tbody>
</table>

What did you learn from observing this role play?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Please record your comments/observations for feedback to participants (both positive and negative):

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Pathfinder International 107
Introduction

This guide is designed to help assessment teams, project managers, trainers, supervisors, and others collect detailed information on the range and quality of services provided to adolescents at a given facility or within a given program. The guide is primarily a needs assessment instrument for determining the physical, informational, and training needs of facilities and programs preparing to improve services for adolescent reproductive health. This needs assessment also provides essential baseline information, allowing for repeated applications in order to examine changes and the impact of program interventions. Although the guide is primarily for use by a team, it may be used by an individual clinician.

Determining minimum requirements for youth-friendly services is a difficult task. Given the great differences in contexts and availability of resources, there is no simple means for quantifying quality of care and services. This assessment guide can help to determine what each facility or program needs in order to improve the quality of services and design appropriate alterations or interventions.

Using This Assessment Guide

Discussing Objectives: Before starting to fill out the individual sections of this guide, it is extremely important that the assessment team discuss the objectives of the assessment with facility/program staff and supervisors. The assessment team leader should explain clearly how and why the assessment will be done, emphasizing that the assessment guide is designed not to find fault, but to identify areas where improvements can be made.

Collecting and Recording the Data

Several methods will be used to collect the data needed to complete the assessment forms. These include:

- Reviewing clinic records.
- Interviewing clinic managers and staff.
- Examining the clinic layout and environment.
- Interviewing clients.
- Observing provider-client interaction.
- Reviewing clinic policies and procedures.

You may need to use a combination of these methods to truly answer a specific question. Beside each question on the assessment form, there is a notation of the suggested methods to evaluate a particular aspect of youth-friendly services.

Below are additional points to keep in mind while conducting the assessment.

- Consider whether a team or an individual will be most appropriate, and decide who will collect the data for different sections.
- Before collecting data, review the descriptions of the characteristics of youth-friendly programs located at the end of the assessment tool. These descriptions should serve as a reference point for your assessment.
- Be as objective as possible—if a team is collecting data, it is important that you agree on definitions and standards before beginning the data collection.
- Take into account the routine of the service providers and try to make data collection as unobtrusive as possible.
- Whenever possible, obtain your information by observation.
Consider timing—which sections require clients, which sections can be completed when there are no clients.

Be flexible—it may be impossible to complete the whole guide at one time. You may have to wait to observe some procedures.

For each section, fill in the information requested.

Use the comments/recommendations column—these observations often provide the useful information.

Use your judgment and ask other pertinent questions that may not be included in this assessment tool.

Completing the Guide: Complete only the sections of the guide that are relevant to the facility and the services it provides. The sections do not need to be completed in a particular order. For example, if there are adolescent clients at the facility, complete those sections that require observation of clients receiving services. You may need additional paper to record all your comments.

Using the Information: Go over the data with facility staff, looking at each section and interpreting the data as a whole. Discuss which areas show the greatest strengths and weaknesses and how care and facilities could be improved. The assessment tool can provide baseline information for planning, prioritizing, and decision-making. However, the guide may be used in a number of other ways:

- As an ongoing monitoring tool
- For annual evaluations
- For designing training opportunities
- For developing workplans
- As a self-assessment tool for staff

Organization of Assessment Guide
This guide is organized according to the sections listed below. Each section starts with some introduction about why the information is being collected, why the topic is important, and how the observations/data collection should be carried out.

I. General Background Information
II. Client Volume and Range of Services Provided
III. Personnel
IV. Assessment of Youth-Friendliness
## I. General Background Information

This section is designed to provide general information about the facility, its size and location, as well as details of the assessment process.

<table>
<thead>
<tr>
<th>Date of Visit: ______________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Facility: ____________________</td>
</tr>
<tr>
<td>Location: ___________________________ Rural _____ Urban _____ Peri-urban_______</td>
</tr>
<tr>
<td>Type of Facility: MOH __________ NGO __________ Other ________________</td>
</tr>
<tr>
<td>Level of Facility: _________________</td>
</tr>
<tr>
<td>Number of Rooms: Total ______ Waiting Room ______ Examination Room ______ Lab ______ Other ______</td>
</tr>
<tr>
<td>Staff Interviewed:</td>
</tr>
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<tr>
<td></td>
</tr>
<tr>
<td>Person Conducting Assessment:</td>
</tr>
</tbody>
</table>
II. Client Volume and Range of Services Provided

This section is for gathering information on client volume and the range of services provided. In order to maintain and improve the quality of services, service providers should have experience in all aspects of adolescent care, including, where appropriate, counseling and the provision of contraceptive methods.

Using the facility record books, record the following statistics for one month. Record the total number of clients served in the first column and the number of young people served, broken down by age, in the second column. If statistics vary greatly from month to month, collect 3 months’ worth of information and record an average for a 1-month period. Any additional comments or recommended actions should be noted in the "Comments/Recommendations" column.

<table>
<thead>
<tr>
<th>Service Provided</th>
<th>Total Clients Served</th>
<th>Total Young Clients Served</th>
<th>Comments/Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(20-24) (15-19) (10-14)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>F M</td>
<td>F M F M F M</td>
<td></td>
</tr>
</tbody>
</table>

- **Counseling**
- Contraception/Dual Protection
- HIV/AIDS
- Nutrition
- Sexual Abuse
- Other RH Issues

- **Testing**
- STI
- VCT
- Pregnancy

- **Treatment**
- STI (note if syndromic or etiologic)
- Postabortion Care
- Sexual Abuse or Violence

- **Other Services**
- Contraception
- Abortion (if legal)
- Prenatal Care
- Delivery
- Postnatal Care
- Other services
Write in the hours (for example, 2-5 pm) for each day of the week that the following services are available to adolescent clients.

<table>
<thead>
<tr>
<th>Services Offered</th>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Counseling</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraception/Dual Protection</td>
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<tr>
<td>HIV/AIDS</td>
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</tr>
<tr>
<td>Nutrition</td>
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<tr>
<td>Sexual Abuse</td>
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</tr>
<tr>
<td>Other RH Issues</td>
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</tr>
<tr>
<td><strong>Testing</strong></td>
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<tr>
<td>STI</td>
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<td>VCT</td>
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<td>Pregnancy</td>
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<tr>
<td><strong>Treatment</strong></td>
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<tr>
<td>Postabortion Care</td>
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<tr>
<td>Sexual Abuse or Violence</td>
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<tr>
<td><strong>Other Services</strong></td>
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<tr>
<td>Contraception</td>
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<td></td>
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<tr>
<td>Abortion (if legal)</td>
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<tr>
<td>Prenatal Care</td>
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<tr>
<td>Delivery</td>
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<td>Postnatal Care</td>
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<tr>
<td>Other services</td>
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</table>
III. Personnel

This section is for gathering information about the staff providing services at the facility and their level of training. In order to provide services of good quality, facilities must have staff who can cover all aspects of adolescent care.

List all personnel involved in the provision of adolescent services and the training they have received, using the codes beneath the table. Common staff titles include manager, midwives, doctors, nurses, counselors, receptionist, and peer counselors; however, some facilities or health systems may use different terms. Give whatever titles are used by the facility staff themselves. Also note what percentage of each provider's work time is devoted to serving adolescent clients.

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Title</th>
<th>Type of Training</th>
<th>Training Agency and Date</th>
<th>% of Time Serving Adolescents</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

1=Counseling  2=Peer Counseling  3=Family Planning
4=Management of STIs  5=Postabortion Care  6=Adolescent Reproductive Health/Youth Friendly Services
7=Life Skills and Livelihood Training  8=Other
### IV. Assessment of Youth-Friendliness

Ask the questions below to the clinic manager or service provider and observe clinic operations where possible. Write brief answers in the "Answer" column. Add additional findings or recommendations in the "Comments/Recommendations" column. Please refer to the "Review of Youth-Friendly Program Characteristics," following this data collection form, for brief descriptions of specific youth-friendly characteristics.

<table>
<thead>
<tr>
<th>1. Location</th>
<th>Method</th>
<th>Answer</th>
<th>Comments/Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>How far is the facility from public transportation?</td>
<td>E, IS, IC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How far is the facility from places where adolescents spend their free time?</td>
<td>E, IS, IC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How far is the facility from schools in the area?</td>
<td>E, IS, IC</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Facility Hours</th>
<th>Method</th>
<th>Answer</th>
<th>Comments/Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>What time is the clinic scheduled to open?</td>
<td>IS, IC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the official closing time for the facility?</td>
<td>IS, IC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the facility have separate hours for adolescents?</td>
<td>IS, IC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a sign with services and clinic working hours?</td>
<td>E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What times are convenient for adolescents to seek services?</td>
<td>IS, IC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Facility Environment</th>
<th>Method</th>
<th>Answer</th>
<th>Comments/Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the facility provide a comfortable setting for adolescent clients?</td>
<td>E, IC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the facility have a separate space to provide services for adolescent clients?</td>
<td>E, IC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the facility have a separate waiting room for adolescent clients?</td>
<td>E, IC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a counseling area that provides both visual and auditory privacy?</td>
<td>E, IC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there an examination room that provides visual and auditory privacy?</td>
<td>E, IC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Staff Preparedness</th>
<th>Method</th>
<th>Answer</th>
<th>Comments/Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are staff trained to serve adolescent clients in RH?</td>
<td>IS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are providers given specialized training?</td>
<td>IS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did all staff members receive at least an orientation about adolescent clients? What type of orientation was this and how long was it?</td>
<td>IS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do providers show respect for the client during counseling and consultations?</td>
<td>IS, IC</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Services Provided</th>
<th>Method</th>
<th>Answer</th>
<th>Comments/Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is counseling on sexuality, safer sex, pregnancy prevention, and STI and HIV prevention provided?</td>
<td>IS, IC, P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What contraceptive methods are offered?</td>
<td>R, IS, IC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are condoms provided to males and females?</td>
<td>IS, IC, O</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are supplies (condoms, other contraceptive methods, and drugs) sufficient to meet the need?</td>
<td>IS, IC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is pregnancy testing offered?</td>
<td>R, IS, IC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is STI testing available? What type is available?</td>
<td>R, IS, IC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Peer Education/Counseling Program</td>
<td>Method</td>
<td>Answer</td>
<td>Comments/Recommendations</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------</td>
<td>--------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Is a peer education/counseling program available? If so, please describe.</td>
<td>IS, IC, O</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many peer counselors are working with the facility?</td>
<td>IS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many hours a week do they each spend at the facility?</td>
<td>IS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a system for supervising and monitoring counselors? If so, what kind of system?</td>
<td>IS, P</td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Educational Activities</th>
<th>Method</th>
<th>Answer</th>
<th>Comments/Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are educational materials available on-site (A/V, computers, printed material)? Which ones?</td>
<td>IS, IC, E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there print materials available for clients to take? Describe materials and comment.</td>
<td>IS, IC, E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In what languages are IEC materials available?</td>
<td>IS, IC, E</td>
<td></td>
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</tr>
<tr>
<td>Are group (or rap) discussions held? Please describe.</td>
<td>IS, IC, O</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there ways clients can access information or counseling off-site (telephone hotline, website, materials sent by mail)? Please describe.</td>
<td>IS, IC, E</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Youth Involvement</th>
<th>Method</th>
<th>Answer</th>
<th>Comments/Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>What ways can adolescents suggest/recommend changes to make services more comfortable and responsive?</td>
<td>IS, IC, E, P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are adolescents involved in decision-making about how programs are delivered? How?</td>
<td>IS, IC, P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How can adolescents be involved in decision-making at the facility?</td>
<td>IS, IC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. Supportive Policies</th>
<th>Method</th>
<th>Answer</th>
<th>Comments/Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there other RH services in demand by young people that you offer? Which ones?</td>
<td>IS, IC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you make referrals for important needs you cannot meet (e.g. sexual abuse)? Please give examples.</td>
<td>R, IS, IC, P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there an effective formal referral system in place?</td>
<td>IS, IC, P</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. Administrative Procedures</th>
<th>Method</th>
<th>Answer</th>
<th>Comments/Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can adolescent clients be seen without an appointment?</td>
<td>IS, IC, P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If appointments are required, can they be expedited for adolescent clients?</td>
<td>IS, IC, P</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How long would an adolescent client wait, on average, to see a provider?</td>
<td>IS, IC</td>
<td></td>
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</tr>
<tr>
<td>What is the average time allowed for client/provider interaction?</td>
<td>IS, IC, O, P</td>
<td></td>
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</tr>
</tbody>
</table>
### 11. Publicity/Recruitment

| Does publicity about the clinic identify services offered and stress confidentiality? | IS, IC, E |
| Are there staff or volunteers who do outreach activities? If so, what type? | IS, IC, O |

### 12. Fees

<table>
<thead>
<tr>
<th>Method</th>
<th>Answer</th>
</tr>
</thead>
</table>

### Review of Youth-Friendly Program Characteristics

#### 1. Location

Existing facilities cannot address this variable, but new operations can consider location as a factor when determining a service site. Young people sometimes express a desire to go out of their neighborhoods so they will not be seen by family and neighbors. At the same time, young people do not want to or cannot travel too far to reach service sites. The locations should be in a safe environment and, ideally, should be available by public transportation.

#### 2. Facility Hours

Having clinics open at times when young people can conveniently attend is fundamental to effective recruitment and service provision. Such times typically include late afternoons (after school or work), evenings, and weekends. While young people who need urgent care may be willing to leave school or work for such services, those who need prevention services but who may be unaware of their importance, are often reluctant and give excuses instead of taking the time off.

#### 3. Facility Environment

The service environment may vary with the specific target audience to be served. In general, young people prefer a setting that is comfortable, has posters or décor that relate to their tastes and interests, and does not present an overly sanitized environment. This might include service providers’ wearing street clothes rather than “medical” whites, but the need for this varies from place to place.

Creating separate space and special hours for adolescents appears more important for certain clients, such as young teenagers, first-time clinic users, non-sexually active clients, and marginalized young people who are especially suspicious of mainstream health care. A separate service can also facilitate providers’ efficiency in arranging specialized youth-friendly features. Before considering such a special adjustment, a strong needs assessment among a diverse group of probable clients should be conducted.

Privacy and confidentiality rank extremely high among young people. Privacy must be arranged for counseling sessions and examinations; young people must feel confident that their important and sensitive concerns are not overheard or retold to other persons. Adequate space is needed for privacy and to assure that counseling and examinations can take place out of sight and sound of
other people. This requires separate rooms with doors, and policies that support minimal interruptions and intrusions.

Although not possible in all societies, welcoming male partners can prove beneficial where feasible. For a young woman, the accompaniment of her boyfriend to the clinic can be an important element in the decision to seek services. This support should not be dampened by his feelings of discomfort. Furthermore, opportunities exist to foster shared responsibility for decision-making and contraception when young men are present, as well as to serve the RH needs of males. It may be necessary to develop clinic programs designed especially for young males that are sensitive to male values, motivations, feelings, and cultural influences while encouraging equitable male and female relationships.

4. Staff Preparedness

Having a specialized staff that is trained to work competently and sensitively with young people is often considered the single most important condition for establishing youth-friendly services. Acquired skills must include familiarity with adolescent physiology and development, as well as appropriate medical options according to age and maturity. At least as important are interpersonal skills so that young people can be at ease and can comfortably communicate their needs and concerns. This objective is sometimes accomplished when providers are closer in age to, and/or of the same sex as, the client. The ability to communicate fluently in languages that young people speak who attend a given clinic is also important. In addition to those providing counseling and medical services to adolescents, other staff members should be positive toward these clients and oriented to young people’s special concerns. Particularly important are the attitude and performance of the receptionist, who is typically the first point of contact for the young person. Refresher courses must be made available to keep staff members informed and their skills current.

While respect for young people—an essential provider characteristic—can be fostered within a training exercise, some providers bring to their job deeply entrenched biases against adolescent sexual activity or find it difficult to relate to adolescents in a respectful way. Given this reality, clinic managers should carefully consider such attitudes as they select trainees or those who will work with—or supervise staff to work with—young people.

5. Services Provided

The more health needs of young people that can be met within the facility or program, the greater assurance that adolescents will receive the care they need. Whenever it is necessary to send young people to another location for another service, there is an increased risk that they will not actually show up. While it is not always possible, attempts should be made to identify and provide the most needed RH services as “one stop shopping.” These services should include sexual and RH counseling, contraceptive counseling and prevention (including emergency contraception), STD and HIV prevention, STD diagnosis and treatment, nutritional services, sexual abuse counseling, pregnancy testing, prenatal and postpartum care, abortion services (where legal), and
postabortion care.

It is desirable, but almost never possible, to provide services that meet all the needs of adolescents, including some types of specialized health care and related social services. Thus, it becomes very important in addressing the adolescent’s overall needs to be able to refer to responsible agencies. Effective working arrangements should be established to ensure that adolescents receive the services they are referred to and to assure that referral sites provide appropriate youth-friendly treatment.

6. Peer Education/Counseling Program

Evidence shows that many young people prefer talking with their peers about certain sensitive issues (although they also tend to believe that health care professionals know more about the technical issues). It is productive, therefore, to have peer educators or counselors available as alternatives or supplements to some aspects of the counseling activities.

A critical element for quality peer education and counseling is effective supervision for the peers, though the amount depends on the types of activities they carry out and the extent of training they have had. In addition to overseeing their activities and needs as volunteers (or paid staff), supervisors need to provide reinforcements of efforts, perhaps including some sort of rewards or morale boosters. Care must be given to maintain attention to peers’ professional needs during their tenure through refresher courses and mentoring and not just during the training phase.

7. Educational Activities

Some young people prefer to learn about sensitive issues on their own, using written or audiovisual materials, because their discomfort level can be too great to retain information during a face-to-face session. Such learning can occur while clients are waiting to be seen, as with educational videos or computer-based health education. Some materials should be available to take home too, so that young people can refer to them later, particularly if the topics are complicated (such as symptoms of STDs).

While not all young people are comfortable in a discussion format with their peers, this type of information exchange can be very productive if facilitated by a trained person. Peer counseling/education helps adolescents to realize that their fears are not unique. It can also provide the support needed to obtain care or seek solutions to problems. Peer counseling sessions can be scheduled, provided as needed, and/or held while young people are waiting to be seen.

Given the challenge of attracting young people to fixed clinic sites, clinics can increase their reach by other means of contact with clients. For example, telephone hot lines can be operated by trained counselors from the clinic site thus eliminating the need to come to the clinic for information or counseling. Counselors (peer or adult) and outreach workers (including community-based distribution agents) can go into the community to deliver services. Clinics can set up smaller branches or satellite clinics closer to where young people congregate or link services to schools. In some settings, clinics can also take advantage of increased computer accessibility by
providing information via websites or interactively through online “chat rooms.”

8. Youth Involvement
A fundamental principle in design of youth-friendly services is to ensure participation of young people in identifying their needs and preferences for meeting those needs. Some characteristics, such as privacy, confidentiality, and respectful treatment are nearly always top priorities. Other features, such as the separateness of the clinic from other services and the importance of peer counselors, may vary according to the overall culture or the specific norms of the target population. In addition to creating an environment more likely to meet their needs, involving adolescents in the design of the program and in continuous feedback will enhance the “ownership” of the program. This feeling of ownership will motivate young people to recruit their peers and to advise on needed adjustments. There are roles that young people can play in the clinic program such as assisting with administrative tasks, sitting on advisory boards, serving as peer counselors, and assisting with monitoring and evaluation.

9. Supportive Policies
Given that reproductive health projects for young adults are new, operational policies governing how providers should serve this group are evolving and not always clearly spelled out. This makes service decisions subjective, placing the responsibility on providers who may have varying views. Clear, detailed operational policies are likely to result in a more consistent and evenhanded provision of services. And to the extent that such protocols are actively supportive of young people’s access, there is a greater potential for recruiting and maintaining a young clientele. These policies should include clear protocols for protecting client confidentiality, including privacy in the registration process and the secure storage of client records.

When laws restrict available services by age, clinics face constraints beyond their control. However, staff should have clear legal guidelines, with operational policies detailing the full extent of services allowable under the law.

A policy that has been pioneered in some youth-friendly clinics is the possibility of delaying procedures feared by young people, especially the pelvic exam and blood tests. This fear can deter young women from going to clinics and obtaining contraception when they first need it. When it is deemed that such procedures can safely wait until a subsequent visit, such a policy might encourage early clinic visits and earlier adoption of a contraceptive method.

10. Administrative Procedures
Because adolescents are present-minded and rarely plan ahead, the possibility of receiving services without an appointment can increase adolescent access. If an adolescent is turned away and told to return at another time, or if the adolescent must wait several weeks to be seen after making an appointment, there is a significantly greater likelihood that the potential client will not show up. With young people, it helps to “seize the opportunity” when they show an interest in getting RH care.
An experimental program succeeded in serving young people by drastically cutting waiting times for appointments; they gave teens priority consideration for family planning appointments, guaranteeing an appointment within 48 hours. Having to wait a long time to be served in a clinic, particularly with an increased chance gives the facility a bad reputation that deters future clients.

Young people tend to need more time than adults to open up and reveal very personal concerns. They usually come to the clinic with considerable fear, often with a worry about being pregnant, and require strong reassurance and active encouragement to speak freely. Time is needed to bring myths (such as girls cannot get pregnant at first intercourse) to the surface, to discuss them, and to dispeel them. When possible, clinicians and counselors should plan from the start to schedule more time with young clients than with adult clients. In addition to responding to client concerns, providers should be able to cover questions about body image and development, relationships, sex and condom negotiation, as well as to clearly explain contraceptive method options and their possible side effects and management; this discussion is crucial to the compliance and retention of the adolescent client.

11. Publicity/Recruitment

Not only must adolescents know that clinics and other service programs exist and where they are located, but they must also know what services are provided. Importantly, they must be reassured that they are welcome and will be served respectfully and that someone will see them there, is also unappealing to the adolescent client. Young people may choose to not even endure the wait initially, but if they do, this situation can be a barrier to their return. This kind of experience is more than likely told to peers—prospective clients—and confidetially. Communicating this information can often be done as part of a community relations or mobilization effort. In this effort, programs explain their services to local adolescents and other groups who can then provide support and referrals. Outreach in the community is particularly important in reaching out-of-school adolescents. Recruitment is often best handled by young people themselves, both formally (such as distributing printed information or making presentations) and informally (by word of mouth). Satisfied clients are usually the best recommendation for use of particular services.

12. Fees

Cost can be a significant barrier to the potential adolescent client. A fee schedule must be designed so that services are free or affordable. They can be established on a sliding scale, possibly including credit and flexible payment options. Some studies have shown that adolescents want to pay something for services or else they will not value what is provided.
<table>
<thead>
<tr>
<th>Obstacles</th>
<th>Date Planned/Completed</th>
<th>Person Responsible</th>
<th>Action Required</th>
</tr>
</thead>
</table>
Participant Handout 13.3: Reproductive Health Services for Adolescents Post-Test

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

1. Identify which of the following more commonly occur near the beginning or end of adolescence:
   ___ Reaches physical and sexual maturity.
   ___ Concerned with peer groups.
   ___ Impulsive, experimental behavior.
   ___ Developed problem-solving abilities.

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

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

3. Which of the following occur more in adolescents than adults:
   a) Heart conditions.
   b) Anemia.
   c) Injuries.
   d) Low-birth weight babies.

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

5. Among the most important conditions a provider can ensure for the adolescent client are:
   a) Privacy.
   b) Popular music playing.
   c) Respect.
   d) Fun atmosphere.
6. Syndromic management of STIs is most effective in diagnosing:
   a) Genital ulcers.
   b) Urethritis.
   c) Vaginal discharge.
   d) Cervicitis.

7. The contraceptive methods that are appropriate for breast-feeding women who are more than 6 weeks postpartum are:
   a) IUD.
   b) Combined oral contraceptives.
   c) Progestin-only contraceptives (progestin-only pills, Norplant, injectables like Depo-Provera).
   d) Lactational Amenorrhea Method (LAM).

8. The major reason condoms break is:
   a) They have been washed with soap.
   b) They are too small.
   c) The vagina is not wet enough.
   d) They are used with an oil-based lubricant such as Vaseline or petroleum jelly.

9. Which of the following complications of pregnancy are more likely to occur in adolescents under the age of 15 compared with older women:
   a) Giving birth to very large babies.
   b) Premature labor.
   c) Dysfunctional labor.
   d) Spontaneous abortion.
   e) Still birth.

10. Which methods of contraception may not be suitable to the adolescent client:
   a) Emergency contraception.
   b) Combined oral contraceptives.
   c) Sterilization.
   d) Condoms.
   e) Injectable contraceptives.

11. WHO estimates that the risk of dying of pregnancy-related causes is:
   a) Twice as high for women ages 15-19 than for older women.
   b) Three times as high for women ages 15-19 than for older women.
   c) Four times as high for women ages 15-19 than for older women.
   d) Five times as high for women ages 15-19 than for older women.
   e) The same for women ages 15-19 than for older women.
12. Which of the following methods are appropriate for counteracting rumors and misconceptions about contraceptives:
   a) Using strong scientific facts to counteract misinformation.
   b) Giving less information so the client is not confused.
   c) Finding where the rumors came from and checking to see if there is any basis for the rumor.
   d) Not telling the client about side effects because it might make them frightened.

Instructions: Write in the correct answers

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

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

15. Two signs of anemia are:

16. Which methods protect adolescents against STIs and pregnancy?

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

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

18. ____International policies agreed to by a majority of the world's countries call for reproductive health information and services to be available to adolescents.

19. ____Rape only happens to females.

20. ____STIs cannot be transmitted through oral sex.
**Participant Handout 13.4: Participant Evaluation Form**

**Module 16: Reproductive Health Services for Adolescents**

Rate each of the following statements as to whether or not you agree with them, using the following key:

- 5 Strongly agree
- 4 Somewhat agree
- 3 Neither agree nor disagree
- 2 Somewhat disagree
- 1 Strongly disagree

### Course Materials

I feel that:

- The objectives of the module were clearly defined. 5 4 3 2 1
- The material was presented clearly and in an organized fashion. 5 4 3 2 1
- The pre-/post-tests accurately assessed my in-course learning. 5 4 3 2 1
- The competency-based performance checklist was useful. 5 4 3 2 1

### Technical Information

I learned new information in this course. 5 4 3 2 1

I will now be able to:

- Provide youth-friendly services to adolescent clients. 5 4 3 2 1
- Adapt the counseling process to address the needs of adolescents. 5 4 3 2 1
- Dispel rumors and misconceptions about using protection. 5 4 3 2 1

### Training Methodology

The trainers' presentations were clear and organized. 5 4 3 2 1

Class discussion contributed to my learning. 5 4 3 2 1

I learned practical skills in the role plays and case studies. 5 4 3 2 1

The trainers encouraged my questions and input. 5 4 3 2 1
Training Location & Schedule

The training site and schedule were convenient.  5 4 3 2 1
The necessary materials were available.  5 4 3 2 1

Suggestions

What was the most useful part of this training? ______________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

What was the least useful part of this training? ______________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

What suggestions do you have to improve the module? Please feel free to reference any
of the topics above. _____________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
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 one’s 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.

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.


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.

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.


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.

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.


**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.


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 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.

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, and self masturbation.

Low Risk
There are other activities that are probably safe, such as masturbating your partner or masturbating together as long as males do not ejaculate near any opening or broken skin on their partners; using a latex condom for every act of sexual intercourse (penis in vagina, penis in rectum, penis in mouth); using a barrier (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 carry 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. Oral sex without a latex barrier is risky in terms of HIV transmission, although it carries less risk than unprotected anal or vaginal intercourse. Some STIs, such as gonorrhea, are easily passed through oral sex while others, such as chlamydia, are not.

High Risk
There are activities that are very risky, because they lead to exposure to the body fluids in which HIV lives. These are having anal or vaginal intercourse without using a condom.

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 shesuspects high risk, treat her for cervicitis and vaginitis, and try to ensure partnertreatment.

• 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.
Unit 9: Counseling the Adolescent On Safer Sex

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

Peretration 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 PRENATAL VISIT**

During the prenatal visit(s), providers can help adolescent women to develop a birth plan that will focus on:

- What to do if any danger signs of pregnancy occur.
- Identifying the person(s) to provide physical and emotional support during labor.
- When to check in with the health staff if they suspect that labor is beginning.
- How they will get to the hospital or clinic.

Childbirth preparation classes will give both the adolescent and her support person(s) the necessary information and techniques to make labor more comfortable. 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 identity 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. Over-diluting will result in the baby receiving inadequate nutrition, failing to gain weight, and will create a situation that could eventually be dangerous to the baby’s kidneys.

If the adolescent mother cannot afford commercial formula, she may choose to make formula. She must be advised:

- Not to use plain cow’s milk for an infant younger than 1 year old—its protein content is too high and is hard to digest, its chemical make-up can burden the baby’s kidneys, and 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

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

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

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

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

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