



Pathfinder
INTERNATIONAL

**Developing an Adolescent Competent
Health Workforce: Training Service
Providers in Adolescent Sexual and
Reproductive Health**

January 2021

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Introduction

In recent years, there have been many steps forward in global efforts to ensure the health and well-being of the world's adolescents and youth, especially their sexual and reproductive health. It is increasingly recognized that ensuring young people's health is pivotal to the world's ability to achieve and sustain health for all. Improving the health of adolescents requires the commitment of families, communities, and institutions across a range of sectors, inclusive of health.

Pathfinder International has a long-standing commitment to adolescents and youth. More than half of the world's population is under the age of 25, and most adolescents and youth live in low-income countries where the leading cause of death is complications from pregnancy and childbirth. Many young women would like to be able to delay their first pregnancy as well as prevent sexually transmitted infections and HIV. Further, gender-based violence against adolescents is pervasive and far too many young women report that their first sex is coerced or forced.

Despite a real need for quality health information, counseling, and services, many young people find it difficult to obtain health care services that are "youth friendly." Barriers to accessing services are even more prominent for marginalized young people and youth with disabilities. Although there are many factors that are essential to the provision of youth friendly services, it is arguably the service provider in the facility or community who is the linchpin of youth friendly and inclusive service delivery. Strengthening the abilities of service providers to provide accurate, unbiased, and empathetic care is central to Pathfinder's efforts to facilitate the health and wellbeing of the world's young people. Skills can be developed in several ways. One optimized approach is to deliver established curricula in classrooms or through workshops.

We are pleased to publish the third edition of our popular training curriculum for service providers. Formerly known as "Module 16: Reproductive Health Services for Adolescents," the new edition is entitled "***Developing an Adolescent Competent Health Workforce: Training Service Providers in Adolescent Sexual and Reproductive Health***". In addition to providing up to date technical content in line with globally agreed upon standards of care, this edition takes participants through an array of participatory exercises and activities that help them more fully explore the attitudes, beliefs, and values that influence their interactions with young people. This edition also integrates a disability inclusion perspective to support participants' interaction with young persons with disabilities. This edition is built on the foundation of the previous version, developed by Judith Senderowitz, Cathy Solter, and Gwyn Hainsworth (2002; revised 2004).

We hope that this edition will contribute to ensuring providers are well prepared to meet and serve adolescent clients with the highest quality sexual and reproductive health services and care so that all adolescents and young people can make healthy and positive choices for their own wellbeing.

January 2021

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NOTES TO THE TRAINER

PURPOSE

This training manual is intended to assist health care providers to develop new skills and competencies in providing comprehensive sexual and reproductive health (SRH) and family planning (FP) information and services to adolescents and young people. It is one of a series of training manuals for health care providers developed by Pathfinder International that touches on different aspects of SRH and FP service delivery.

The manual is designed to be used to train physicians, nurses, counselors, and midwives. The manual can be used in conjunction with other trainings intended to improve provider capabilities or can be implemented as a stand-alone training. This is not a training to improve clinical skills in service delivery, but a training to improve provider comfort and competencies in providing quality SRH information and clinical services to adolescents and young people in line with best practice standards of care. By integrating a disability inclusion perspective, the training aims to improve providers' knowledge and skills to welcome young persons with disabilities in their facilities and to improve their communication with them. This represents a first important step to addressing the communication and attitudinal barriers young persons with disabilities often face in accessing SRH information and services. While some content addresses clinical aspects of care, the manual presumes that trainers and participants already have some experience with SRH terminology and service delivery. The manual may also be adapted for use with community-based health outreach workers, auxiliary workers, support staff, pharmacists, and anyone engaged in providing SRH and FP information and services to adolescents and young people.

Training implemented using this manual will actively involve participants in the learning process. Alongside trainer presentations, sessions include case study discussions, role plays, interactive games, values clarifications activities, and a site visit. Whenever possible, the training should be implemented with trainers who are young people, including young persons with different types of disabilities.

PLANNING THE TRAINING

The manual allows trainers to design their own training schedule based on local training needs and resources. Each unit can be used independently, but the training is most effective when all sessions are completed. If it is not possible to schedule a full 9 days for training, we recommend that the training be implemented as modules and taught sequentially over a longer period. This training is an appropriate tool to improve providers' skills and knowledge on disability-inclusive sexual and reproductive health only when the "Adolescents with Disabilities" unit is taught in combination with the other 15 units. The "Adolescents with Disabilities" unit is not designed to be taught as a standalone module. If the training is meant to focus on selected themes and modules, it is recommended to combine these modules with the "Adolescents with Disabilities" unit to ensure a disability-inclusive perspective. The units can also be lengthened or shortened depending on the level of training and expertise of the participants. Additional training guidance materials are included in the introduction to each unit for facilitators wishing to go more in-depth on any particular topic.

Participant Selection

This training is intended for mid-level providers of SRH services (nurses, nurse-midwives, nurse assistants, physicians, counselors, and others) who already have some skills in SRH but would benefit from specialized training in how to provide youth-friendly services. Consider including a member of management staff so that they are made aware of the goals, challenges, and resources needed to provide youth-friendly services and can provide needed management support.

Youth friendly health services need to be accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient.

World Health Organization

DESIGN/HOW TO USE THIS MANUAL

Each unit in this manual contains 3-4 specific learning objectives with a short unit summary. Activities and content presentations are included throughout the units. Content presentations and supplementary information are incorporated into facilitation instructions, while participant handouts and trainer's tools are found at the end of each session.

Guide to Symbols

Symbols are used throughout the unit to help guide and instruct facilitators. These symbols include:



Methodologies: Training methods used in the module, for example, large group discussion or role play.



Materials needed: Materials needed to teach the module, for example, flip chart and markers.



Resources: A listing of guidelines, books, journals, websites, and other documents that may be useful to trainers or participants who want more information on particular topics or issues related to a specific module's content.



Advance preparation: Planning and preparation for a session or exercise that should be undertaken in advance.



Total session/module time: Estimated time needed for each module or session. All times listed are suggested and subject to change depending on participant learning needs.



Trainer's instructions: Step-by-step guidance for the trainer.



Key points: A summary of the material presented in a particular module. The key points for each module should be reviewed with participants at the end of that module.

In addition, the following designations are used throughout the guide:

- Content: Text or information that should be presented directly to participants as a lecture.
- Supplemental Content: Text or information that guides the trainer in their interaction with participants. This content does not need to be presented directly to participants, unless the trainer decides to do so.
- Slides: Content or text contained on the accompanying powerpoint slides.
- Participant Handouts: Documents to be printed and distributed during sessions.
- Trainer’s Tools: Answer keys or discussion guides that accompany a participant handout.
- Notes to Trainers: Facilitation tips for how to organize and present an activity or content.

Preparatory Work

Each unit in this manual has information about work to be done in advance of the sessions in that unit. This includes:

- Reviewing the facilitation steps and activities before the session(s) to ensure trainers are comfortable with the process and familiar with the content.
- Reviewing the content of case studies and role plays, to ensure local and contextual relevance. As needed, facilitators can adapt or add new case studies based on local statistics, cultural practices, social traditions, and common health issues. In any event:
 - Case studies can be removed or modified to reflect local content.
 - Names should be changed to reflect local names.
- Reviewing the slide presentations and flow of the session.
- Printing all participant handouts needed for the sessions.
- Gathering any additional materials.

Ask participants and youth co-trainers with disabilities about any accommodations they need and prepare the training venue and relevant materials accordingly to ensure their full participation. Ask local Organizations of Persons with Disabilities (OPDs) if you need support. For some sessions, facilitators may wish to:

- Divide facilitation responsibilities with youth-co-trainers.
- Prepare flipcharts in advance.
- Arrange the training space and equip the room to ensure it is accessible for participants with disabilities and youth-co-trainers and that it allows room for the relevant activities.
- Conduct some research and preparation on local laws, policies, or context.

For the final session, facilitators are asked to arrange a site visit for participants to a nearby clinic(s). This should be organized in advance when planning the training.

WORKING WITH YOUTH CO-TRAINERS

Some of the sessions in this manual are specifically designed to be co-facilitated with youth trainers, although all sessions can be conducted with youth co-trainers. To ensure the integration of a disability inclusion perspective, the participation of youth trainers with different types of disabilities and a

background on sexual and reproductive health is essential. If your organization does not work directly with young people, reach out to partner organizations or youth networks directly to identify potential trainers and participants. Youth co-trainers can often be recruited from existing youth networks and youth-led organizations, which have expertise in sexual and reproductive health and rights. In many countries, youth may work with service delivery organizations as peer educators, volunteers, and even as clinicians. If your organization does not work directly with persons with disabilities, reach out to local OPDs to identify youth trainers with different types of disabilities.

Working with youth co-trainers will benefit your training for the following reasons:

- It models participatory design and meaningful participation of young people, which is needed for high-quality service delivery.
- Young people are experts in their own experience and provide a unique perspective on the barriers that prevent young people from seeking services and the gaps in service delivery strategies.
- Young people can help providers re-evaluate their assumptions and beliefs about young people's capabilities and behaviors.
- Young persons with disabilities themselves are in the best position to help providers understand the barriers they face when accessing SRH information and services. These youth can guide providers in re-evaluating their assumptions, myths and preconceptions related to sexuality and disability, and they can also provide guidance on how providers can better communicate with their peers.

When working with a youth co-trainer, be sure to review the content and activities with them ahead of the session, prepare the training materials in accessible formats to ensure full participation of young persons with different types of disabilities, and decide on which role each trainer will play. Ensure that all young co-trainers feel comfortable in expressing their opinions and applying their particular skills.

PARTICIPATORY TRAINING METHODOLOGIES

This manual is firmly grounded in a participatory approach to learning through interactive activities, discussions, small group work, and games. Participatory learning methodologies help learners build their knowledge and skills through shared reflection, critical analysis, and collective problem solving.

Participatory methodologies are particularly important for learning about sexual and reproductive health because of the many strong social assumptions, taboos, and stigmas that surround issues of sexuality, gender, and disability. Judgmental and negative provider attitudes are commonly cited by adolescents and youth as one of their top reasons for not seeking SRH services. Participatory learning activities are important tools for clarifying values and changing attitudes, and this manual strives to address attitudes about young people's SRH and their right to quality, inclusive, non-judgmental care, in addition to relevant clinical and practical information.

To facilitate open and non-judgmental discussions, trainers should take time to:

- Consider their own assumptions and biases. Sometimes we are quick to make assumptions or judgments about young people’s sexual behavior and decision-making. Take time to consider your opinions about young people’s sexuality and why you hold them.
- Practice using inclusive and neutral language (this includes gender-neutral and disability inclusive language) and avoid making judgments about “right” or “wrong”, “normal” or “abnormal” behavior.
- Avoid disparaging people’s experiences or opinions of sexuality and sexual desire and discourage others from reacting negatively to any information shared in the sessions or by their fellow participants.

The role of the trainer in a participatory session is one of guidance, not authority. Training should be a learning journey that participants and trainers take together, not a one-off delivery of information from expert to audience. While there are content presentations (“lectures”) included in the manual, the trainer should always strive to achieve a dialogue with participants.

SETTING GROUND RULES FOR SRH DISCUSSIONS

Before starting the training, work with participants to agree to a set of “ground rules.” Because of the sensitive nature of discussions on SRH and rights, the ground rules should emphasize:

- Privacy and confidentiality for participants.
- The use of non-judgmental language in the training room.
- Allowing space for reaction and emotion.
- Admitting when you do not know (both the trainer and the participants).
- Treating each other with respect.
- Creating space for each person to speak and contribute.

It is good practice to post the list of ground rules in the room where participants can readily access them, and periodically revisit them during the training. Make sure the ground rules are available in accessible formats according to the accommodation needs shared by participants and youth co-trainers.

DO’S AND DON’TS OF TRAINING

The following “do’s” and “don’ts” should always be kept in mind by the trainer in any learning session.

Do’s:

- Maintain good eye contact.
- Prepare in advance.
- Involve participants.
- Use visual aids where possible. To ensure the meaningful participation of persons with visual disabilities, make sure videos include captions and, for each visual aid, briefly describe what is on the screen. The same applies to PowerPoints or any other form of presentation. Speakers should briefly describe out loud each slide.
- Speak clearly, loudly, and slowly.
- Encourage questions.

- Admit when you don't know an answer and commit to revisiting it.
- Recap at the end of each session.
- Bridge one topic to the next.
- Encourage participation.
- Write clearly and legibly.
- Summarize discussions.
- Reflect participants' reactions back to them.
- Use good time management.
- Give constructive and positive feedback.
- Be aware of the participants' body language and level of participation.
- Provide clear instructions.
- Check to see if your instructions are understood.
- Evaluate and adjust as you go.
- Be patient, understanding, and empathetic.

Don'ts

- Talk to the flip chart or slide presentation.
- Block the visual aids.
- Stand in one place. Trainers should move around the room.
- Ignore participants' questions, comments, or feedback.
- Force anyone to participate.
- Shout at or criticize participants.
- Dismiss participant's beliefs or opinions.
- Let factually incorrect, biased, or judgmental statements go uncorrected.
- Let one strong participant dominate conversation.

EXAMPLE #1 OF SAMPLE TRAINING SCHEDULE

Adolescent and Youth Health Services - Training for Health Providers – 5-day Training Program

DAY 1: Introduction & Setting The Stage	DAY 2: Adolescent As A Client	DAY 3: Sexual Reproductive Health	DAY 4: Package Of Adolescent Services	DAY 5: Practicalities Of Adolescent And Youth Services
08:30 – 10:30 <ul style="list-style-type: none"> Welcome Introductions Expectations Objectives of training Overview & situational analysis 	08:30 – 08:45 <ul style="list-style-type: none"> Recap, Q&A 08:45 – 10:30 <ul style="list-style-type: none"> Values Clarification 	08:30 – 08:45 <ul style="list-style-type: none"> Recap, Q&A 08:45 – 10:00 <ul style="list-style-type: none"> The Pregnant Adolescent 10:00 – 10:30 <ul style="list-style-type: none"> The Pregnant Adolescent (cont.) 	08:30 – 08:45 <ul style="list-style-type: none"> Recap, Q&A 08:45 – 10:30 <ul style="list-style-type: none"> Tuberculosis in Adolescents Adolescents living with HIV (ALHIV) 	08:30 – 08:45 <ul style="list-style-type: none"> Recap, Q&A 08:45 – 10:30 <ul style="list-style-type: none"> Group Feedback
10:30 – 10:45 <i>TEA BREAK</i>	10:30 – 10:45 <i>TEA BREAK</i>	10:30 – 10:45 <i>TEA BREAK</i>	10:30 – 10:45 <i>TEA BREAK</i>	10:30 – 10:45 <i>TEA BREAK</i>
10:45 – 11:15 <ul style="list-style-type: none"> Overview of the Youth Health Policy 11:15 – 13:00 Nature of the Adolescence <ul style="list-style-type: none"> Development Adolescent Vulnerabilities and Adolescent Risk Taking Behaviour 	10:45 – 13:00 <ul style="list-style-type: none"> Communicating with an Adolescent Client Sexual Reproductive Health Visit (consultation, history taking and physical examination) 	10:45 – 13:00 <ul style="list-style-type: none"> Dealing with Sexual & Gender Based Violence (SGBV) 	10:45 – 13:00 <ul style="list-style-type: none"> ALHIV (cont.) 	10:45 – 12h45 <ul style="list-style-type: none"> Group Feedback 12:45 – 13:00 <ul style="list-style-type: none"> District summary and support available 13h00 – 13:30 <ul style="list-style-type: none"> Way forward (Provincial, District and Support Partner) Programme evaluation
13:00 – 13:45 <i>LUNCH</i>	13:00-13:45 <i>LUNCH</i>	13:00 – 13:45 <i>LUNCH</i>	13:00 – 13:45 <i>LUNCH</i>	
13:45 – 16:30 <ul style="list-style-type: none"> Adolescent Risk Taking Behaviour (substance abuse in adolescence) Life Skills <ul style="list-style-type: none"> Communication Negotiation skills Decision making The Very Young Adolescent 	13:45 – 15:15 <ul style="list-style-type: none"> Adolescent Contraceptive Options and decision-making 15:15 – 16:30 <ul style="list-style-type: none"> Common Sexually Transmitted Infections 	13:45 – 15:30 <ul style="list-style-type: none"> Mental Health Definition Policy guidelines (international & national) Screening & Referral pathways 15:30 – 16:30 Sexual Orientation Gender Identity, and Expression (SOGIE) <ul style="list-style-type: none"> Definitions Health services Support structures Role of the Health Care Provider 	13:45 – 15:45 Becoming an adolescent and youth friendly facility <ul style="list-style-type: none"> Quality Improvement <ul style="list-style-type: none"> QIP development for AYFS Implementation process Assessment (standards) Next steps for AYFS implementation 16:30– 16:45 <ul style="list-style-type: none"> Group discussion – implementation activities & mentoring (application as per sub-district) 	
16:30 – 16:45 <i>EVALUATION & CLOSURE</i>	16:30 – 16:45 <i>EVALUATION & CLOSURE</i>	16:30 – 16:45 <i>EVALUATION & CLOSURE</i>	16:30 – 16:45 <i>EVALUATION & CLOSURE</i>	13:30 <i>Closure, Lunch and Departure</i>

EXAMPLE #2 OF SAMPLE TRAINING SCHEDULE

	DAY 1	Day 2	Day 3	Day 4	Day 5	Day 6
TIME						
9:00 am – 10:30 am	Opening Introduction and Pre-test (1 hr, 45 min.)	"Where Are We?" Unit 4: Communicating/ Counseling (4 hrs, 30 min)	"Where Are We?" Unit 6 continued	"Where Are We?" Unit 8 continued	"Where are We?" Unit 11: Sexual Abuse (4 hrs, 15 min)	Where Are We? Unit 13: Providing Adolescent Services Assessment (1/2 day)
10:30 am – 10:45 am	Break	Break	Break	Break	<i>Break</i>	Unit 13 Assessment continued
10:45 am – 1:00 pm	Introduction continued Unit 1: Nature of Adolescence (2 hrs, 45 min.)	Unit 4 continued	Unit 7, Contraceptive Options (3 hrs, 40 min)	Unit 8 continued Unit 9: Counseling on Safer Sex (3 hrs, 45 min)	Unit 11 continued	Unit 13 Assessment continued
1:00 pm- 2:00 pm	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch

2:00 pm – 3:30 pm	Unit 1 continued Unit 2: Adolescent Vulnerabilities and Risk-Taking (55 min)	Unit 4 continued	Unit 7 continued	Unit 9 continued	Unit 11 continued Unit 12: Pregnancy, Birth, and Postpartum Issues (2 hrs, 40 min)	Unit 13 Assessment continued
3:30 pm – 3:45 pm	Break	Break	Break	Break	<i>Break</i>	<i>Break</i>
3:45 pm – 6:00 pm	Unit 3: Adolescent Behavior (1 hr, 55 min) Reflections	Unit 5: RH Visit and Adolescent Client (1 hr, 15 min) Unit 6, Safer Sex Protection (1 hr, 40 min) Reflections	Unit 8: STIs/HIV (3 hrs, 25 min) Reflections	Unit 9 continued Unit 10: Sexual Identity and Orientation (1 hr, 10 min) Reflections	Unit 12 continued Reflections	Unit 13 continued


UNIT 1: INTRODUCTION

 **UNIT TRAINING OBJECTIVE:**




To introduce participants to each other and provide an overview of the expectations for the training.

 **SPECIFIC LEARNING OBJECTIVES:**

1. Introduce participants to each other.
2. Establish shared objectives for the training.

 **TOTAL TIME: 2 hours 5 minutes**

UNIT OVERVIEW:

Session	Methods 	Materials 	Time 
1.1	Ice-breaker Interview activity	Participant Handout 1a Flipcharts and markers	1 hour
1.2	Group brainstorm	Participant Handout 1b Flipcharts and markers	30 minutes
Unit Summary	Pre-test	Participant Handout 1c	35 minutes

 **WORK FOR TRAINERS TO DO IN ADVANCE:**

- Review and prepare Participant Handouts 1a-1c

 **MAJOR REFERENCES AND TRAINING MATERIALS:**

- Amnesty International. (2011). *Facilitation Manual: A guide to using participatory methodologies for human rights education.*

SPECIFIC OBJECTIVE 1.1: INTRODUCE PARTICIPANTS TO EACH OTHER



TIME

60 minutes



METHODS

- Ice-breaker
- Pair interview



MATERIALS NEEDED

- Participant Handout 0a: Defining Expectations
- Flipcharts and markers



STEPS

Time: 30 minutes

1. Introduce yourself. Have participants stand in a circle facing each other.
2. Explain that you'll be playing a game to get to know each other. The point of this game is to learn each other's faces and names.
3. Say that participants will go around the circle in turns and introduce themselves. They should introduce themselves using their first name and the name of an animal that starts with the same letter as their name. For example, if your name is Rosa, you might say "Rosa Rhinoceros."
4. The next person should do the same. For example, if their name is Mohammed, they might say "Mohammed Mongoose."
5. After each participant says their name, they should go back to the person next to them and say their name, and then continue around the circle back to the first person. So, for example, Mohammed would introduce himself, then say "Mohammed Mongoose, Rosa Rhinoceros." If the next person is named Samuel, he might say "Samuel Snail, Mohammed Mongoose, Rosa Rhinoceros."
6. Start with the person next to you and continue around the circle away from you, so that you will be the last participant to go. With each participant, another name is added, so as the last participant you will need to say everyone's name and animal.

Time: 30 minutes

7. Once everyone has been introduced, have participants give each other a round of applause. Distribute **Participant Handout 1a: Defining Expectations**.

8. Divide participants into pairs. Give each pair **10 minutes** to interview each other using the handout.
9. Bring participants back to the circle. Have each member of each pair introduce their partner and their partner's expectations to the group. Note the responses on a flipchart.
10. Have participants review the expectations as a group.



PARTICIPANT HANDOUT 1A: DEFINING EXPECTATIONS

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

2. What is your greatest skill when it comes to providing services to adolescents?

3. Do you anticipate any difficulties during this training?

4. In the future, what would you like people to say about your work with adolescents?

5. How do you think this training will help you at work?

SPECIFIC OBJECTIVE 1.2: ESTABLISH SHARED OBJECTIVES FOR THE TRAINING



TIME

30 min



METHODS

- Group discussion
- Brainstorm



MATERIALS NEEDED

- Participant Handout 1b: Training Schedule
- Flipcharts and markers



STEPS

Time: 15 minutes

1. Distribute **Participant Handout 1b: Training Schedule** to participants. Review the units to be covered over the course of the training. Allow time for clarifying questions or concerns.
2. Ask participants which units they are particularly interested in. Ask if there are any topics they think are missing or that they want more time with.
3. Ask participants if there are topics or content they think might be challenging or difficult to discuss.

Time: 15 minutes

4. Remind participants that many topics related to sexual and reproductive health are uncomfortable and even taboo in almost all societies and cultures. To have positive discussions, it will be important to establish ground rules for how to treat each other.
5. Write “GROUND RULES” on the top of the flipchart. Ask participants to think about what agreements they want to make with each other for how they want to behave while in the training together.
6. Volunteer a rule for yourself: say “I promise to leave space for others to speak and express themselves.” Write your rule on the flipchart.
7. Have participants brainstorm other rules for each other. Supplement their brainstorm with **Supplementary Content: Ground Rules** below.

Supplemental Content: Ground Rules

- Ensure privacy and/or confidentiality.
 - Use neutral, disability-inclusive and non-judgmental language.
 - Allow space for reaction and emotion.
 - Admit when you do not know.
 - Treat each other with respect.
- 8.** Review the agreed ground rules with the group. Ask if everyone can commit to holding each other accountable to their agreements. Place the ground rules somewhere in the room where they can be accessible to all trainers and participants throughout the training.



PARTICIPANT HANDOUT 1B: TRAINING SCHEDULE

Facilitators should prepare a handout with the schedule for the training to share with participants. See the examples provided in the Introduction that can be used as models.

UNIT 1 SUMMARY



TIME

35 minutes



METHODS

- Quiz



MATERIALS NEEDED

- Participant Handout 1c: SRH Services for Adolescents Pre-Test



STEPS

1. Distribute **Participant Handout 1c: SRH Services for Adolescents Pre-Test**.
2. Remind participants that the purpose of the pre-test is to evaluate the training, not the participants, so there is no need to put their names on the test forms. Allow **30 minutes** for participants to complete the test.



PARTICIPANT HANDOUT 1C: SRH SERVICES FOR ADOLESCENTS PRE-TEST

Instructions: Write in “V” for very young adolescents (10-14) “O” for older adolescents (15-19), or “B” for both.

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

- ___ reaches physical and sexual maturity
- ___ focus on the present with limited ability to plan for the future
- ___ increased capacity for abstract thought
- ___ exhibits concern about being “normal” and frequently compares self to others in peer group
- ___ displays rapidly changing sense of sexuality and gender

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

2. Providers who are specially trained to serve adolescents are important because:

- a) Communicating with adolescents can require special care with regards to language, tone, and establishing trust.
- b) Understanding the socio-cultural pressures on adolescents can help providers understand and address adolescent risk-taking.
- c) Adolescents may need different services from adults.
- d) Life-long health habits and behaviors are established during adolescence.
- e) Adolescent clients may ask to see a training certificate.

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

- a) Heart conditions.
- b) Anemia.
- c) Depression and self-harm.
- d) Injuries.
- e) Giving birth to 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) Adolescents face sociocultural barriers to health information and services.
- c) Young people have less power to make decisions about their sexual behavior.
- d) Adolescents are more susceptible to colds, flu, and other infections.

- e) Services for adolescents are too expensive.
- f) Services are not accessible

5. Among the most important things a provider can ensure for adolescent clients are:

- a) Privacy.
- b) Popular music playing in the waiting room.
- c) Respect.
- d) A fun atmosphere.

6. Some appropriate prevention strategies for adolescents that reduce their risk of sexually transmitted infections include:

- a) Practicing abstinence from all sexual activity.
- b) Vaccination for HPV.
- c) Consistent and correct use of male and female condoms.
- d) Regular testing between partners.
- e) Douching after sex.

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

- a) IUD
- b) Combined oral contraceptives
- c) Progestin-only contraceptive (progestin-only pills, implants, injectables)
- d) Lactational amenorrhea method

8. You can assess the ability of an adolescent client to make good health decisions by:

- a) Watching for signs that the client is nervous or refuses to provide information.
- b) Looking for decisions the adolescent has made independently about their health care.
- c) Allowing the adolescent to express their opinion about their health care and considering that opinion in your advice.
- d) Their age alone.
- e) Their disability alone.

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) Spontaneous abortion.
- d) Stillbirth.
- e) Anemia.
- f) Delivery complications.

10. Which rights do adolescents have?

- a) The right to information and education about sexual and reproductive health.
- b) The right to control and protect ones' own body.
- c) The right to sexual pleasure.
- d) The right to privacy and confidentiality when accessing health services.
- e) The right to choose one's sexual and romantic partners
- f) The right to make decisions about their sexual and reproductive health.

11. What responsibilities does a provider have to disclose an adolescent client's HIV status?

- a) To disclose to the adolescent's parent/guardian.
- b) To disclose to the adolescent.
- c) To disclose to the adolescent's sexual or romantic partners.
- d) To disclose to the parent/guardian of the adolescent with disability

12. Which methods of contraception may not be suitable for an adolescent client?

- a) Emergency contraception
- b) Combined oral contraceptives
- c) Sterilization
- d) Condoms
- e) IUDs

13. Which of the following reactions are appropriate when an adolescent client is struggling with sexual orientation or gender identity?

- a) Suggesting counseling to help "fix" the problem or make it go away.
- b) Offering non-judgmental counseling and support.
- c) Ignoring the issue or telling adolescents they will "grow out of it."
- d) Electro-shock or invasive sexual treatments.
- e) Referring the adolescent to a pastor or priest.
- f) Providing SRH counseling and services with an open clinical manner.

14. Which of the following strategies are appropriate for addressing myths and misinformation about contraceptives?

- a) Using strong scientific facts.
- 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.
- e) Dismissing the rumor as "stupid" or "obviously wrong."

15. Which of the following reactions are appropriate when dealing with adolescent clients with visual

disabilities?

- a) Raising the tone of your voice.
- b) Offering non-judgmental counseling and support.
- c) Focusing on the origin of their impairment.
- d) Providing accessible information and materials.

Instructions: Write in the correct answers.

16. Name two common sources of sexual and reproductive health information for adolescents.

17. Name two models of youth-friendly service delivery that are most effective at providing services to adolescents.

18. What does dual protection mean?

19. Name the major barriers to SRH information and services youth with disabilities face.

20. What does universal design mean?

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

21. ___ International policies agreed to by a majority of the world's countries call for sexual and reproductive health information and services to be available to adolescents.

22. ___ Rape only happens to women.

23. ___ International conventions signed by a majority of the world's countries call for sexual and reproductive health information and services to be available to persons with disabilities.

24. ___ STIs cannot be transmitted through oral sex.

25. ___ Rape does not happen to youth with disabilities.

26. ___ Young persons with and without disabilities have equal rights to access sexual and reproductive health information and services.

27. ___ Young persons with disabilities are asexual.

28. ___ Young persons with disabilities are more vulnerable to contract HIV.

TRAINER'S TOOL 1A: PRE- AND POST-TEST ANSWER KEY

Instructions: Write in "V" for very young adolescents (10-14) "O" for older adolescents (15-19), or "B" for both.

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

O reaches physical and sexual maturity

V focuses on the present with little future-planning

B increasingly able to think abstractly

O has concerns about being "normal" and compares self to others in peer group

O has a rapidly changing sense of sexuality and gender

Instructions: Correct answers appear in bold below.

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) **Understanding the sociocultural pressures on adolescents can help providers address adolescent risk-taking.**
- c) Adolescents need different services from adults.
- d) **Life-long health habits are established during adolescence.**
- e) Adolescent clients may ask to see a training certificate.

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

- a) Heart conditions.
- b) **Anemia.**
- c) **Depression and self-harm.**
- d) **Injuries.**
- e) **Giving birth to 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) **Adolescents face sociocultural barriers to health information and services.**
- c) **Young people have less power to make decisions about their sexual behavior.**
- d) Adolescents are more susceptible to colds, flu, and other infections.
- e) Services for adolescents are too expensive.
- f) **Services are not accessible.**

5. Among the most important conditions a provider can ensure for the adolescent client are:
- Privacy.**
 - Popular music playing.
 - Respect.**
 - Fun atmosphere.
6. Some appropriate prevention strategies for adolescents to reduce risk of STI transmission include:
- Only abstinence from all sexual activity.
 - Vaccination for HPV.**
 - Consistent and correct use of male and female condoms.**
 - Regular testing between partners.**
 - Douching after sex.
7. The contraceptive methods that are appropriate for breast-feeding women who are more than 6 weeks post-partum are:
- IUD**
 - Combined oral contraceptives
 - Progestin-only contraceptive (progestin-only pills, implants, injectables)**
 - Lactational amenorrhea method**
8. You can assess the capacity of an adolescent client to make health decisions by:
- Watching for signs that the client is nervous or refusing to provide information.**
 - Looking for decisions the adolescent has made independently about their health care.**
 - Allowing the adolescent to express their opinion about their health care and considering that opinion in your advice.**
 - Their age alone.
 - Their disability alone.
9. Which of the following complications of pregnancy are more likely to occur in adolescents under the age of 15 compared with older women?
- Giving birth to very large babies.
 - Premature labour.**
 - Spontaneous abortion.**
 - Still birth.**
 - Anemia.**
 - Delivery complications.**
10. Which rights do adolescents have?
- The right to information and education about sexual and reproductive health.**
 - The right own, control, and protect ones' own body.**

- c) **The right to privacy and confidentiality when accessing health services.**
- d) **The right to choose one's sexual and romantic partners.**
- e) **The right to make decisions about their sexual and reproductive health.**

11. What responsibilities does a provider have to disclose an adolescent client's HIV status?

- a) To disclose to the parents/guardians of adolescents without disabilities.
- b) To disclose to the adolescent.**
- c) To disclose to the adolescent's sexual or romantic partners.
- d) To disclose to parents/guardians of an adolescents with disabilities.

(Note: This could vary in some countries. Please ensure you are familiar with standards and guidelines within your country as in some rare circumstances, there may be additional requirements related to disclosure).

12. Which methods of contraception may not be suitable to the adolescent client?

- a) Emergency contraception
- b) Combined oral contraceptives
- c) Sterilization**
- d) Condoms
- e) IUDs

13. Which of the following reactions are appropriate when an adolescent client is struggling with sexual orientation or gender identity?

- a) Suggesting counseling to help "fix" the problem or make it go away.
- b) Offering non-judgmental counseling and support.**
- c) Ignoring the issue or telling adolescents they will "grow out of it."
- d) Electro-shock or invasive sexual treatments.
- e) Referring the adolescent to a pastor or priest.
- f) Providing SRH counseling and services with an open clinical manner.**

14. 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.
- e) Dismissing the rumor as "stupid" or "obviously wrong."

Instructions: Write in the correct answers.

15. Name two common sources of sexual and reproductive health information for adolescents.

Friends/peers

Family members

Media

Social media

Internet

Library

School

Health care providers

Etc.

16. Name two models of youth-friendly service delivery that are most effective at providing services to adolescents.

Standalone clinic

Separate space for YFS

YFS mainstreamed into existing services

Mobile outreach/mobile services

Community-based services

Drug shops/pharmacies

Non-health settings (workplace, school, etc.)

17. What does dual protection mean?

Dual protection is the use of one or more contraceptive methods to prevent pregnancy, STIs and HIV. Condoms (male and female) are the only method that can provide dual protection against unintended pregnancies *and* STIs. Dual protection can also be achieved by using a hormonal method of contraception, such as oral contraceptives or an implant to protect from unintended pregnancy, along with the use of a male or female condom to protect against STIs and HIV.

Instructions: Write “T” for true and “F” for false.

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

19. F Rape only happens to women.

20. _F_ STIs cannot be transmitted through oral sex.
21. _T_ Young persons with and without disabilities have equal rights to access sexual and reproductive health information and services.
22. _F_ Young persons with disabilities are asexual.
23. _T_ Young persons with disabilities are more vulnerable to contract HIV.
24. _T_ Young persons with and without disabilities have similar SRH needs.

UNIT 2: NATURE OF ADOLESCENCE

INTRODUCTION:

Adolescence is a life stage of change and transition. The World Health Organization (WHO) defines adolescence as the period between the ages of 10 and 19. During adolescence, young people experience the process of physical, psychological, and social maturation, which marks the transition from childhood to adulthood. Many adolescents are exploring and coping with their changing bodies as well as their changing emotions and thoughts. They are building life skills, such as communication and decision-making, and testing their boundaries and limits.

Adolescence is a time of opportunity but also a time of risk, especially in terms of sexual and reproductive health. They may face social pressures around sex, sexuality and gender, and may make unhealthy or unsafe choices. Counselors and care providers need to understand and normalize the stages of adolescence and be prepared to help adolescents remain healthy. Acknowledging the human, sexual and reproductive rights of all adolescents independently from their age, sex, gender identity, sexual orientation, disability, ethnicity, race, religion and other status is a key foundation for the provision of quality services.


UNIT TRAINING OBJECTIVE:

To help providers understand why adolescent sexual and reproductive health is important to understand the stages of adolescent development, the evolving capacity of adolescents to make health decisions, the desired state of health and well-being, and the sexual and reproductive rights of adolescents.




SPECIFIC LEARNING OBJECTIVES:

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

- Explain the rationale for special training on adolescent sexual and reproductive health.
- Identify physical, cognitive, social and emotional changes that occur during adolescence.
- Understand and apply the concept of evolving capacity to promote adolescent health and well-being.
- Identify the sexual and reproductive rights of adolescents.

 *TOTAL TIME: 6 HOURS 35 MINUTES*

UNIT OVERVIEW:

Session	Methods 	Materials 	Time 
2.1	Storytelling exercise Group discussion Brainstorm	Flipcharts and markers Red cards for each participant	1 hour
2.2	Brainstorm Trainer presentation	Flipcharts and markers Slides 2.1-2.7 Participant Handout 2a	1 hour 10 minutes
2.3	Group activity Trainer presentation Group discussion Case studies	Flipcharts and markers Slides 2.8-2.10 Life event cards and tape or post-its – Trainer’s resource 2a	2 hours 25 minutes
2.4	Trainer presentation Small group activity	Flipcharts and markers Slides 2.11-2.16 Participant Handout 2b	1 hour 40 minutes
Unit Summary	Reflection	None	20 minutes



WORK FOR TRAINERS TO DO IN ADVANCE:

- Prepare Participant Handouts and props for role play (refer to red cards).
- Review PPT Slides 2.1-2.16
- SO #2.3: Write out age ranges on cards or flip charts.

- SO #2.3: Write out or print life events on cards for group activity.
- SO #2.3: Write out Agree/Disagree/Not Sure on flip charts.
- Where possible, be familiar with the local policies/regulations concerning adolescent access to services, including age of consent to sexual activity or to seek medical services, laws regarding parental/spousal consent, laws regarding married/unmarried adolescents seeking services, and any regulations on services or commodities for adolescents. Find out if and how these policies, regulations, and laws refer to young persons with disabilities.



MAJOR REFERENCES AND TRAINING MATERIALS:

Amnesty International. (2015). *Respect My Rights, Respect My Dignity: Module 3 – Sexual and Reproductive Rights are Human Rights*. London: Amnesty International.

IPPF. (2011). *Exclaim! Young People’s Guide to Sexual Rights: An IPPF Declaration*. London: IPPF.

IPPF. (2012). *Keys to Youth-Friendly Services: Understanding evolving capacity*. London: IPPF.

IPPF. (2012). *Understanding Young People’s Right to Decide 01: What is childhood and what do we mean by ‘young person’?* London: IPPF.

Sawyer, S., Afifi, R., Bearinger, L., Blackmore, S-J., Dick, B., Ezeh, A., & Patton, G. (2012). *Adolescence: A foundation for future health*. *Lancet* 2012; 379: 1630-1640.

Stackpool-Moore, Lucy and Singh, S. (2015). *Sexual and reproductive health and rights and HIV 101 workshop guide*. East Sussex: International HIV/AIDS Alliance.

SPECIFIC OBJECTIVE 2.1: EXPLAIN THE RATIONALE FOR UNDERGOING A SPECIAL TRAINING FOR ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH



TIME

60 min



METHODS

- Storytelling exercise
- Group discussion
- Brainstorm



MATERIALS NEEDED

- Red cards for each participant
- Flipcharts and markers



STEPS

Time: 30 minutes

1. Introduce the exercise to participants by explaining that volunteers will act out a story as the trainer reads it aloud.
2. Tell participants that adolescents often encounter many barriers to obtaining sexual and reproductive health information and services. This exercise is intended to help participants explore those barriers and generate solutions to address them.
3. Ask for volunteers to play the following roles:
 - Abena, a 16-year-old woman
 - Clinic administrator/receptionist
 - Three women in waiting room
 - Nurse
 - Doctor
4. The rest of the participants should all have a red card. Instruct the participants that they should hold up the red card, like a football referee, when they think Abena has encountered any kind of barrier to her ability to obtain services.
5. Read **Content: Abena's Story** below aloud. The volunteers will act out what they hear. The other participants will listen for potential barriers and display their red card when they hear one.

Content: Abena's Story

My name is Abena. I am sixteen years old. I live 5 kilometres from here. I don't go to school, and I normally sell biscuits on the roadside to earn money for my mother and younger siblings.

I have a boyfriend and I don't want to fall pregnant. Some of the girls that I sell with have fallen pregnant. For one or two girls, their lives have gotten much harder. One girl doesn't have support from the father and another was sent away to the country. I know that there are pills you can take to prevent pregnancy, but you have to go the clinic to get them, and it's not easy for me to find the time to go to the clinic. I am also afraid because I have heard bad things about the clinic and there are lots of rumors about what will happen to you if you take contraception.

Last week, I decided to go to the clinic because I had a pregnancy scare. I went to the clinic early in the morning because I needed to get back to sell before the day ended. When I arrived at the clinic there were several women with small children waiting outside. I made sure none of them knew me, but when I walked up they kept looking at me and whispering. One of the older women asked me why I was there since the clinic was only for married women with children. She told me this was no place for a "small girl" like myself.

The staff was late to arrive. I sat there for over an hour waiting for the front doors of the clinic to open. Because I had come early, I had not yet had breakfast and I was hungry and thirsty.

Once the clinic opened at 8 am, I wondered how I would get to talk with the nurse. I finally got up enough courage to speak to the woman behind the table with a sign saying "reception." When I approached, her face became stern. She asked me why I was here and why I wasn't in school. When I explained that I wanted to talk with a nurse, she asked me why I needed to see the nurse. I was too embarrassed to tell her why I was here. She then told me that the morning was only for antenatal clinic and for maternal and child health services. She said that I would have to come back later in the day. When I asked her what time I should come back, she just ignored me.

I had nowhere to go, so I sat down under a tree nearby while I waited to be seen. I still hadn't eaten anything, and I had to keep watch to make sure no one saw me at the clinic. Once, I thought I saw a woman who sells near me and ran to hide behind a building until she was gone. Around noon, I asked the receptionist when I could see the nurse, but she told me that the nurses had gone for lunch and they would resume clinic in an hour. The receptionist was still very unfriendly. I could tell she didn't think I should be there.

After an hour and a half, the nurses came back, and the receptionist directed me to the exam room. When I went into the exam room, the nurse looked annoyed. She asked me why I was there. I told her that I didn't want to fall pregnant and I had heard there were some pills to take to prevent pregnancy. She told me that if I didn't want to become pregnant then I shouldn't

have sex. She said I should be in school or helping at home and not running around with boys. She told me that boys were only a distraction and only wanted one thing.

I told her that I wasn't running around with boys and that I had a longtime boyfriend. The way she was looking at me, I could tell that she thought I was promiscuous. She told me that before I could use the pill, I would have to be sure that I was not pregnant and that I would have to come back when I had my menstruation.

On the way home, I thought about whether I would go back. I didn't want to fall pregnant, but I was embarrassed by the way the nurse treated me, like she thought I was a bad person. I was also worried because it would mean another day when I wasn't working. The next few days were very stressful for me. Finally, I decided that I would go again when next I had my menstruation. This time, I didn't arrive so early, but I was still worried I might meet someone I knew. After I arrived at the clinic, I went to the receptionist. It was the same person as last time. She again asked me why I was there, and when I told her why I was there she repeated in a very loud voice 'oh, so you are here for family planning.' I could feel all the women in the waiting room staring at my back. I was so embarrassed.

The receptionist told me to go back to see the nurse for counseling. There wasn't really a room for counseling, just a desk with a curtain so everyone could hear what was being said. I started to explain to the nurse why I was there, but then another nurse came over and interrupted me to talk about another patient. They both ignored me and I felt both ashamed and angry. When the other nurse was finished and walked away, my nurse sighed loudly and looked at her watch impatiently. She then asked me if I was having my menstruation. When I said yes, she pulled a packet of pills out of her desk and told me if I did not want to become pregnant, I should take these pills. She talked very fast and used a lot of words I didn't know. For example, she talked about "side effects" but I didn't understand what she meant. She also talked about what might happen to me from taking the pill. It sounded very frightening, and I just wanted to leave, even though I also wanted to ask how the pills prevent pregnancy and do the pills make you infertile and do they in fact make you promiscuous and will I gain a lot of weight?

She told me to come back to the clinic when I had two or three pills left. The next day, I started taking the pill every morning. Since I began taking the pills, sometimes I feel nauseous and I get headaches. My breasts are sore, too. Sometimes I forget to take the pill. I try to remember what the nurse said about the pills, but it was very confusing, and I am afraid to go back again to the clinic. I am worried that the pills might make me infertile. I think I will just stop taking them and pray to God that I don't get pregnant.

Time: 15 minutes

6. Bring all participants together in a group to discuss the types of barriers they found in the story and brainstorm other types of barriers adolescents face when seeking sexual and reproductive health services.

Ask participants to brainstorm barriers Abena would face if she had one or multiple disabilities.

Supplement participants' conversation with information from **Supplemental Content: Barriers for Adolescents** below, as needed.

Supplemental Content: Barriers for Adolescents

Adolescents face many barriers to access comprehensive information and services for sexual and reproductive health. The service provider who sees the value of reaching adolescents may also have to convince their colleagues and managers that all adolescents have a right to services independent of their age, sex, gender identity, sexual orientation, disability, ethnicity, race, religion and other status. Service providers may have to come up with effective ways to educate, counsel, and provide services to all adolescents.

Barriers come in many forms and can be both internal to the adolescent as well as external. Some examples of the types of barriers young people face are listed below. You can add these points where relevant to the barriers generated by participants.

Internal Barriers

- Lack of knowledge about sexuality.
- Lack of knowledge on contraception.
- Shame related to sexual activity, whether consensual, coerced, or abusive.
- Fear about contraceptive methods.
- Lack of knowledge on how to navigate clinical services.
- Anxiety about being seen at the clinic.
- Lack of self-confidence.

Legal Barriers

Laws and policies that:

- Mandate an age of consent to sexual activity.
- Require parental/guardian or spousal consent for medical and/or sexual and reproductive health services.
- Restrict what types of services or contraceptive methods are available to adolescents based on age, disability, marital, parity, or other status.
- Prevent health care workers or other professionals from providing condoms or other contraceptives to adolescents in certain settings, such as schools, or youth clubs.
- Require waiting periods for certain services or methods, such as emergency contraception or safe abortion services.
- Overlook the rights and needs of young persons with disabilities and lack a disability inclusion perspective.

Structural/Economic Barriers

- Limited clinic hours, or clinic hours that overlap with times when adolescents are typically in school or working.
- Few providers trained to provide services to young people and adolescents.
- Services for adolescents only available in select clinics, instead of being available at all facilities.
- Youth-friendly services not available within a reasonable distance from the community they aim to serve.
- Services accessible to persons with disabilities not available within a reasonable distance from the community they aim to serve.
- Lack of or limited accessible and affordable transportation to the clinic.
- Stock-outs or shortages in contraceptives or other sexual health-related commodities.
- Limited contraceptive choice provided to adolescent clients.
- Lack of audio and visual privacy and confidentiality in facilities.
- High cost for services or products.
- Loss of income related to spending time at a clinic.
- Extra or hidden fees for services, testing, or contraceptives.

Socio-cultural Barriers

- Provider, parent, teacher, and community attitudes that are not supportive of youth and sexuality.
- Beliefs that young people are not sexually active.
- Beliefs that young persons with disabilities are asexual or hypersexual.
- Ignorance about SRH needs and rights of young persons with disabilities.
- Concern that providing SRH information and/or services will result in sexual activity.
- Community stigma against non-marital sexual activity.
- Community norms that expect young married couples to demonstrate fertility.
- Community norms that limit youth voice and discourage young people from asking questions about sex or sexuality or sexual health.
- Gender inequalities and stereotypes that acknowledge adolescent boys' sexuality and condemn adolescent girls' sexual health needs and sexuality.
- Pervasive myths and misinformation about sex, sexual health, and side effects of contraceptives.
- Pervasive myths and misinformation about sexuality and disability.
- Stigma and exclusion of persons with disabilities.

Time: 15 minutes

7. Ask participants to identify what issues raised in the story could be addressed through provider training. Ask if it's important for providers to have specialized training on adolescent sexual and

reproductive health. Ask if it's important for providers to have specialized training on sexual and reproductive health and disability. What other things are needed besides specialized training for providers? Supplement participants observations as needed with information below:



Supplemental Content: Adolescence and Services for Adolescents

What is Adolescence?

The World Health Organization (WHO) defines adolescence as the period between the ages of 10 and 19. Adolescence is a stage of life defined by change and transition where young people experience physical, psychological, emotional, cognitive and social maturation which marks the change from childhood to adulthood. This is often a time of exploration of beliefs, ideas and values, and the testing of boundaries and limits, while simultaneously developing new skills such as communication and decision-making.

Why do adolescents need specialized attention?

Well-trained and non-judgmental health professionals can help adolescents make informed choices that protect as well as empower them through the counseling, education, and clinical care they provide:

- Adolescence is an opportunity to help young people establish health behaviors and habits that last their whole lives.
- Adolescents may lack the information and skills they need to make good health decisions.
- Adolescents may face social stigma based on their age, gender, sexuality, disability, or other factors. They may be confused or feel ashamed of their emerging sexuality. These and other factors may prevent them from seeking or accessing information and services.
- Adolescents can be particularly vulnerable to sexual coercion, abuse, violence, and harmful traditional practices which expose them to health and social risks. Adolescents with disabilities are 3 to 4 times more likely than their peers without disabilities to experience sexual coercion, violence, and abuse.
- Adolescents may have to cope with multiple socio-cultural, legal, and structural barriers that influence their ability to seek or access services.
- Adolescents may require more time with counselors, service providers, and other health professionals. Providers are frequently asked to play a dual role of service provider and educator/counselor to adolescents in their care, especially in regard to sexual and reproductive health.
- There may be specific laws and policies that are directed at adolescents that differentiate them from older/married clients and may require specific responses.

SPECIFIC OBJECTIVE 2.2: IDENTIFY THE CHANGES THAT OCCUR DURING ADOLESCENCE



TIME

1 hour 10 minutes



METHODS

- Brainstorm
- Trainer Presentation



MATERIALS NEEDED

- Flipcharts and markers
- Slides 2.1-2.7
- Participant Handout 2a: Developmental Characteristics of Adolescence and Young Adulthood



STEPS

Time: 40 minutes

1. Introduce the activity to participants by explaining that they will work in two groups to brainstorm the many changes that adolescents experience. Point out that it is important to understand and accept adolescent development as normal and natural so as to be able to work with adolescents in a respectful, inclusive and positive way.
2. Divide participants into two groups, assign each group a stage of adolescence (very young adolescents aged 10-14, and older adolescents aged 15-19), and give each group a flipchart.
3. Ask groups to spend **3-5 minutes** thinking about their own experiences as adolescents, or to think about an adolescent they might be close to. Give **15 minutes** for groups to list the changes and experiences that occur during adolescence. Emphasize that adolescence is a time not only of physical change, but also intellectual, social, and emotional growth.
4. Bring groups back together to present to each other and discuss each other's lists.

Time: 30 minutes

5. Pass out **Participant Handout 2a: Developmental Characteristics of Adolescence and Young Adulthood** and present the **Content: Changes During Adolescence** below (**Slides 2.1-2.7**). Tell participants they can follow along on the handout.

Content: Changes During Adolescence (Slides 2.1-2.2)

Adolescence as a life stage was first recognized in the 20th century and is now understood by the WHO and many countries as the stage of life that occurs between the ages of 10 and 19.

Adolescence is characterized by **change** in young people's physical, cognitive, and social and emotional development.

The following changes are typical for adolescence, though individual young people will mature and experience change at different rates.

Slide 2.3: Physical Changes

- *Early Adolescence (aged 10-14):*
 - Puberty
 - Growth of body hair
 - Increased perspiration and oil production in hair and skin
 - Physical growth (both height and weight)
 - Breast and hip development and onset of menstruation (girls)
 - Growth of testicles and penis, wet dreams, and deepening of voice (boys)
- *Late Adolescence (aged 15-19):*
 - Physical growth slows for girls
 - Physical growth continues for boys

Slide 2.4: Cognitive Changes

- *Early Adolescence (aged 10-14):*
 - Mostly interested in present with little thought for future
 - Tend towards concrete thinking, although capacity for abstract thinking begins to evolve
 - Expansion of and increased importance placed on intellectual interests
 - Deepening of moral thought
- *Late Adolescence (aged 15-19):*
 - Continued growth in capacity for abstract thought
 - Increased and evolving capacity for goal-setting and decision-making
 - Interest in moral reasoning
 - Growth in connection to peer group and community
 - Questioning of faith, beliefs, and meaning of life
 - Growing interest in social justice, equity, and fairness

Slide 2.5-2.6: Social and Emotional Changes

- *Early Adolescence (aged 10-14):*
 - Struggle with "who they are"
 - Feel awkward about themselves and their body
 - Worry about being "normal"
 - Become more critical of and experience conflict with parents
 - Increasingly identify with their peers

- Experience greater desire for independence
 - Experience sudden changes in mood
 - Test rules and boundaries
 - Demonstrate increased interest in privacy
 - Are increasingly aware of their sexual feelings
 - *Late Adolescence (aged 15-19):*
 - Are intensely self-involved and may alternate between high expectations for and poor understanding of self
 - Cope with changing body
 - Experience swings in self-esteem and confidence
 - Worry about being “normal” while comparing self to others in peer group
 - May experience rapid changes and internal conflicts in their understanding of sexuality and gender
 - Demonstrate a heightened sense of justice and fairness
 - Have an increased need for independence and increasingly distance themselves from parents or other authority figures
 - Become more aware of family and community responsibilities
 - Become reliant on networks of friends and peer group
 - Begin to experience the ability to regulate their emotions
 - Begin to experience feelings of love and passion
 - Show increased interest in relationships and sex
6. Pause here and ask participants if any of this sounds familiar. If there is time, invite participants to share stories with each other or the group about their memories of adolescence.
7. Conclude your presentation by saying the following (**Slides 2.7**):

Although we define adolescence as those between the ages of 10 and 19, young people aged 20-24 can also be considered as the final stage of adolescence or “young adulthood.” During the early 20s, young people continue to mature and research shows that the brain continues to develop until the mid-20s. In young adulthood, young people once again become closer to their families and communities, but these years may still be a time of uncertainty. Young people feel social pressure and experience new types of challenges related to their schooling, employment, and decisions about intimate and family relationships. No matter when they decide to begin a sexual relationship, they have the right to the information and services they need to protect themselves from unwanted SRH outcomes.

PARTICIPANT HANDOUT 2A: DEVELOPMENTAL CHARACTERISTICS OF ADOLESCENCE AND YOUNG ADULTHOOD (SOURCE: THE LANCET ADOLESCENT HEALTH 2012)

[HTTPS://WWW.THELANCET.COM/SERIES/A DOLESCENT-HEALTH-2012](https://www.thelancet.com/series/adolescent-health-2012)

	Physical Development	Cognitive Development	Social and Emotional Development
Early Adolescence			
Puberty (10-14)	<ul style="list-style-type: none"> • Growth of body hair • Increased perspiration and oil production • Physical growth (height and weight) • Breast and hip development and onset of menstruation (girls) • Growth of testicles and penis, wet dreams, and deepening of voice (boys) 	<ul style="list-style-type: none"> • Increased capacity for abstract thought • Mostly interested in present with little thought for future • Increased importance placed on intellectual interests • Deepening of moral thought 	<ul style="list-style-type: none"> • Struggle with sense of identity • Feel awkward about self and body • Worry about being “ normal” • More critical of and heightened conflict with parents • Increased identification with peer group • Increased desire for independence • Mood swings • Testing of rules and boundaries • Increased interest in privacy • Increased awareness of sexual desire
Late Adolescence (15-19)	<ul style="list-style-type: none"> • Physical growth slows for girls but continues for boys 	<ul style="list-style-type: none"> • Continued growth in capacity for abstract thought • Increased and evolving capacity for goal-setting and decision-making • Increased interest in moral reasoning • Stronger connection to peer group, community • Increased questioning of faith, beliefs, and meaning of life • Growing interest in social justice, equity, and fairness 	<ul style="list-style-type: none"> • Intense self-involvement, alternates between high expectations and poor self-identity • Adjustments to changing body and swings in self-esteem and confidence • Worry about being “ normal” and comparing of self to others in peer group • Fluid or rapidly changing understanding of sexuality and gender • Heightened sense of justice and fairness • Increased drive for independence and distance from parents/authority figures • Increased awareness of responsibilities to family and community • Greater reliance on friendship networks and peer group • Heightened capacity for emotional regulation • Feelings of love and passion; increasing interest in sex
Young Adulthood (20-24)	<ul style="list-style-type: none"> • Young women typically fully physically developed • Young men continue to gain height, weight, muscle mass, and body hair 	<ul style="list-style-type: none"> • Ability to plan ideas from beginning to end • Increased ability to delay gratification • Deeper examination of inner experiences • Increased concern for the future • Deepening of moral reasoning 	<ul style="list-style-type: none"> • Firmer sense of independent and sexual identity • Increased emotional stability and self-reliance • Deeper connections to peers, community and Family relationships • Regrowth of interest in social and cultural traditions • Development of serious romantic relationships

SPECIFIC OBJECTIVE 2.3: UNDERSTAND AND APPLY THE CONCEPT OF EVOLVING CAPACITY TO PROMOTE ADOLESCENT HEALTH AND WELL-BEING

TIME

2 hours 35 minutes

METHODS

- Group activity
- Trainer presentation
- Group discussion
- Case Studies

MATERIALS NEEDED

- Flipcharts and markers
- Slides 2.8-2.10
- Prepare Life Event cards so that each participant has at least three Life Event cards. (Use Trainer's Resource 2a)

STEPS

Time: 1 hour 15 minutes

1. Place cards or flip charts around the room with the following age ranges written on them:
 - 8-10 years
 - 11-12 years
 - 13-15 years
 - 16-19 years
 - 20-24 years
2. Distribute 3 life event cards to each person.
3. Ask participants to take **10-15 minutes** to go around the room and tape each of their life event cards under the sign or on the flip chart for the age range when they think it should happen. Stress to participants that there are no right or wrong answers to this exercise.
4. Gather participants at the flip chart for the youngest age range (8-10 years) and review which cards are taped here. Ask if there are strong reactions to any of the cards: does anyone feel strongly that cards should be moved to a later age? Are any missing? What common cards are here?
5. Repeat with each successive age range. Are there patterns in what ages certain events show up

in? Are there clear disagreements? Is there a difference between when things “should” happen and when they most commonly do happen?

6. Remind participants that everyone has a different experience of adolescence, whether from their own childhood or from watching their children and young people in the community go through adolescence. Say: It can be hard to find a “right” time for anything, which is why it is so important to understand adolescence as a time of individual change and evolving capacity.

Time: 10 minutes

7. Ask participants to revisit **Participant Handout 1a** from the previous session which outlines the physical, cognitive, and social and emotional changes that adolescents experience. Ask participants to reflect for a moment on how these changes may affect the adolescent’s ability to cope with the life events presented here to make their own sexual and reproductive health decisions.
8. Introduce the concept of evolving capacity by presenting **Content: Evolving Capacity (Slides 2.8-2.10)** below.

Content: Evolving Capacity (Slides 2.8-2.10)

In 1989, the United Nations Convention on the Rights of the Child adopted the concept of “evolving capacity.” This term has special meaning for health providers who work with adolescents. Evolving capacity integrates ideas about individuality, autonomy, and empowerment, meaning that as children acquire enhanced competencies, there is less need for protection and a greater capacity to take responsibility for decisions affecting their lives. The Convention also recognizes that children in different environments, cultures, and faced with diverse life experiences will acquire competencies at different ages. Health care providers can contribute balancing young people’s need for accurate information and guidance while acknowledging their desire to make independent decisions -- including about sex and sexuality.

Slide 2.9-2.10: Evolving Capacity

How does one assess the actual evolving capacity of an individual adolescent client? Here are some simple points to keep in mind:

- Young people have valuable knowledge about their own health and well-being. Encourage dialogue and listen to what young people have to say – both verbally and non-verbally.
- Determine if adolescents are voluntarily seeking services. Give adolescents information, explore choices and provide them with opportunities to make their own decisions. At a minimum, **all** young people have a right to express an opinion and to have that opinion considered in decisions about their health care. Don’t make decisions for them.

- Always regard adolescents as your main interlocutors, even when they visit a clinic accompanied by a family member or caregiver.
- Disability does not necessarily affect adolescents' capacity to take action for their own wellbeing, but many people mistakenly believe the opposite. Allow yourself to fully assess the capacity of all adolescents—independent of their disability. Ensure you give all adolescents the opportunity to express themselves and make their own decisions.
- The decision to visit a clinic already demonstrates responsibility and willingness to take action for their own health and wellbeing. Acknowledge and commend their action.

Time: 1 hour

9. Tell participants that we are going to do a group activity to help them better understand the concept of evolving capacities. Explain that you will read aloud several statements and you will invite participants to express their opinions of the statement. Emphasize that there are no right or wrong answers, only opinions.
10. Write 'Agree' on a sheet of flipchart paper or a card, 'Disagree' on a second sheet, and 'Not Sure' on a third sheet. Place the sheets around the room with space for participants to move between them. Explain to participants that they should move to the sign that best reflects their opinion after each statement is read.
11. Read aloud the Part 1 of Case Study 1 from **Content: Case Studies** below. Ask participants to move and stand next to the sign that best represents their feeling about the scenario. Then read aloud the second part of the case study and tell participants they can change their position if they wish. Ask participants why they chose their position, and whether the extra information contributed to changing their opinion. Repeat with each of the case studies.

➤ **Note to Trainer:** *If you like, you can change the age and sex of the characters and include a disability factor to see if this makes people change their opinion. If they do, ask what would be the 'right' age for the character(s) to make their decision and why, or why the sex and the disability of the character matters. This helps emphasize the importance of separating age, sex, and disability from the capacity and abilities of the individual, as well as their circumstances.*

Content: Case Studies

Case Study 1:

- **Part 1:** You are a service provider. A young woman aged 17 has come to you for a pregnancy test. The test is negative, but during counseling she reveals that she and her partner aren't using condoms or any modern contraceptive method. She asks you if will provide her with emergency contraceptive pills for the next time her boyfriend doesn't pull out in time.

- *Do you think you should provide this young woman with emergency contraception, as requested?*
 - *Would you change your response if the young woman has a physical, sensory, mental or psychosocial disability?*
 - *Would you change your response if the young woman has an intellectual and developmental disability?*
- *Part 2:* The young woman reveals that when her boyfriend drinks, he is violent towards her. She has told him she wants to use contraception, but this has made him angry. She wants to break off the relationship and is waiting for a safe time to do so.
 - *Would you change your response as a result of this new information?*

Case Study 2:

- *Part 1:* You are a service provider in a mobile clinic. While visiting a community in a remote area, a 15-year-old adolescent girl comes to you and asks for a contraceptive method that she can keep hidden from her family.
 - *Do you think this young woman should have access to a contraceptive method without her parents' knowledge or consent?*
 - *Would you change your response if the young woman had a physical, sensory, mental or psychosocial disability?*
 - *Would you change your response if the young woman had an intellectual and developmental disability?*
- *Part 2:* The adolescent confides that her parents are forcing her to marry an older man in the village when she turns 16 next month. She knows this means that she will have to have sex, but she doesn't want to get pregnant right away, so that she can finish secondary school.
 - *Would you change your response as a result of this new information?*

Case Study 3:

- *Part 1:* You are a nurse in a clinic that serves mostly people living in a slum area. A young man aged 16 comes in asking for an HIV test. During counseling, you learn that that he is in a relationship with a 30-year-old adult who pays him for sex. The young man clearly states that he is happy for this situation to continue.
 - *Do you think this young man is capable of making a decision to continue the*

relationship?

- *Would you change your response if the young man has a physical, sensory, mental or psychosocial disability?*
- *Would you change your response if the young man has an intellectual and developmental disability?*

- *Part 2:* The young man then tells you that following the death of his mother, he lived on the streets for several years. Now, he is able to support his two younger siblings to remain in school.

- *Would you change your response because of this new information?*

- 12.** Remind participants that there are no easy answers. Providers are constantly being asked to use their best judgment about the interests of and services for their clients. A provider must balance the need to protect adolescents and also empower them to make their own decisions.
- 13.** Bring participants back for feedback and discussion. Ensure participants understand that cases like these are difficult because they challenge our attitudes and beliefs, as well as what is legal, acceptable, just, and ethical. It is important that providers recognize cases where there are different interests at play, and to know the tools (such as the key points for assessing capacity, presented in slides) that can help you provide the appropriate service.

Get a job

Finish school

**Learn about sex and sexual
health**

Learn about contraception

**Start becoming interested
in the opposite sex**

Have a serious relationship

**Learn about puberty and
menstruation**

**Learn about puberty and
“wet dreams”**

Have first kiss

**Have first sexual
experience**

Learn a trade

**Contribute to the
household income**

Leave home

Go to the market alone

Travel alone

Go to a dance club or bar

Have close friends of the same sex

Have close friends of the opposite sex

Visit a health provider

Learn about sexual orientation

Explore masturbation

Learn about sexual pleasure

SPECIFIC OBJECTIVE 2.4: IDENTIFY THE SEXUAL AND REPRODUCTIVE RIGHTS OF ADOLESCENTS

TIME

1 hour 40 minutes

METHODS

- Trainer presentation
- Small group activity

MATERIALS NEEDED

- Slides 2.11-2.16
- Flipcharts and markers
- Participant Handout 2b: Adolescent Sexual and Reproductive Rights

STEPS

Time: 40 minutes

1. Introduce the concept of sexual rights and reproductive rights using **Content: Sexual Rights and Reproductive Rights** below (**Slides 2.11-2.16**).

Content: Sexual Rights and Reproductive Rights (Slides 2.11-2.16)

Slide 2.11- 2.12: Human Rights: Sexual and Reproductive Health (SRH) and Rights include all Adolescents

The United Nations states that human rights are rights inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, disability, or any other status.

Human rights include the right to life and liberty, freedom from slavery and torture, freedom of opinion and expression, the right to work and education, the right to vote, the right to health, the right to equality, and many more. The right to health includes sexual and reproductive health.

UNFPA states that good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so.

People need access to accurate information and the safe, effective, affordable and acceptable contraception method of their choice. They must be informed and empowered to protect themselves from sexually transmitted infections and HIV. And when they decide to have children, women must have access to services that can help them have a healthy pregnancy, safe delivery, and healthy baby.

Every individual, including adolescent, has the right to make their own choices about their sexual and reproductive health. This includes the right to make well-informed, independent decisions, and to be provided with information about sexuality and sexual and reproductive health (SRH) and well-being guidance from a trained professional, and quality SRH services. Adolescents with disabilities have the same SRH rights of their peers without disabilities. These equal rights are affirmed by articles 23 and 25 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD), a comprehensive human right instrument adopted in December 2006 and currently ratified by 177 states. Please refer to the chapter “Adolescents with disabilities” to learn more about the CRPD.

Slide 2.13: SRH Definitions

The WHO defines sexual health as: *a state of physical, mental and social well-being in relation to **sexuality**. It requires a positive and respectful approach to **sexuality** and **sexual** relationships, as well as the possibility of having pleasurable and safe **sexual** experiences, free of coercion, discrimination and violence.*

Source: World Health Organization

The UN defines reproductive health as: *a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity. Reproductive health deals with the reproductive processes, functions and system at all stages of life.*

Source: UNFPA

Slide 2.14: Sources for Sexual and Reproductive Rights (SRR)

Sexual and reproductive rights come from established human rights principles and protections. These protections are spelled out in national laws and policies, regional human rights documents and in major international conventions, including:

- The Program of Action of the 1994 International Conference on Population and Development and subsequent review documents
 - The Program of Action of the 1995 4th World Conference on Women
 - The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW)
 - The Convention on the Rights of the Child
 - The Convention on the Rights of Persons with Disabilities (CRPD)
 - The Maputo Protocol on the Rights of Women in Africa
 - The agreed conclusions of the annual Commission on the Status of Women and the Commission on Population and Development
2. Pause and ask participants to brainstorm some examples of sexual and reproductive rights that they think apply to adolescents. Return to the presentation with **Slide 2.15: Adolescents’ Sexual**

and Reproductive Rights

Slide 2.15: Adolescents' Sexual and Reproductive Rights

Policies and conventions establish that everyone, including adolescents, have the right to freely, without fear, coercion, violence, or discrimination:

- Make decisions about their own health, body, sexual life, and identity.
- Ask for and receive information about sex, contraception, and related health services.
- Have access to comprehensive education on human sexuality, sexual and reproductive health, human rights, and gender equality.
- Decide whether and when to have children.
- Choose whether or not to marry and what type of family to create.
- Have access to comprehensive and integrated sexual and reproductive health services.
- Live free from rape and other violence, including forced pregnancy, forced abortion, sterilization without consent, forced marriage, or female genital mutilation/cutting.

Source: Amnesty International

Slide 2.16: Sexual Rights

Good sexual and reproductive health is underpinned by sexual rights. Many governments, institutions, and individuals deny young people's sexuality and agency and promote the common misconception that young people are not, or should not be, sexual beings. Sexual rights, when applied to adolescents, includes the following principles:

- Sexuality is an integral part of being human for all young people.
- Sexuality and sexual pleasure are important for all young people, regardless of reproductive desires.
- The evolving capacities of all children and young people must be recognized.

Time: 1 hour

3. Distribute **Participant Handout 2b: Adolescent Sexual and Reproductive Rights** and ask participants to divide into small groups of 3-4 people each. Divide the rights listed on the handout according to the number of groups so that each group has a different set of rights to discuss. Ask participants to take **30 minutes** to look at their set of rights and discuss the following questions:
 - What are some barriers that might prevent each of the rights from being fulfilled? Can you list some barriers that are specific to young persons with disabilities? What are some steps I can take in my clinic/service location to address these barriers?
4. Ask the small groups to report back their ideas to the larger group and discuss common or unique ideas with each other.

PARTICIPANT HANDOUT 2B: ADOLESCENT SEXUAL AND REPRODUCTIVE RIGHTS
Adapted from International Planned Parenthood Federation's Rights of the Client

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.

The right to own, control, and protect ones' own body.

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

The right to expect and demand equality, full consent, and mutual respect in sexual relationships.

The right to quality, affordable and accessible sexual and reproductive health care regardless of sex, disability, creed, color, marital status, parity, sexual orientation, gender identity, HIV status, or location.

The right to audio and visual privacy and confidentiality when consulting 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, and to safe expression of one's gender identity.

The right to receive sexual and 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.

UNIT 2 SUMMARY



TIME

20 minutes



METHODS

- Reflection



MATERIALS NEEDED

- None



STEPS

1. Ask participants to reflect on everything they've discussed as part of this unit. In plenary, ask participants to comment on the following questions:
 - What are some of the challenges we as service providers face in providing adolescent sexual and reproductive health services? Please reflect on the challenges in providing services that may be linked to adolescents' sex, age, disability, ethnicity, race, religion, marital status, sexual orientation, gender identity, HIV status, and other status.
 - How are these similar or different from the challenges adolescents face in accessing services? Please keep in mind that some challenges may be linked to their sex, age, disability, ethnicity, race, religion, marital status, sexual orientation, gender identity, HIV status, and other status.
 - How might adolescent health services be affected when providers believe adolescent clients have the same rights as adults?
 - How does the relationship with the adolescent client change when we apply the concepts of evolving capacity and rights to sexual and reproductive health services?

UNIT 3:

ADOLESCENT VULNERABILITIES, RISK-TAKING BEHAVIORS, AND CONSEQUENCES

INTRODUCTION:

Adolescence is more than a time of individual social, emotional and physical change. Their interactions with adults and their peers change as well. Understanding the social and cultural forces that shape adolescents and young people’s choices and behaviors, and create risks and vulnerabilities enables providers and counselors to better serve youth. Understanding and managing risk is a vital part of the transition from adolescence to adulthood, and one that cannot be managed without support, especially since some risks have long-reaching consequences. Providers need to discuss with young people the potential outcomes of risk-taking, help them to learn from their experiences, and counsel on protective factors.

UNIT TRAINING OBJECTIVE:

To help providers identify adolescent vulnerabilities, understand adolescent risk-taking behavior and its consequences, and promote protective behaviors that better address the sexual and reproductive health needs of all adolescent clients.

SPECIFIC LEARNING OBJECTIVES:




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

1. Identify vulnerabilities, social and cultural pressures, rights and concerns of adolescents.
2. Identify the WHO standards of care for adolescents.
3. Discuss specific vulnerabilities and adolescent risk-taking behavior and its benefits and consequences.
4. Build skills and advance protective factors that empower adolescents with regards to risk-taking, vulnerability, and health.



TOTAL TIME: 3 HOURS

UNIT OVERVIEW:

Session	Methods 	Materials 	Time 
3.1	Powerwalk exercise	Trainer’s Tool 3a	45 minutes

3.2	Group discussion Trainer presentation	Participant Handout 3a (from previous Unit) Slides 3.1-3.10	10 minutes 45 minutes
3.3	Fishbowl debate Group discussion	Chairs	1 hour
Unit Summary	Reflection		20 minutes



WORK FOR TRAINERS TO DO IN ADVANCE:

- Review Slides 3.1-3.10
- SO 3.1: Prepare participant role cards (Trainer’s Tool 3a) for powerwalk exercise. Review for local contextual relevance and print onto cards or slips of paper for participants.



MAJOR REFERENCES AND TRAINING MATERIALS:

United Nations Definitions of Human Rights, found at <http://www.un.org/en/sections/issues-depth/human-rights/>

UNFPA Definition of sexual and reproductive health, found at <http://www.unfpa.org/sexual-reproductive-health>

World Health Organization Definition of sexual health found at: http://www.who.int/topics/sexual_health/en/

SPECIFIC OBJECTIVE 3.1: IDENTIFY VULNERABILITIES, SOCIAL AND CULTURAL PRESSURES, AND RIGHTS CONCERNS OF ADOLESCENTS.



TIME

45 minutes



METHODS

- Powerwalk Exercise
- Group discussion



MATERIALS NEEDED

- Trainer's Tool 3a: Powerwalk role cards



STEPS

Time: 45 minutes

1. Explain that people experience different levels of vulnerability and understand their rights differently depending on their age, sex, disability and other factors. Tell participants that this activity is to explore the experience of being young or marginalized in their society.
2. Ask participants to line up on one side of the room. Make sure there's enough space for participants to move in front of them. This may require moving chairs or pushing tables out of the way.
3. Hand out Powerwalk Role Cards (see **Trainer's Tool 3a: Powerwalk Role Cards** below) to participants. You can adapt these cards to fit your context as needed. Give each participant one card.
4. Explain to participants that for this activity you want them to assume the 'role' on their card. Invite participants to visualize their character. Where would they live? Do they have one or multiple disabilities? If yes, which type(s)? What would their family be like? What would they do during a typical day? What kinds of problems would they have to face?
5. Tell participants that you will read out a series of statements. For each statement, consider whether it would be "true" for their character or "false." If the statement would be "true" for their role, participants should take one step forward. If it doesn't, they should stay where they are.
6. Read **Content: Powerwalk Statements** (below) one statement at a time, giving participants time to consider each statement and take a step as appropriate.

Content: Powerwalk Statements

(Adapted from Amnesty International: Respect my rights, respect my dignity)

- I can read and write.
- I know where my next meal will come from.

- I can move about easily and freely.
 - I have had or will have opportunities to complete my education.
 - My family would support me if I got pregnant now.
 - I have time to read and keep up with news every day.
 - I know and understand what changes are happening in my body.
 - I have people in my life that I can talk to about my body and my relationships.
 - I know where I can find money when I need it.
 - I can decide when to see a doctor and what doctor to see.
 - I can refuse sex for money or other resources, such as school fees or a place to live.
 - I can leave my partner if s/he threatens my safety.
 - If my sister or my friend gets pregnant, I know where to take her.
 - I can ask my partner to use a condom or some other form of contraception.
 - I can easily obtain contraception.
 - I have emotional support when I'm unhappy.
 - I can choose who I marry and when I marry.
 - I can decide how many children I have and when.
 - I know how to protect myself from unwanted pregnancy.
 - I know how to protect myself against HIV and other sexually transmitted infections.
 - I can take steps to protect myself from HIV and other sexually transmitted infections.
 - I am in control of my sexuality.
 - I am in control of my future.
 - If a crime is committed against me, the police would listen and help.
 - I can be out at night and not worry about being assaulted.
 - I can easily find work.
 - I am respected by most members of my community.
7. After reading all the statements, have participants stay in place. Start with the participant closest to the front of the room, who has taken the most steps forward, and ask them to reveal to the group who their character was. Compare their character with a participant at the back of the room, who has taken fewer steps.
8. Ask the group why they think they ended up distributed this way. Have participants reflect individually on how they feel about where they have ended up.
9. In plenary or in small groups of 2-3, have participants consider the following questions:
- a. How did your character's age affect your answers to these questions? How did their sex affect your answers? How did their disability status affect your answers?
 - b. What vulnerabilities did your character have? How did these vulnerabilities affect your answers with respect to their health?
 - c. Did the "non-health" questions raise any areas of concern for you when it comes to young people's abilities to obtain health services? How so?
 - d. What general risks and vulnerabilities do you think adolescents experience?
 - e. What are some things that might protect young people from these risks and vulnerabilities? Refer to Trainer's Resource 3b as needed.

- f. What things could you as a health care provider do to make it easier or safer for young people to seek services? How can you promote these protective factors?

TRAINER'S TOOL 3A: POWERWALK ROLE CARDS

14-year-old boy, with a visual disability, attending a special school	Unmarried, mother of 1 or more children with physical disabilities.	17-year-old gay male with depression	Married mother of 3, with a psychosocial disability
Commercial sex worker, 21, female, with a hearing disability	16-year-old, with a hearing disability, domestic worker	Refugee, 17, out of school	Girl, 12, living in a rural community
Bank teller, female	University student, male	14-year-old girl, in school	15-year-old girl, married, out of school
Male business executive	12-year-old girl living in slum area	Women's rights activist, female	17-year-old gay male
Male from a minority ethnic group	Teenage girl living in a very religious/traditional family	Teenage boy living in a very religious/traditional family	25-year-old questioning their sexual orientation

Commercial sex
worker, 21, female

Political leader, 35,
male

Grandmother, 65,
living in poverty

10-year-old male,
living on the street

16-year-old domestic
worker

Married mother of 3,
working in a market

Unemployed openly
gay male activist, 32

Female doctor, 42

Male taxi driver, 33

SPECIFIC OBJECTIVE 3.2: DISCUSS SPECIFIC VULNERABILITIES AND ADOLESCENT RISK-TAKING BEHAVIOR AND ITS BENEFITS AND CONSEQUENCES



TIME

55 minutes



METHODS

- Trainer presentation
- Group discussion



MATERIALS NEEDED

- Slides 3.1-3.10



STEPS

Time: 10 minutes

1. Ask participants to revisit their handout from the previous unit, **Participant Handout 3a: Developmental Characteristics of Adolescence and Young Adulthood**. Draw their attention to the language under “Social and Emotional Development” that discusses how adolescents push boundaries, take risks, and demonstrate increased independence.
2. Tell participants that the discussion will focus on how adolescence is a time when young people are comfortable with and attracted to taking risks. We will discuss how “risk taking” affects the adolescent both positively and negatively.
3. Ask participants to call out some examples of adolescent risk-taking behavior.
4. Challenge participants to brainstorm some positive reasons for and results from adolescent risk taking. Use this brainstorm to transition into presenting **Content: Adolescent Risk-Taking** (Slides 3.1-3.10) below.

Time: 45 minutes

Content: Adolescent Risk-Taking (Slides 3.1-3.2)

Slide 3.1-3.2: Reasons for Risk-Taking

We know that major physical, cognitive, emotional, sexual and social changes occur during adolescence that affect young people’s behavior. These include:

- **New social relationships.** Peers become very influential and family influence decreases. Adolescents may engage in risky behaviors that identify them with their peer group or demonstrate how they “fit in”.
- **Curiosity combined with sexual maturity.** Adolescence is naturally a time of experimentation. Experimentation is a normal aspect of development because it helps adolescents learn more about their body, feelings, and values
- **Questioning authority and established “rules”.** An important “task” of adolescence is to create an independent identity and personality. However, this

questioning of authority can also lead to impulsive decision-making and a lack of awareness of future consequences.

- **Adolescents test their limits.** Young people often underestimate risk, although the level of risk and vulnerability varies with culture, individual personality traits, social influences, needs, pressures, and opportunities.
- **Brain development.** There is a period of significant brain development during adolescence; however, areas of the brain grow and mature at different rates. The limbic system grows rapidly in early adolescence, while the prefrontal cortex completes its growth in late adolescence/young adulthood. The limbic system gives us a rewarding feeling when we take a risk, which likely contributes to young people's propensity to engage in "risk behaviors." Since the pre-frontal cortex completes its growth later as young people mature they also develop better reasoning skills, more control over impulses and better judgment.

Pause and ask participants to reflect on adolescents they know, whether personal or as clients. What types of risks do they take? What kinds of vulnerabilities do they face that might contribute to risk taking? Are there benefits to risk-taking?

5. Return to presentation with **Slide 3.3: Common Vulnerabilities** below. Encourage participants to add additional vulnerabilities

Slide 3.3-3.8: Common Vulnerabilities

- Age-based discrimination
 - Adolescents are frequently denied information and services based on their age or marital status.
 - Adolescents are denied the choice and autonomy/independence to make their own decisions.
- Gender inequality
 - Adolescent women are discriminated against for being sexual.
 - Adolescent women are not encouraged to act independently and make their own choices, especially with regards to sexuality.
 - Adolescent women are expected to be responsible for their own and their partners' health.
 - Adolescent women are more likely to experience discrimination in housing, education, employment, or other areas.
 - Harmful traditional practices, like female genital mutilation and early and forced marriage, seriously affect the sexual and reproductive health of adolescents.
 - Adolescent boys are expected to conform to rigid norms of masculinity, including expectations around sexual prowess.
- Sexual and gender-based violence
 - Adolescents experience violence in their families, intimate partnerships, and societies.
 - Adolescents who experience sexual violence are frequently stigmatized or shamed for their experience when they report it.
 - Adolescent women and men may face violence to correct their behaviors when they fail to conform to social norms about gender and sexuality.
- Economic hardship

- Adolescents have less access to money, employment opportunities, and disposable income than other age cohorts.
- Adolescents who work, frequently do so to support their families.
- Disability-based discrimination
 - Adolescents with disabilities are rarely regarded as subjects of sexual rights.
 - Adolescents with disabilities are often assumed as asexual, not sexually active, or hypersexual.
 - Adolescents with disabilities are often assumed as not able to decide by themselves about their sexual life.
 - Adolescents with disabilities face significant attitudinal, physical, communication and financial barriers in reporting violence and abuse and when accessing SRH information and services.
 - Adolescents girls with disabilities are often denied their reproductive autonomy.
 - Adolescent boys with disabilities may be considered less able to meet the expectations around sexual prowess.
 - Adolescents with disabilities are three to four times more likely, to face violence than their peers without disabilities.
 - Behaviours such as undressing or masturbating in public, hugging, kissing or touching other people's breasts and genitalia without permission have been reported as frequent among young persons with intellectual and developmental disabilities who are entering adolescence. They are usually unaware of such behaviours being perceived as inappropriate. Parents and teachers often recur to punishment trying to control and prevent them.
 - Mental health conditions such as depression or schizophrenia often set in during adolescence and result in psychosocial disabilities. Parents and teachers often mistakenly attribute them to adolescents' attitudes and tend to criticize or punish them instead of providing adequate support.

Slide 3.9: Types of Risk-Taking Behavior

- Impulsive decision-making
- Failure to consider consequences
- Lack of information about risk
- Social, sexual, or other experimentation
- Provoking or testing limits through argument

Slide 3.10: Outcomes of Adolescent Risk-Taking

- Development of sense of independence, resiliency
- Potential for unintended pregnancy, infection with HIV/STIs
- Growth in or failure of social and family relationships
- Early child-bearing, complications in childbirth and/or unsafe or forced abortion,

and forced sterilization

- Risk of sexual or interpersonal violence
- Loss of educational or economic opportunities
- Poor nutrition or other health outcomes

6. Ask participants to reflect on the relationship between vulnerability and risk. Ask for examples of how they can help adolescents navigate risk. What are some factors that can protect adolescents from or lessen the effect of risk?

SPECIFIC OBJECTIVE 3.3: BUILD SKILLS TO EMPOWER ADOLESCENTS WITH INFORMATION ABOUT RISK-TAKING, VULNERABILITY, AND HEALTH



TIME

1 hour



METHODS

- Fishbowl debate
- Group discussion



MATERIALS NEEDED

- None



STEPS

Time: 1 hour

1. Set up the room with all the chairs in a circle and two chairs in the center. Ask for two volunteers to sit in the center chairs to start the conversation. Identify one of the chairs as the “pro-adolescent” position, and the other as the “health provider” position.
2. Explain to participants that they will be taking part in a fishbowl debate/discussion, using the following rules:
 - a. The participant in the “pro-adolescent” position will be asked to respond to the prompts (below) posed by the facilitator from the perspective of an adolescent who wants to be able to “take risks” and have fun while staying healthy.
 - b. The participant in the other, “health provider” chair will be asked to respond to the prompt as a provider who discourages risk taking.
 - c. At any time, participants in the outside circle of chairs can jump in to the discussion by tapping one of the participants on the shoulder and taking their seat.
 - d. When a new participant joins the discussion, they take on the position of the seat they are in.
 - e. When a participant in one of the fishbowl seats is tapped on the shoulder, they should finish their immediate thought or sentence and then allow the new participant to come in. They can tap back in later if they would like to rejoin.
3. Give participants the following prompt and allow **5-10 minutes** for discussion. If the discussion slows, or starts to falter, move on to the next prompt.

Prompt 1: Having information about sexuality and sexual and reproductive health, could encourage young people to begin sexual activity at a younger age.

4. Use the following prompts to continue discussion. You may use as many or as few of the prompts as needed to keep discussion going.

Prompt 2: Adolescents should explore their sexuality through masturbation or watching porn before entering a sexual relationship with another person.

Prompt 3: All adolescents need the same information about the risks of sexual activity and be counseled to avoid sexual activity, regardless of their sex as well as economic, relationship, disability, educational, or other status.

Prompt 4: Since adolescent girls are most likely to experience negative consequences associated with sexual activity such as pregnancy or HIV, they have the most responsibility to avoid risk.

Prompt 5: Since adolescent girls with disabilities are more likely to be affected by sexual violence than their peers without disabilities, they should refrain from dating or engaging in intimate relations.

5. When participants are finished discussing the prompts, have them remain in the circle for a quick wrap-up discussion. Ask participants to reflect on how they found playing the “pro-adolescent” and “health provider” role. Ask the participants if they felt constrained by either role, and how they found common ground between the two roles.

UNIT 3 SUMMARY



TIME

20 minutes



METHODS

Reflection



MATERIALS NEEDED

None



STEPS

1. Ask participants to come together to reflect on the sessions. Use the following questions to guide discussion:
 - What new information did participants learn in these sessions about adolescent vulnerability and risk-taking?
 - How does adolescent vulnerability affect risk-taking behavior?
 - How can we reduce adolescent vulnerabilities?
 - What are some protective factors that we can encourage?
 - What, if anything in these sessions surprised you? Why or why not?

NOTES PAGE

What was the least useful part of this training?

What suggestions do you have to improve the module?

UNIT 4: ADOLESCENT BEHAVIOR AND SOCIAL ISSUES: CONCERNS AND SKILLS

INTRODUCTION:

Adolescents experience many sources of pressure, both internal and external. Pressure can be both positive and negative, and sources of pressure include self-perceptions; friends, family and romantic partners; and even social norms and expectations about how to look and how to behave. These pressures can influence both the choices and decisions they make and in turn, affect their sexual and reproductive health. By understanding the pressures young people face, while also understanding the types of skills that they need to develop, providers can help adolescents to learn and apply skills that contribute to healthy development.

UNIT TRAINING OBJECTIVE:

To help providers recognize and understand adolescent psychosocial and behavioral concerns and support adolescents to develop life skills necessary for healthy development.




SPECIFIC LEARNING OBJECTIVES:

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

1. Describe the internal and external factors that influence the behaviors of adolescents.
2. Explain why assertiveness and decision-making skills support healthy adolescent development.

TOTAL TIME: 4 HOURS

UNIT OVERVIEW:

Session	Methods 	Materials 	Time 
4.1	Trainer presentation Talk show role play	Slides 4.1-4.11 Participant Handout 4a	2 hours 15 minutes
4.2	Trainer presentation Role play	Slides 4.12-4.18 Small ball or other object	1 hour 40 minutes

	Small group work	Participant Handout 4b Flipcharts and markers	
Unit Summary	Reflection	Paper	10 minutes



WORK FOR TRAINERS TO PREPARE IN ADVANCE:

- Review Slides 4.1-4.18
- Review Participant Handout 4a: Gender Role Case Studies to make sure the situations listed are relevant and/or add others that are meaningful to the group.
- Prepare copies of Participant Handouts 4a and 4b
- SO 4.2: Obtain a small ball for the assertiveness practice exercise



REFERENCES AND TRAINING MATERIALS:

Gates, S., Lippman, L., Shadowen, N., Burke, H., Diener, O., and Malkin, M. (2016). Key Soft Skills for Cross-Sectoral Youth Outcomes. Washington, DC: USAID's YouthPower: Implementation, YouthPower Action.

SPECIFIC OBJECTIVE 4.1: DISCUSS PSYCHOSOCIAL AND BEHAVIORAL CONCERNS OF ADOLESCENTS



TIME

2 hours 15 minutes



METHODS

- Trainer presentation
- Talk show role play exercise



MATERIALS NEEDED

- Participant Handout 4a: Gender Role Case Studies
- Slides 4.1-4.11



STEPS

Time: 15 minutes

1. Start by explaining the unit objectives to the participants. Introduce the trainer presentation **Content: Internal and External Factors that Influence Adolescent Behaviors** (Slides 4.1-4.11) below by explaining that self-perception, as well as certain social relationships, can exert significant pressure during adolescence. These pressures wield significant influence on decision-making and sexual and reproductive health.

Content: Internal and External Factors that Influence Adolescent Behaviors (Slides 4.1-4.11)

Slide 4.1: Gender Roles

When we talk about the social and cultural norms that proscribe the “expected” behaviors of men and women we are talking about gender roles. Gender roles are:

- **Learned** They are passed on from families, peers and friends, media and stories, and societies.
- **Variable** What it means to “act like a woman” or “act like a man” differs from culture to culture. Gender roles can even change over time and be expressed in different ways at different points in our lives, based on things like age, disability, marital status or parity.
- **Stereotypical** Gender roles are based on assumptions about how “all women” or “all men” should behave, rather than an understanding and acceptance of individuals.

Slide 4.2-4.4: Gender Roles (cont)

Societies and communities powerfully promote accepted gender roles during later childhood, puberty, and adolescence. While experiences vary, for many young people,

adolescence is a time when options expand for young men and become more restricted for young women. For example:

- Boys may be allowed more autonomy, mobility, and power.
 - Girls may be expected to remain home and take on more household responsibilities.
 - Boys are expected to express dominance in social and sexual relationships. This sometimes leads to interpersonal or sexual violence.
 - Girls are expected to defer to men both in and out of the home, to be passive and “virginal” and to not express any sexual feelings. They are expected to be in control of their sexual feelings as well as those of men. They are expected to be responsible for sexual health which includes actions that prevent STIs or HIV and unintended pregnancy.
 - Boys are expected to take, and to be more logical and rational. They are given more power in sexual decision-making when compared to girls and can more openly express their sexuality and desires.
 - Girls are expected to give, be accommodating, and be more emotional.
 - According to the circumstances, perceptions of disability and stereotypes may or may not reinforce gender roles and expectations. For example, as mentioned in unit 2, adolescent boys with physical disabilities may be considered less able to meet expectations around sexual prowess and dominance while a physical disability in girls may reinforce the expectation of female passivity and deference. Moreover, when disability prevents adolescents from performing common and widespread gender roles, this may increase the risk of violence and abuse. This is the case, for example, of girls with physical disabilities who may be less at ease to take on household responsibilities and, for this reason, mistreated by their family members or in-laws in case of early marriage.
2. Pause here. Ask participants to think about and provide some examples of common gender stereotypes and expectations in their community. Ask participants how these common stereotypes and expectations might affect the ability of adolescents to make good choices and decisions and how this in turn could affect their health and wellbeing.

Time: 1 hour 30 minutes

3. Pass out **Participant Handout 4a: Gender Role Scenarios** (below). Ask for 10 volunteers (if possible, 5 women and 5 men) and ask male volunteers to play female roles, and female volunteers to play male roles. Ask for a final volunteer to be the “host” of a reality show these characters will be appearing on.
4. Tell the volunteers that they will be appearing as their characters on a reality show to discuss the events described in their scenario. Give the volunteers **5 minutes** to review the scenarios. Volunteers should interpret their characters in their own way (traditional, stereotypical, progressive, or otherwise), as long as they are able to explain their interpretation. While they are doing this, set up three chairs at the front of the room and ask the “host” to sit in one.
5. Begin with the first scenario. (**Content: Aunt Rekha**, below). Ask the participant playing Aunt Rekha to spend **10 minutes** discussing/debating her scenario with

the talk show host. Give the “host” permission to take audience questions if there is time.

Content: Aunt Rekha

Aunt Rekha wants to give a doll as a present to her young nephew. She says that dolls will help teach her nephew about taking care of someone and how to be loving. Her husband thinks it is a bad idea, because a doll will not teach their nephew how to be manly.

6. When the participant has finished their discussion, ask them: How did it feel to be asked to assume a particular gender role?
7. Continue to the next volunteers and the second scenario, Esther and David. Allow **10 minutes** for their discussion. When they finish, ask them the same question: How did it feel to be asked to fit into a particular gender role?

Content: Esther and David

Esther and David are the two oldest children in the family. Both attend the same boarding school, but they each have their own circle of friends. Esther is concerned that David’s friends are a bad influence on him. She has heard various rumors that his friends bully and beat up other boys, that they are disrespectful of girls, that they force girls to have sex, that they are gay, and that they are in a cult. She doesn’t know what to make of the rumors. When she tries to talk to David about what she’s heard, he dismisses her and tells her it’s none of her business. She is considering telling their parents about what she has heard when her parents come to visit, but is worried that David will never speak to her again.

8. Repeat with the next three scenarios, one by one.

Content: Sonia and Ron

Sonia and Ron have known each other since childhood, and are good friends, but are not romantically involved. Sonia wants to go see a popular movie and decides to ask Ron to go with her. Although Ron is interested in going to the movie with Sonia, he turns her down because he believes he should have been the one to do the asking.

Content: Jose and Maria

Jose and Maria have been seeing each other for a year. Their relationship is good – and even their parents approve! But lately Jose has been putting pressure on Maria to have sex, and she is not ready for that. But she feels like any time she expresses any sort of affection to Jose, even just wanting to hold his hand, he takes that as permission to push for more. She believes she should be able to say “no” without being accused of not loving him or putting

stress on their relationship. He says she is giving him “mixed messages” and that, as a woman, she should try harder to please him.

Content: Maggie and Ali

Maggie is in her third year of university, and she has a minor physical disability. She feels uncomfortable about it and she always tries to hide it. She idealizes boys without disabilities as handsome and perfect. She dreams about dating and marrying someone who does not have a disability but she is always reminded by her friends that boys without disabilities usually look down at girls “like her”. When Maggie succeeds in dating Ali, a boy without a disability, he puts pressure on her to have sex. Maggie is not ready for that, but she is afraid that by rejecting Ali she will lose the opportunity to have the partner she has been dreaming of.

Content: Femi

Femi is in his second year of university, and his family is struggling financially since his father died last year. He has been thinking about dropping out of university and getting a job to help his mother and younger siblings. And now, just last week, his girlfriend told him that she is pregnant. Femi is feeling very stressed over his responsibilities to his mother and his girlfriend, and it is affecting his studies. When he raises the topic with his mother, she insists that he should complete university so that he can get a better job. She also suggests that perhaps his girlfriend is lying about the pregnancy or that maybe he is not the father. Femi doesn’t know which way to turn.

Content: Nadia

Nadia is 17 years old. She was born with a hearing disability and she knows sign language. She is in love with her classmate Willy. They attend the same special school. Nadia’s parents are worried about her future and often discuss the importance of finding a man without a disability who agrees to marry Nadia and look after her once they are gone. One day, while alone at home, Nadia receives a visit from her neighbor Hans, who is 45 years old and unmarried. He rapes her. Nadia gets pregnant and Hans proposes to Nadia’s parents. They put pressure on her to marry Hans and secure her future.

Content: Jim and Jane

Jim is a boy with a visual disability who attends a mainstream school. He spends a lot of time with his female classmates who are always available to support his learning or assist him in doing homework. Among them there is Jane, who is Jim’s favorite. Jim and Jane start dating but Jane’s parents are not happy about their daughters’ decision to date a boy with a disability. They put pressure on Jane to stop their relationship because, as they say, he will never be able to take care of Jane as a man should do.

9. When volunteers have acted out/discussed all five case studies, have them discuss the following questions together:
 - a. For those who played male roles, ask if there were things they felt their

characters could do as men that they wouldn't have been able to do as women. Ask if there were things their male characters couldn't do because they were men.

- b. For those who played female roles, ask if there were things they felt their characters could do as women that they wouldn't have been able to do as men. Ask if there were things their female characters couldn't do because they were women.
- c. For those who played the role of a girl with a disability, ask if there were things they felt their characters could do as a girl with a disability that they wouldn't have been able to do as a girl without a disability. Ask if there were things their female characters couldn't do because of their disability.
- d. For those who played the role of a boy with a disability, ask if there were things they felt their characters could do as a boy with a disability that they wouldn't have been able to do as a boy without a disability. Ask if there were things their male characters couldn't do because of their disability.

- 10. Invite the volunteers to rejoin the rest of the participants. Ask the audience what they observed. How do gender and gender roles affect sexual and reproductive health? How do gender roles affect our expressions of sexuality? How might gender norms and gender roles affect adolescents differently than adults?
- 11. How does having a disability affect a young person's expression of sexuality?
- 12. How does having a disability affect a young person's sexual and reproductive health? (i.e. are there greater/different risk factors)
- 13. How does having a disability affect the way a young person is perceived as a sexual being/potential partner by parents/caregivers, peers, community members, etc.?
- 14. Ask participants if there were other aspects of the case studies that might affect adolescent behaviors and health, and why?

Time: 30 minutes

- 15. Resume presentation with **Slide 4.5: Peer Relationships** below.

Slide 4.5: Peer Relationships

During adolescence, relationships with friends and peers become increasingly important. Adolescents develop close relationships with their peers, and demonstrate their group association through dress, language, and behaviors. Their relationships with their peer group help them develop a sense of belonging and security but can at times can make young people vulnerable to negative peer pressure around certain behaviors, including sex. The way that adolescents understand and perceive the sexual behavior and activity of their

friends, such as when they think their peers start having sex and whether or not they use condoms or contraception, often has a large influence on their own choices and decision. Due to discrimination and social exclusion, young persons with disabilities may be more inclined to develop close relations with other peers with disabilities rather than peer without disabilities. While giving them a sense of security and mutual understanding, this may also increase their isolation and exclusion.

Slide 4.6-4.8: Relationships with Parents and Family

As adolescents build their peer relationships and networks, they also become more independent from their parents, guardians, and/or adult caregivers. It is normal for adolescents to test limits and boundaries, but this can create strained relationships between parents and their adolescent children.

Supportive parent/child relationships or relationships with caring adults are still important to adolescents, however. Research suggests that these types of relationships are important to adolescent development especially when adults show respect for and demonstrate confidence in adolescents' abilities.

Parents/guardians tend to be extremely protective of young persons with disabilities and often become a barrier to their healthy development. There is also a widespread inclination among adults to consider young persons with disabilities as unable to make decisions about their sexual and reproductive health. As a result, parents/ guardians tend to make decisions on their behalf. When it comes to girls with intellectual and developmental disabilities this often translates into forced sterilization or abortion. When dealing with the sexual development of their children with disabilities, parents may rely on the advice and support of outside sources such as health providers and peer parent groups. However, to ensure their children's wellbeing, it is critical to first consider their individuality and unique needs.

Health providers can help parents/guardians to understand these changes and provide suggestions on how parents can support their own adolescent children to develop independent thinking skills, decision-making skills and resilience, as well as self-esteem and self-efficacy. Health care providers trained on disability inclusion can also support parents to understand that young persons with disabilities have the same sexual rights and needs of their peers without disabilities.

Slide 4.9: What is Self-Esteem?

The ability to feel confidence in, and respected for, oneself. It is a feeling of personal competence and worth.

Involves how one feels about one's self, and is affected by our interactions with family, friends, and our social circumstances.

Plays a key role in a young person's sense of how well s/he can deal with life's opportunities and challenges.

May be strained during adolescence because of rapid physical and social changes and because adolescents are examining and creating their own systems of values and beliefs

As a result of discrimination, exclusion or over-protection of the family, young persons with disabilities often lack self-esteem more than their peers without disabilities.

Influences how young people make judgments about relationships, sex, and sexual responsibility.

Slide 4.10 – What is Self-Efficacy?

Self-efficacy is the belief in one's ability to perform and succeed at tasks. Such tasks could include daily activities such as self-care, schoolwork, and leisure activities or they could be more specific to sexual and reproductive health such as the ability to delay sexual debut, or use a condom or contraceptive method. As a result of discrimination, exclusion or over-protection from the family, young persons with disabilities often lack self-efficacy more than their peers without disabilities.

We can help adolescents develop self-efficacy by:

- Supporting them to understand the outcomes of their behaviors.
- Encouraging mastery, competence and learning from experiences.
- Encouraging adolescents to believe they have what it takes.
- Helping them to break down large tasks into small, manageable steps.

Ask participants what characterizes resilience in adolescents. After a few responses, summarize and define resilience as follows:

Slide 4.11 What is Resilience?

Resilience is the ability of an individual to function competently in the face of adversity or stress. An **adolescent** who is **resilient** is likely to enter adulthood with a good chance of coping well— even if he or she has experienced difficult circumstances in life.

Close the presentation by asking participants for examples of strategies to build adolescent clients' self-esteem, self-efficacy and resilience and discuss how to support parents and young people to develop decision-making and communication skills.

PARTICIPANT HANDOUT 4A: GENDER ROLE CASE STUDIES

1. Aunt Rekha wants to give a doll as a present to her young nephew. She says that dolls will help teach her nephew about taking care of someone and how to be loving. Her husband thinks it is a bad idea because a doll will not teach their nephew how to be manly.
2. Esther and David are the two oldest children in the family. Both attend the same boarding school, but they each have their own circle of friends. Esther is concerned that David's friends are a bad influence on him. She has heard various rumors that his friends bully and beat up other boys, that they are disrespectful of girls, that they force girls to have sex, that they are gay, and that they are in a cult. She doesn't know what to make of the rumors. When she tries to talk to David about what she's heard, he dismisses her and tells her it's none of her business. She is considering telling their parents about what she has heard when her parents come to visit but is worried that David will never speak to her again.
3. Sonia and Ron have known each other since childhood, and are good friends, but are not romantically involved. Sonia wants to go see a popular movie and decides to ask Ron to go with her. Although Ron is interested in going to the movie with Sonia, he turns her down because he believes he should have been the one to do the asking.
4. Jose and Maria have been seeing each other for a year. Their relationship is good – and even their parents approve! But lately Jose has been putting pressure on Maria to have sex, and she is not ready for that. But she feels like any time she expresses any sort of affection to Jose, even just wanting to hold his hand, he takes that as permission to push for more. She believes she should be able to say “no” without being accused of not loving him or putting stress on their relationship. He says she is giving him “mixed messages” and that, as a woman, she should try harder to please him.
5. Maggie is in her third year of university, and she has a minor physical disability. She feels uncomfortable about it and she always tries to hide it. She idealizes boys without disabilities as handsome and perfect. She dreams about dating and marrying someone who does not have a disability, but she is always reminded by her friends that boys without disabilities usually look down at girls “like her”. When Maggie succeeds in dating Ali, a boy without a disability, he puts pressure on her to have sex. Maggie is not ready for that, but she is afraid that by rejecting Ali she will lose the opportunity to have the partner she has been dreaming of.

6. Femi is in his second year of university, and his family is struggling financially since his father died last year. He has been thinking about dropping out of university and getting a job to help his mother and younger siblings. And now, just last week, his girlfriend told him that she is pregnant. Femi is feeling very stressed over his responsibilities to his mother and his girlfriend, and it is affecting his studies. When he raises the topic with his mother, she insists that he should complete university so that he can get a better job. She also suggests that perhaps his girlfriend is lying about the pregnancy or that maybe he is not the father. Femi doesn't know which way to turn.
7. Nadia is 17 years old. She was born with a hearing disability and she knows sign language. She is in love with her classmate Willy. They attend the same special school. Nadia's parents are worried about her future and often discuss the importance of finding a man without a disability who agrees to marry Nadia and look after her once they are gone. One day, while alone at home, Nadia receives a visit from her neighbor Hans, who is 45 years old and unmarried. He rapes her. Nadia gets pregnant and Hans proposes to Nadia's parents. They put pressure on her to marry Hans and secure her future.
8. Jim is a boy with a visual disability who attends a mainstream school. He spends a lot of time with his female classmates who are always available to support his learning or assist him in doing homework. Among them there is Jane, who is Jim's favorite. Jim and Jane start dating but Jane's parents are not happy about their daughters' decision to date a boy with a disability. They put pressure on Jane to stop their relationship because, as they say, he will never be able to take care of Jane as a man should do.

SPECIFIC OBJECTIVE 4.2: EXPLAIN WHY ASSERTIVENESS AND DECISION-MAKING ARE NECESSARY FOR HEALTHY ADOLESCENT DEVELOPMENT



TIME

1 hour 40 minutes



METHODS

- Trainer presentation
- Role play
- Small group work



MATERIALS NEEDED

- Participant Handout 4b: Decision-Making Scenarios
- Ball or small object
- Flipcharts and markers
- Slides 4.12-4.18



STEPS

Time: 10 minutes

1. Start with the trainer presentation **Content: Life Skills for Healthy Development** (Slides 4.12-4.18) below.

Content: Life Skills for Healthy Development (Slides 4.12-4.18)

Slide 4.12: Why Life Skills?

Adolescents need skills to:

- Clarify their needs, values and rights.
- Set goals for themselves.
- Express themselves effectively.
- Decide upon a course of action.
- Practice independent critical thinking and decision-making.

Slide 4.13-4.14: Which Life skills?

A recent review of life and soft skills found five key life skills contributed to better SRH outcomes among adolescents. These are:

- Positive self-concept
- Self-control
- Higher order thinking skills
- Communication
- Goal-setting

Source: YouthPower

Youth programs play a key role in supporting adolescents developing these life skills. Many young persons with disabilities have fewer opportunities than their peers without disabilities to learn about life skills and, due to discrimination and exclusion, often lack in positive self-concept and communication skills and/or encounter different communication barriers. Moreover, they are often considered unable to make decisions in relation to their sexual and reproductive health and adults tend to make decisions on their behalf. For many adolescents, especially young women and young persons with disabilities, it is important to learn how to communicate with confidence and assertiveness. Health care providers can help adolescents to develop and practice positive self-concept and good communication skills as part of education and counseling. They can also support the empowerment of young persons with disabilities to become more autonomous and to make decisions regarding their SRH.

Slide 4.15-4.16: Assertive Communication

Assertive communication involves expressing beliefs, thoughts and feelings in a direct, clear way at an appropriate moment. To communicate assertively implies the ability to say “yes” or “no” depending on what one wants. For example:

“No, I don’t want to have sex.”

“Yes, I want to have sex, but only if we use a condom.”

Being able to communicate one’s true feelings can positively influence adolescent sexual and reproductive health. Communicating clearly and assertively may enable youth to:

- Feel less guilt.
- Feel more self-respect.
- Resist pressures to engage in unhealthy or dangerous behaviors.
- Negotiate contraceptive and condom use.
- Resist unwanted sexual advances or sexual coercion.
- Identify and obtain the right sexual and reproductive health services such as:
 - Contraception
 - Safe abortion
 - Post-abortion care
 - Care for sexual violence
 - Antenatal and postpartum care
 - STI/HIV diagnosis, counseling and treatment

Time: 40 minutes

2. Introduce the assertive communication practice exercise. Explain that this exercise will help participants understand how adolescents can develop and use assertive communication skills.
3. Ask participants to sit in a circle. They will be playing the role of adolescents, ages 14-19. Two of them will play the role of adolescents with disabilities. You will read statements and participants will communicate assertively. Hold up the ball or small object and explain that after you read the statement, you will throw/roll the ball to the participant whose turn it is to respond. After they respond, they can throw/roll the ball to the next participant.
4. Toss the ball to the first participant and read the first statement from **Content: Assertive Communication Statements** below. After his/her response, ask the other participants to assess how assertive the response was. Participants can also provide other suggestions.
5. Repeat with another participant and statement until you complete the list of statements.

Content: Assertiveness Statements

1. "There's nothing wrong with spending the night together."
2. "Why are you asking about contraception? You shouldn't even be thinking about these things until after you are married."
3. "I'll leave you if you don't sleep with me."
4. "If you were a real man, you'd take a girl to bed."
5. "Come on, baby, just this one time."
6. "You're not a real man until you've been in a fight."
7. "Try some, it won't hurt you."
8. "Don't worry, we don't need a condom. You trust me, right?"
9. "Someone your age doesn't need contraceptives, you need self-respect."
10. "I'll give you this money if you do what I say."
11. "Getting this excited with no release can cause me to get very sick."
12. "Everyone else is fine with having sex, what's wrong with you?"
13. "You know you want to."

6. Ask the group if it was difficult to communicate assertively, and, if so, why. Also ask if the group found the topic and dynamics useful for working with adolescents.

Time: 10 minutes

7. Invite participants to return to their original seats. Suggest that providers can also help young people to develop skills around **decision-making and self-control**. Return to the presentation with **Slide 4.17: Decision-Making and Self Control** below.

Slide 4.17-4.18: Decision-Making and Self Control

One aspect of good self-control is the ability to make good decisions.

Decision-making is a process of actions and conclusions to achieve desired results.

Young people's abilities to make decisions varies depending on their culture and sense of self-efficacy, among other factors.

Young persons with disabilities are often considered unable to make decisions about their sexual and reproductive health.

Adolescents make decisions frequently. Some are simple with no major consequences. What are some examples of simple decisions we all make regularly?

Other decisions can be large and potentially consequential. What are some examples of potentially consequential decisions that adolescents might make?

Some cultures explicitly define social expectations for adolescent behavior that limits their decision-making options.

Some laws and policies are aimed at making decisions for young people about their body and health, such as age of consent laws for sexual activity or health services, policies that require parental or spousal consent to services, or restrictions on services based on marital status. Some people may believe that fate or luck determine what happens to them, while others believe that their own knowledge, skills, and efforts determine their fate.

Young people with a sense of self-efficacy and self-control will be more likely to make their own decisions and may feel greater commitment to and satisfaction with these decisions.

8. Stop and ask if participants have any questions. Leave time for discussion before moving to the next exercise.

Time: 40 minutes

9. Explain that this next exercise will help participants understand a variety of challenging situations that young people may face. (Note: Review the exercises beforehand to make sure they are relevant and/or add others that are meaningful to your group.)
10. Break participants into small groups of 4 to 6 people, explaining that each group will discuss consequences for different decisions adolescents might make. Give each group a copy of **Participant Handout 4b: Decision-Making Scenarios** (below).
11. Ask the groups to think about each decision and predict the three most likely consequences. Once they have listed three, the group should circle the "best" possible consequence and put a line through the worst possible consequence. Allow **15-20 minutes** for this process.
12. Bring participants back together in the larger group. Using a flipchart and markers, write the number of the first scenario on the board and ask the groups for their best possible consequence. List the responses, then ask the whole group to review and select the "best" option. Repeat with the negative consequences and each of the scenarios in turn.

- 13.** Conclude the activity with discussion on the following questions:
- a. How similar or different were the groups' predictions? Why do you think that happened?
 - b. Is it possible for two people to make the same decision and experience very different consequences? How could that happen?
 - c. What assumptions do we make about people's decisions based on their gender and disability as well as our understanding of the consequences? How do these assumptions affect our interactions with adolescents?
 - d. Which decision had a negative consequence you hadn't thought of?
 - e. Are there other positive consequences you hadn't thought of?
 - f. How can we help adolescents think through consequences and make decisions without making the decision for them?

PARTICIPANT HANDOUT 4B: DECISION-MAKING SCENARIOS

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. Discuss if and how disability plays a key role in shaping the consequences for each of the decisions and if yes, why.

1. A. Amina decides to steal a skirt from the store.
B. Amina, a girl with Down syndrome, decides to steal a skirt from the store.

2. A. Kojo is late for his curfew and decides to beg a ride with someone he doesn't know very well.
B. Kojo, a boy with a psychosocial disability, is late for his curfew and decides to beg a ride with someone he doesn't know very well.

3. A. Maria agrees to start a relationship with a wealthy friend of her father's, who offers to pay for clothes and school costs.
B. Maria, a girl with a physical disability, agrees to start a relationship with a wealthy friend of her father's, who offers to pay for clothes and school costs.

4. A. Teresa decides to go to a party with a new friend, Robert, but she doesn't know him very well. Robert thinks Teresa is romantically interested in him.
B. Teresa, a girl with a visual disability, decides to go to a party with a new friend, Robert, but she doesn't know him very well. Robert thinks Teresa is romantically interested in him.

5. A. Daniel and Lucy have several drinks and decide to find an empty room at a party.
B. Daniel and Lucy have several drinks and decide to find an empty room at a party. Lucy is a girl with cerebral palsy.

6. A. Pamela has decided to leave her home in the village and move to the capital to look for work.
B. Pamela, a girl with a hearing disability, has decided to leave her home in the village and move to the capital to look for work.

7. A. Carlene decides that she wants to start having sex with her steady boyfriend and goes to the chemist to get condoms.

B. Carlene, a girl with a visual disability, decides that she wants to start having sex with her steady boyfriend and goes to the chemist to get condoms.

8. A. Kaseem decides to drop out of secondary school in the middle of his final year.

B. Kaseem, a boy with depression, decides to drop out of secondary school in the middle of his final year.

UNIT 4 SUMMARY



TIME

10 minutes



METHODS

Reflection



MATERIALS NEEDED

None



STEPS

1. Ask participants to take out a blank sheet of paper and write down the following three questions:
 - a. What did I like about today and why?
 - b. What did I not like about today and why?
 - c. What did I learn and experience today that I will be able to use?

2. Give participants **10 minutes** to reflect and jot down their thoughts for themselves.

UNIT 5: Very Young Adolescents

INTRODUCTION:

Adolescents and young people in general are frequently stigmatized, discriminated against, and underserved because of their age. Particular sub-populations of young people are further marginalized or ignored completely. One such sub-population is very young adolescents (VYAs), or adolescents aged 10-14. Very little data exists on VYAs, which are almost entirely excluded from the Demographic and Health Surveys (DHS), and while there is growing interest in this age group, it has yet to translate into many sexual and reproductive health programs and services for VYAs.

Many providers and programs are uncomfortable providing SRH information and services to VYAs, and this is particularly true in the case of VYAs with disabilities. But it is important to remember that in some LMICs, including West Africa and South Asia, early or child marriage is common, and one in nine girls marry before age 15. Pregnancy related concerns are still a major cause of morbidity and mortality for adolescents in many countries. For many VYAs, services are unavailable, of poor quality or, when it comes to VYAs with disabilities, often inaccessible.


UNIT TRAINING OBJECTIVE:

To discuss concerns about appropriateness of providing services to very young adolescents and promote good practice in service provision as social protection.




SPECIFIC LEARNING OBJECTIVES:

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

1. Discuss the sexual and reproductive health needs and vulnerabilities of very young adolescents.
2. Identify WHO standards of care that are relevant to the SRH of very young adolescents.
3. Identify appropriate services and interventions for very young adolescents.

 *TOTAL TIME: 4 HOURS 25 MINUTES*

UNIT OVERVIEW:

Session	Methods 	Materials 	Time 
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5.1	Group brainstorm Trainer presentation	Flipchart and markers Slides 5.1-5.9	1 hour 30 minutes
5.2	Trainer presentation Group discussion	Flipchart and markers Slides 5.1 – 5.9 Participant handout 5A	1 hour
Unit Summary	Reflection		10 minutes



WORK FOR TRAINERS TO PREPARE IN ADVANCE:

- Review Slides 5.1-5.9
- Prepare Participant Handout 5a



MAJOR REFERENCES AND TRAINING MATERIALS:

ACPF (African Child Policy Forum). 2010. *Breaking the silence: Violence against children with disabilities in Africa*. Addis Ababa: ACPF.

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569. May 2014.

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UNESCO. 2009. *International Technical Guidance on Sexuality Education: Volume II, Topics and Learning Objectives*. Paris: UNESCO.

UNICEF. 2014. *A Statistical Snapshot of Violence against Adolescent Girls*. New York: UNICEF.

WHO: Essential Training Package for a 2-dose schedule HPV vaccine introduction: http://www.who.int/immunization/diseases/hpv/2dose_schedule/en/

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SPECIFIC OBJECTIVE 5.1: DISCUSS THE SEXUAL AND REPRODUCTIVE HEALTH NEEDS AND RISKS OF VERY YOUNG ADOLESCENTS.



TIME

1 hour 30 minutes



METHODS

- Group Brainstorm
- Trainer Presentation



MATERIALS NEEDED

- Flipcharts and markers
- Slides 5.1-5.9



STEPS

1. Introduce the topic. Remind participants of the importance of respectful disagreement and active listening. Take the time to revisit the ground rules for the training if you've set them.

Time: 30 minutes

2. Tell participants that as challenging as it can be to provide sexual and reproductive health services to older adolescents aged 15-19, it can be even more challenging to think about, talk about, or advocate for the sexual and reproductive health needs of very young adolescents aged 10-14.
3. Tell participants that gender and disability represent other key factors to be taken into account when it comes to dealing with the challenges of thinking, talking about or advocating for the sexual and reproductive health needs of very young adolescents.
4. Tell participants that you're going to start today's session with a quick brainstorm. Remind them that there are no "right" or "wrong" answers, and that they are not responding to each other right now, just volunteering their own ideas and experience. On a flipchart at the front of the room, write "10-14 Years Old."
5. Ask participants to help brainstorm some examples of the types of messages young people in this age group **hear** from their societies, cultures, families and peers about sexuality, gender, disability, and sexual and reproductive health. Jot down their answers on the flip chart. If the discussion is slow to start, add your own example to the chart: "you're too young to be thinking about that now."
6. Once participants have run out of ideas or slowed down, remove the flipchart paper and post it on the wall. On the next blank flipchart paper, again write "10-14 Years Old."

7. Ask participants to brainstorm again, this time about the health, gender, disability and social messages that they think young people **need** when they are this age. Remind participants again that there are no “right” or “wrong” answers and there is no need to respond to each other, just share their own ideas. If it is helpful, start with another example: “Information about puberty.”
8. When participants are done with this brainstorm, move the second flip chart to the wall. Ask for a volunteer to reflect back to the group how they feel about the idea that 10-14-year-olds might need sexual and reproductive health information and services. Ask participants to reflect on the following questions, either silently or to the group if they are comfortable.
 - a. What has been your experience – if any – in providing information or services to a young person in this age group? Were they boys or girls? Did they have a disability or not?
 - b. What are your concerns about providing information or services for this age group? Do you have different/additional concerns related to the gender and/or disability of very young people?
 - c. What reactions do you think you’d get from your community if you actively provided services to this age group? Do you think you would get a different reaction if you provide services to boys? To girls? Very young adolescents with disabilities?

Time: 1 hour

9. Introduce the presentation **Content: SRH Needs of Very Young Adolescents** (Slides 5.1-5.9), below. Tell participants that many health providers don’t know how to provide information or services to this age group, that lack of information and experience is even more significant when it comes to very young adolescents with disabilities, and that this presentation is designed to provide information that will enable them to interact with this age group taking into account not only their age but also their gender and disability. Pause for questions frequently between slides to allow for clarification and discussion.

Content: SRH Needs of Very Young Adolescents (Slides 5.1-5.9)

Slides 5.1-5.2: Information

Very young adolescents need *accurate, unbiased* information about sexuality and reproductive health from their service providers and parents. Overall, young people have limited access to comprehensive sexuality education or other sources of reliable information about their sexual and reproductive health, and this is particularly true for adolescents aged 10-14, girls who are married before age 15, and VYAs with disabilities.

Very young adolescents are exploring their values and beliefs around their emerging sexuality, including what it means to be a man or a woman. It is during this period

of life that young people adopt and establish their gender roles and identities. They are very receptive to information about the following topics:

- What changes to expect during puberty, including information about menstruation and nocturnal emissions.
- Gender roles, gender norms, and expressions of gender.
- Relationships.
- Violence, consent, and bodily autonomy.
- Sexuality, body image, personal values, tolerance, respect, and inclusion.
- For girls who are married, contraception, healthy timing and spacing of pregnancy, and healthy pregnancies.

Slide 5.3: Gender

A growing body of evidence suggests that providing positive messages on gender roles and promoting gender equitable behaviors and practices are particularly important for very young adolescents.

This is an important time to reinforce the following messages:

- Both young men and young women need time and space to determine who they want to be and how they want to get there.
- Violence towards other people is not “manly.”
- Violence and abuse against very young boys and girls with disabilities is not acceptable.
- Men do not need to experiment sexually to be “real men.”
- Women can also experience attraction and sexual desire without being “bad girls.”
- No partner in a romantic relationship, independent of their age, gender or disability should have physical, social, or economic power over the other.
- Both young men and young women with and without disabilities should have knowledge and information about their bodies and their health and how to prevent unintended pregnancy, STIs or HIV.

Slides 5.4-5.5: Early/Child Marriage

- Girls from poor households are more likely to marry early than girls from wealthier households.
- Girls with more schooling are less likely to marry as children. Keeping girls in school is critical to increasing the age of marriage and age of first pregnancy.
- Pregnancy is still a leading cause of morbidity and mortality for adolescents, especially for those under 15.
- Child brides are more likely to contract HIV, because they often marry a much older, more sexually experienced man. Girls aged 15-19 are anywhere from 2 – 6 times more likely to contract HIV than boys of the same age in sub-Saharan Africa.

- Child brides are more likely to experience domestic violence, show signs of sexual abuse, and experience post-traumatic stress such as feelings of hopelessness, helplessness, and severe depression.
- Limited and scattered data show that in regions and communities where child marriage is a common phenomenon, children with disabilities are likely to be proposed for marriage around the same age as their peers without disabilities.
- Disability adds an additional layer of vulnerability to the practice of child marriage and further enhances a girls' likelihood of being forced into marriage.
- While the driving causes of child marriage are similar for children with and without disabilities, parents of children with disabilities see marriage as a way to secure the child's future.

Slides 5.6-5.8: Protective Screening

Very little data is available on very young adolescents need for sexual and reproductive health services, and when they are available, data are not often disaggregated based on disability. However, it is safe to assume that 10-14-year-olds, particularly girls, who need these services are likely to be highly vulnerable.

- 1 in 10, or approximately 120 million girls worldwide, have experienced forced intercourse or other forced sexual acts. (*Source: UNICEF 2014*)
- In 18 countries reporting, anywhere from 10 to 70% of girls who experienced forced intercourse or other forced sexual acts were under the age of 15.
- 15 million girls or one out of every three girls in developing countries are married before the age of 18 every year, and one out of nine are married by age 15.
- In 15 countries reporting, between 10% and 27% of girls said they were married before they turned 15. (*Source Interagency Youth Working Group 2014*)
- Adolescents with disabilities are particularly vulnerable to sexual harassment, violence and abuse (ACPF, 2010; WHO and World Bank, 2011). Such incidents are rarely reported and, as a result, accurate and comparable disaggregated data are unavailable. However, a systematic review estimated that children and adolescents with disabilities are nearly three times more likely to experience sexual violence than their peers without disabilities (Jones et al., 2012).
- The risk of sexual violence increases for girls as soon as they reach puberty with most incidents having taken place between the ages of 14 and 17. While boys with disabilities are also at risk of sexual violence and abuse, girls are more likely to experience it (ACPF, 2010; Groce and Kett, 2014).

Many of these girls will only be seen by health providers when they present with a pregnancy, with HIV or with complications from an undiagnosed STI. Girls with disabilities face additional barriers and are often denied access to services as they are often inaccessible, health providers have little knowledge about disability and

feel unable or unequipped to provide services to this group of young people. Providers should be able to screen and treat girls with and without disabilities for sexual violence in addition to sexual and reproductive health or maternal services. Sexual and gender-based violence screening and services will be covered in Unit 13.

Slide 5.9: Preventative and Basic Services

In addition to protective and emergency services, some sexual and reproductive health services are best delivered in early adolescence:

- The WHO recommends that all girls aged 9-13 should receive vaccination against HPV in a two-dose schedule at 0 and 6 months [*Note: Females ≥ 15 years at the time of first dose should receive: a 3-dose schedule (0, 1-2, 6 months)*].
- All girls aged 10-14 need information and supplies to appropriately prepare for and handle menarche and menstruation.
- Data compiled by the Interagency Youth Working Group (2014) showed that between 9 to 27% of girls and 2 to 31% of boys aged 15-19 report initiating sexual activity before the age of 15. Disability disaggregated data on the age of sexual debut are scattered and very limited.
- Adolescents need contraception and dual protection strategies whenever they become sexually active. These should be available and accessible to all adolescents, including adolescents with disabilities.
- Many girls experience forced or coerced sex or violence, so they should have access to services, including counseling, post exposure prophylaxis and emergency contraception. These should be available and accessible to all girls, including girls with disabilities.

- 10.** Close the presentation by reminding participants that while there is limited attention to services for this age group, there is also little demand. Ask participants to revisit the concerns and fears they listed at the beginning of the session. Ask if any of them think they are better equipped to respond to criticism about providing services for this age group now.

SPECIFIC OBJECTIVE 5.2: IDENTIFY APPROPRIATE SERVICES AND INTERVENTIONS FOR VERY YOUNG ADOLESCENTS.



TIME

1 hour 45 minutes



METHODS

- Small group work



MATERIALS NEEDED

- Flipcharts and markers
- Participant Handout 5a: Services for Very Young Adolescents



STEPS

Time: 1 hour 45 minutes

1. Set up 4 flipcharts in the corners of the room, each with one of the following categories written on them:
 - a. Information
 - b. Healthy gender norms
 - c. Protection
 - d. Prevention and Basic Health
2. Pass out **Participant Handout 5a: Services for Very Young Adolescents** (below). Divide participants randomly into 4 groups by having them count off and assign each group to a flipchart.
3. Introduce the group work. Tell participants that each of the four groups should design a strategy to introduce the category of services listed on the top of the flip chart at their clinic for very young adolescents. Tell them that the handout they've received has some examples of types of services they may want to consider in each category but is not an exhaustive list. They can also consider the previous discussion on quality standards and statements.

When designing a strategy, they should consider: the SRH needs of very young adolescents, how to integrate services for this age cohort into their existing SRH services, where else such services can be provided, how to ensure quality of care, how to ensure these services are accessible to adolescents with disabilities, and if there are particular changes or stand-alone strategies they would need to add.

4. Give each group **25-30 minutes** to discuss and develop their strategy. The trainer should wander the room during this time and answer questions/clarify the assignment as needed.
5. Ask for a representative from each group to present back to the plenary. Give each group **five minutes** for their report back, then allow **10 minutes** for the whole group to respond and ask questions. After each group reports, the trainer can prompt responses from the whole group with the following questions:

- Would this strategy work in your clinic? What changes would you need to make if you wanted to introduce this kind of service? What changes would you need to make to ensure these services are accessible to adolescents with disabilities?
 - Does anyone already provide these services to this age group? Are they accessible to adolescents with disabilities? Are young adolescents with disabilities asking for them? What challenges do you have? What might be some ways to overcome the challenges?
 - Which of these services do you think are the highest priority for very young adolescents in your community? Which are less urgent? Do you think young adolescents with and without disabilities have the same or similar priorities? If not, why and how do you plan to address these differences?
6. Close the discussion by thanking all of the participants for their work during this unit. Acknowledge the difficulty of this topic and remind participants of resources available to them, including those listed at the beginning of this unit and others in their community.

PARTICIPANT HANDOUT 5A: SERVICES FOR VERY YOUNG ADOLESCENTS

Information

- Information about what changes to expect during puberty, including information about menstruation and nocturnal emissions.
- Information about gender roles and gender norms, including positive messages about gender equitable relationships, gender expressions, and social expectations of men and women.
- Information about violence, consent, and bodily autonomy.
- Positive messages about sexuality, body image, personal values, tolerance, respect and inclusion.
- Information on contraception including condoms.

Healthy Gender Norms

- IEC materials and behavior change interventions that address dominant gender roles, discrimination and violence based on gender, age, and disability.
- Stories, media, and films featuring positive depictions of masculinity, femininity, gender equality, women's empowerment, and inclusion.
- Counseling and social support for young people experiencing bullying or discrimination based on their gender identity or gender expression.

Protection

- Screening for violence or abuse (physical, emotional, or sexual) in the home, orphanages or other institutions.
- Screening for violence or abuse (physical, emotional, or sexual) in intimate relationships.
- Screening for violence or abuse (physical, emotional, or sexual) in the community (school, public spaces, rehabilitation centers, etc).
- Social support for married adolescents.
- Support for young adolescents with disabilities.
- Access to contraception, condoms, emergency contraception, safe abortion or post-abortion care, and HIV prevention including pre- and post-exposure prophylaxis.
- Counseling and support services for those who have experienced force, coercion, or abuse.

Prevention and Basic Health

- Information, training, and supplies for menarche and menstruation.
- HPV vaccinations.
- Access to information and supplies for contraception and dual protection for very young adolescents who are already or who are considering becoming sexually active.
- Screening for sexual abuse or violence.
- Information about and screening for STIs, including HIV.

UNIT 5 SUMMARY



TIME

10 minutes



METHODS

Reflection



MATERIALS NEEDED

None



STEPS

1. Bring participants into a group and ask them to reflect on the following questions:
 - Why is it especially important to consider the SRH needs of very young adolescents? What is especially important to consider regarding young adolescents with disabilities?
 - What sort of resistance to serving very young adolescents might we face in our clinics and facilities?
 - What are some ways we could better determine the SRH needs of very young adolescents with and without disabilities and develop programs to serve them?

UNIT 6:

SEXUAL ORIENTATION AND GENDER IDENTITY AND EXPRESSION

INTRODUCTION:

For many service providers, few subjects can feel more difficult, confusing, or complicated than sexual orientation and gender identity and expression. Things like gender identity and sexual orientation, which feel basic to many people, are built into our assumptions through our language, through the way we learn, through the ways we are taught to interact with each other and our communities. Sometimes, our personal, cultural, or religious values and experiences put us into conflict with our desire to help clients who may have sexual or gender identities that feel foreign – even wrong – to us.

As providers and counselors, we must understand that there are a range of sexual orientations and identities and gender identities and expressions. Adolescence is a time of learning, when young people begin to define an individual identity, explore gender and sexuality and analyze how these pieces fit together. An adolescent client who is struggling with their sexual orientation or gender identity often faces not only internal conflict and confusion, but also extreme stigma, discrimination, pressure, and even violence from their society, their peers, and their families. When sexual orientation and gender identity intersect with other discrimination factors such as disability, ethnicity and race, the risk for adolescents to experience, stigma, pressure and violence is even higher. It is the responsibility of providers to provide accurate, accessible and unbiased information and services to all adolescent clients, even if their sexual orientation, gender identity or gender expression conflicts with their personal values and opinions.


UNIT TRAINING OBJECTIVE:

To help providers support all adolescent clients of different sexual orientations and gender identities and expressions with inclusive services and non-judgmental counseling.




SPECIFIC LEARNING OBJECTIVES:

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

5. Define concepts related to sexuality, sexual orientation, gender, gender identity, and gender expression.
6. Describe challenges, pressures, and risks for adolescents based on their sexual orientation and gender identity and expression and how these can multiply when it comes to adolescents with disabilities.
7. Identify specific service and counseling needs for transgender and intersex adolescents.
8. Model inclusive counseling techniques for all adolescents regardless of sexual orientation or gender identity or expression.

 **TOTAL TIME: 3 hours 45 minutes**

UNIT OVERVIEW:

Session	Methods 	Materials 	Time 
6.1	Group work	Flipcharts and markers Term and definition cards Tape	30 minutes
6.2	Group discussion Trainer presentation	Slides 6.1-6.13 Participant Handout 6a	1 hour
1. 6.3	Values clarification Trainer presentation	Flipcharts and markers Slides 6.14-6.21	1 hour 15 minutes
6.4	Fishbowl role play	Trainer's Tool 6b	45 minutes
Unit Summary	Ice-breaker		15 minutes



WORK FOR TRAINERS TO DO IN ADVANCE:

- Review slides 6.1-6.21
- Research legal and clinical policy on rights of LGBTQI clients in your area
- Find a local organization that works with LGBTQI young people and with LGBTQI adolescents with disabilities if possible, as a resource for participants. If that is not possible, find a local Organization of Persons with Disabilities (OPD) that works on disability, gender, and sexuality as an additional resource.
- SO 6.1: Prepare term and definition cards for group exercise. Review terms and definitions and research any unfamiliar information.
- SO 6.4: Prepare Trainer's Tool 6b: Client descriptions.



MAJOR REFERENCES AND TRAINING MATERIALS:

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SPECIFIC OBJECTIVE 6.1: DEFINE CONCEPTS RELATED TO SEXUALITY, SEXUAL ORIENTATION, GENDER, GENDER IDENTITY, AND GENDER EXPRESSION



TIME

30 minutes



METHODS

- Group exercise



MATERIALS NEEDED

- Flipcharts and markers
- Trainer's Tool 6a: Term and Definition Cards
- Tape



STEPS

1. Set up the room: place flipchart pages in various places around the room. Tape Term Cards (see **Trainer's Tool 6a: Term and Definition Cards**) to the pages, leaving room for definitions.

Time: 10 minutes

2. Introduce the topic using **Content: Introduction to SOGIE** below.

Content: Introduction to SOGIE

For many service providers, few subjects can feel more difficult, confusing, or complicated than sexual orientation and gender identity and expression or SOGIE. Things like gender identity and sexual orientation, which feel basic to many people, are built into our assumptions through our language, through the way we learn, through the ways we are taught to interact with each other and our communities. Sometimes, our personal, cultural, or religious values and experiences put us into conflict with our desire to help clients who may have sexual or gender identities that feel foreign – even wrong - to us.

As providers and counselors, we must understand that there are a range of sexual orientations and identities and gender identities and expressions. Adolescence is a time of learning, when young people begin to define an individual identity, explore gender and sexuality and analyze how those pieces fit together. An adolescent client who is struggling with their sexual or gender identity often faces not only internal conflict and confusion, but also extreme stigma, discrimination, pressure, and even violence from their society, their peers, and their families. When sexual orientation and gender identity intersect with other discrimination factors such as disability, ethnicity and race, the risk for adolescents to experience, stigma, pressure and violence is even higher. It is the responsibility of providers to provide accurate, accessible and unbiased information and services to all adolescent clients, even if their sexual orientation, gender identity or gender expression conflicts with their personal values and opinions.

3. Tell participants that you'll be conducting a quick exercise to help everyone in the room assess their comfort with today's topic. Ask participants to close their eyes while you ask a series of questions. Ask them to raise their hands in response if they are comfortable, but stress that no one needs to raise their hands if they do not want to.

***Trainer's Note:** pause after each statement for participants to put their hands back down if they have raised them. Take note if any participants look uncomfortable or are not participating at all.*

4. Ask participants to raise their hands if:
 - a. They are usually happy with or comfortable with their assigned gender.
 - b. They ever feel like they are expected to behave in a certain way because of their gender.
 - c. They are ever frustrated with how someone treats them because of their gender.
 - d. They are married or in a relationship.
 - e. They have ever struggled to find someone they felt like they could connect with.
 - f. They have ever felt like someone was judging them or unnecessarily unkind to them.
 - g. They feel comfortable talking about issues related to sexual orientation and gender identity and expression.
 - h. They know of anyone who identifies as lesbian, gay, bisexual, transgender, or intersex.
 - i. They feel capable of seeing/caring for someone who is or might be lesbian, gay, bisexual, transgender, or intersex.
 - j. They feel capable of seeing/caring for someone who is or might be lesbian, gay, bisexual, transgender, or intersex and has a disability.
5. Tell participants to take a deep breath and open their eyes again when they are ready. Ask participants to consider how they felt when answering the questions and take a moment to set aside their concerns and discomfort and open their thinking for the next session.

Time: 20 minutes

6. Divide the group into two teams. Distribute the Definition Cards evenly between the groups. Give the groups **five minutes** to match the definitions on the cards with the terms taped around the room.
7. With the whole group, review the terms and definitions according to the answer key included in **Trainer's Tool 6a**. Take time with each definition to clarify terms or answer questions and correct misinformation.

TRAINER'S TOOL 6A: TERM AND DEFINITION CARDS

Term Cards:

<p>1. Biological Sex</p>	<p>2. Gender Identity/Expression</p>	<p>3. Queer</p>
<p>4. Gender Norm</p>	<p>5. Gender Stereotype</p>	<p>6. Sexuality</p>
<p>7. Sexual Orientation</p>	<p>8. Lesbian</p>	<p>9. Gay</p>
<p>10. Bisexual</p>	<p>11. Transgender</p>	<p>12. Intersex</p>

Definition Cards

Source: Adapted from Amnesty International 2015

- A.** Q woman who is primarily physically, sexually, and emotionally attracted to other women. It can refer to same-sex sexual attraction, same-sex sexual behavior, and same-sex cultural identity for women.
- B.** Individuals who have genital, chromosomal, or hormonal characteristics which do not correspond to the given standard for “male” or “female” categories of sexual or reproductive anatomy. It may take many forms and covers a wide range of bodily characteristics.
- C.** An expected mode of behaving in society based on a person’s real or perceived physical sex, or whether they are male or female.
- D.** The physical, genetic, and chromosomal characteristics that make a person physically male, female, or intersex.
- E.** The combination of sex, gender identity and role, eroticism, pleasure, intimacy, and reproduction. It is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles, and relationships.
- F.** Men or women who are primarily physically, sexually, and emotionally attracted to people of the same sex. It can refer to same-sex sexual attraction, same-sex sexual behavior, and same-sex cultural identity. It is not gender-specific and can refer to a person of any gender who experiences same-sex sexual attraction, though in common usage it usually refers to men.
- G.** Individuals whose gender identity and/or gender expression is different from the biological sex they were assigned at birth. Some people may choose to modify their biological sex to match their gender identity, either through surgery or hormonal treatments, and some may not. The term can include a wide range of other identities, such as members of third genders, as well as individuals who identify as more than one gender or no gender at all.
- H.** A person’s deeply felt individual experience of gender, which may or may not correspond with the sex assigned at birth, or with the way they are expected to express their gender. It includes a personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical, or other means) and other expressions including dress, speech, and mannerisms.
- I.** A person who is attracted to and/or has sex with people of all genders. It can also refer to a cultural identity.
- J.** A person whose sexual orientation, gender identity, and/or gender expression fall outside the expected norm for their society, or a person of any gender whose sexuality is not heterosexual or straight.
- K.** Generalized assumptions made about how a person is or should be based on their gender identity or expression. Assumptions made about people’s value on the basis of their biological sex, sexual orientation, or gender identity or expression. They may not be based in fact and can be both positive and negative.
- L.** Refers to each person’s capacity for emotional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender, the same gender, or more than one gender.

Answer Key: 1-D, 2-H, 3-J, 4-C, 5-K, 6-E, 7-L, 8-A, 9-F, 10-I, 11-G, 12-B.

SPECIFIC OBJECTIVE 6.2: DESCRIBE CHALLENGES, PRESSURES, AND RISKS FOR ADOLESCENTS BASED ON THEIR SEXUAL ORIENTATION AND GENDER IDENTITY AND EXPRESSION



TIME

1 hour



METHODS

- Group Discussion
- Trainer Presentation



MATERIALS NEEDED

- Slides 6.1-6.13
- Participant Handout 2a: Developmental Characteristics of Adolescence and Young Adulthood (from Unit 2)



STEPS

1. Ask participants to take out and revisit **Participant Handout 2a: Developmental Characteristics of Adolescence and Young Adulthood** (distributed in Unit 2).

Time: 30 minutes

2. Ask participants to work quickly in pairs with the person sitting next to them to underline or highlight those characteristics of adolescent development that they think are particularly important to note for adolescents who identify as or might be lesbian, gay, bisexual, transgender, queer, or intersex. Give participants no more than **5 minutes** to complete this activity.
3. Draw participants attention to these statements on their handout in the “Social and Emotional Development” Column:

Early Adolescence (Ages 10-14)

- *Struggle with a sense of identity*
- *Worry about being ‘normal’*
- *Increased awareness of sexual desire*

Late Adolescence (Ages 15-19)

- *Swings in self-esteem and self-confidence*
- *Worry about being ‘normal’*
- *Occasionally fluid or rapidly changing understanding of sexuality and gender*
- *Feelings of love and passion*
- *Increasing interest in sex*

Early Adulthood (Ages 20-14)

- *Firmer sense of sexual identity*

- *Development of serious romantic relationships*
4. Ask participants to reflect individually on the messages they hear in their communities about sexual orientation and gender identity. Facilitate a short group discussion using the following questions:
 - a. Are the messages about sexual orientation and gender identity in their communities mostly positive? Mostly negative?
 - b. Are there negative or positive messages that refer specifically to sexual orientation, gender identity, and disability?
 - c. When do adolescents start hearing negative messages about sexual orientation and gender identity in their community?
 - d. How would those messages affect their ability to navigate their adolescence? How would those messages affect things like their self-esteem, sense of being 'normal,' or sense of belonging?
 - e. Would those messages affect adolescents with disabilities differently?
 - f. What resources are available in the community for adolescents struggling with these issues? Are they accessible to adolescents with disabilities? Who can they talk to if they need to talk?

Time: 30 minutes

5. Introduce **Content: Health Needs of LGBTQI Adolescents** (Slides 6.1-6.13). Explain to participants that for many adolescents, their sexual orientation or gender identity or expression can put them in the path of increased harassment, discrimination, and even violence from their peers, their families, and their communities. Explain to the participants that the intersection of these discrimination factors with disability exposes LGBTQI adolescents with disabilities to a higher risk of harassment and violence.

Content: Health Needs of LGBTQI Adolescents (Slides 6.1-6.13)

Sources: Advocates for Youth 2016, IOM 2011, SAHM 2013, Amnesty International 2015

Slides 6.1-6.2: Concerns of LGBTQI Adolescents

Adolescence is a time of exploration of your place in society, including your gender, gender expression, sexuality, and sexual desire. For some adolescents who may not have a sexual orientation, gender identity, or gender expression that conforms to their society's expected "normal," this can mean extra social pressure and even harassment, discrimination, or violence from all corners. Moreover, LGBTQI adolescents with disabilities, and especially those with intellectual and developmental disabilities, often face additional barriers in expressing their sexuality or gender identity. This may affect their ability to form social and intimate relationships, and to connect with mainstream LGBTQI and disability support groups and communities.

From a health provider's perspective, the health concerns of LGBTQI adolescents may be largely the same as those of their peers, but they are amplified by the

additional stigma they experience related to their sexual orientation or gender identity:

- They have questions about the changes in their bodies and emotions during adolescence.
- They face social stigmatization of their sexual desire and sexual behavior.
- They risk unintended pregnancy and infection with STIs, including HIV.
- They may be subject to sexual or gender-based violence, sexual coercion, or intimate partner or domestic violence in the household. This risk affects both their physical and mental health.

Slide 6.3: Specific Health Risks of LGBTQI Adolescents

When it comes to unintended pregnancy and STI risk, including risk for HIV, there are some assumptions about lesbian, gay, bisexual, transgender, queer, and intersex youth that need clarification:

- Young men who have sex with men have higher risk for HIV and other STI transmission.
- Young women who have sex with women have lower HIV risk, but are at risk for other STIs, especially those that are transmitted skin to skin or orally.
- Young lesbian women and young gay men may have opposite-sex partners because of social pressure or experimentation.
- Young lesbian, bisexual, and transgender women are frequent targets for sexual violence, such as “corrective rape” and need access to emergency contraception and post-exposure prophylaxis. Corrective rape occurs when a person is raped because of their perceived sexual orientation or gender identity. The common intended “consequence,” as seen by the perpetrator, is to turn the person heterosexual or to enforce conformity with gender stereotypes.

Slides 6.4-6.8: Harassment and Discrimination

In addition to the amplified concerns of these adolescents related to sexual and reproductive health, LGBTQI adolescents also face additional harassment and discrimination. This is particularly true for persons with disabilities who identify as LGBTQI.

<p>Homophobic bullying in schools, in the home, and in communities can inflict psychological, emotional, and physical harm on young people who are targeted based on their real <i>or perceived</i> sexual orientation or gender identity.</p>	<p>In Bangladesh, a 2007 study showed that boys who behave in more stereotypically “feminine” ways are more likely to drop out of school due to harassment and bullying. Source: Amnesty International</p>
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<p>Young people who “come out” to their families as lesbian, gay, bisexual, transgender, or queer may face rejection or abuse from their parents, caretakers, or other family members, increasing their risk for depression, suicide, and self-abuse.</p>	<p>Young people who face rejection from their families during adolescence are 3.5 times more likely to experiment with drug use or have unprotected sex, 6 times more likely to suffer from depression, and 8.5 times more likely to report having attempted suicide. Source: SAHM 2013</p>
<p>Adolescents who identify as LGBTQ may be forced into emotionally abusive or damaging “reparative” therapies or may be subject to “corrective” rape or sexual violence.</p>	<p>One 2011 study in South Africa reported as many as 500 cases of “corrective” rape of lesbian-identified women in the previous year. Source: Open Society Initiative for Southern Africa</p>
<p>People who identify as transgender or have gender identities or expressions which are not considered “normal” by their communities are particularly targeted for violence.</p>	<p>Between January 2008 and October 2014, there were 1,612 reported killings of transgender people in 62 countries.</p>
<p>Persons with disabilities who identify as LGBTQI are more likely to report having experienced harassment or violence than those without disabilities.</p>	<p>One study published in Australia in 2018 reported that 46% of LGBT people with a disability versus 33% without reported having experienced at least one form of harassment or violence in the last 12 months prior to completing the survey. LGBT respondents with a disability were more likely to have been subject to verbal abuse than respondents without disability (32% versus 24%); more likely to have ‘received written threats of abuse including emails and graffiti’ (11% versus 5%); more likely to have been subject to harassment (21% vs 14%); and more likely to have been subject to threats of physical violence or physical assault such as being punched, kicked, or beaten (13% vs 8%). Source: W. Leonard & R. Mann, 2018</p>

6. Pause here. Ask participants to reflect on if these statistics mean anything for their practice as health providers. Return to the presentation with **Slide 6.9: Advice for Health Providers** below.

Slides 6.9-6.10: Advice for Health Providers

Source: SAHM 2013

- Health care providers who care for adolescents should be trained in competent and nonjudgmental care for all LGBTQI youth. This includes an understanding of adolescent sexuality development, the ability to identify mental health concerns related to harassment, discrimination, and violence, and familiarity with physical and sexual health issues related to sexual orientation or gender identity and their intersections with disability, ethnicity, race and other discrimination factors.
- Providers should understand that most LGBTQI young people are healthy adolescents and young adults. The high-risk behaviors exhibited by some LGBTQI adolescents are often reactions to social stigma and non-acceptance by peers and society, not as a result of moral failure or disease related to their sexual orientation or gender identity.
- LGBTQI youth face harassment, discrimination, and violence in most societies, which is associated with increased risk of depression and suicide.
- LGBTQI adolescents with disabilities can also experience discrimination from within the LGBTQI and disability communities, compounding their sense of social marginalization and isolation and contributing to their increased risk of developing mental health problems.
- LGBTQI people with disabilities' experiences of systemic discrimination and exclusion are associated with reduced health and wellbeing and reduced access to services.
- LGBTQI people with disability present even higher rates of anxiety and psychological distress than LGBTQI people without disabilities and are at increased risk of self-harm.
- Health care providers should be comfortable screening for and discussing these issues with their LGBTQI patients with and without disabilities and members of the community.

Slides 6.11-6.12: Screening for Harassment, Discrimination and Violence

Young people may be subject to harassment, discrimination, and violence due to their sexual orientation or gender identity or expression. For many young people, this harassment can manifest in health service settings if providers are not fully informed or have incorrect information about or stereotypical attitudes towards sexuality and gender. In the case of LGBTQI adolescents with disabilities, discrimination factors that are related to sexual orientation, gender identity, and disability intersect, increasing the risk of harassment when accessing health services. Some things to remember:

- LGBTQI young people are at more risk for depression and suicide, but the solution is not to change or hide their identity.
- LGBTQI adolescents with disabilities face multiple challenges in finding support at the community level as, in most of the cases, health services,

- local LGBTQI organizations and networks are not disability inclusive.
 - No therapy or treatment has ever been proven to successfully “change” someone’s sexual identity or orientation. Such therapies and treatments are harmful to young people.
 - Gender expression is not a symptom of sexual orientation: young men who are “feminine” or young women who are “masculine” are not necessarily lesbian, gay, or bisexual.
7. Pause and ask participants if they would be comfortable counseling an adolescent client who identified as lesbian, gay, bisexual, transgender, queer, or intersex. Ask participants if they would feel the same in the case of an adolescent client with disabilities. Ask for any volunteers to offer tips to the other participants.
 8. Finish the presentation with **Slide 6.13: Communicating with LGBTQI Adolescent Clients**.

Slide 6.13: Communicating with LGBTQI Adolescent Clients

Sexual orientation and gender identity are dynamic concepts, and adolescent sexuality can be fluid and change rapidly. Health providers should be cautious in assigning labels to adolescent’s gender and sexuality.

- Providers should ask adolescents how they self-identify and be guided by their language and self-concept.
 - Providers should be careful not to make assumptions about the gender identity of their clients’ sexual partners.
 - Providers should be careful to control their reaction and react in a neutral or positive manner to statements about the gender identity or sexual orientation of their adolescent clients.
9. Close by asking for questions or clarifications. Thank participants for their input and attention.

SPECIFIC OBJECTIVE 6.3: IDENTIFY SPECIFIC SERVICE AND COUNSELING NEEDS FOR TRANSGENDER AND INTERSEX ADOLESCENTS



TIME

1 hour 15 minutes



METHODS

- Values clarification activity
- Trainer presentation



MATERIALS NEEDED

- Slides 6.14-6.21
- Flipcharts and markers



STEPS

1. Introduce the topic. Explain to participants that gender identity and expression can be one of the most difficult things to understand for many people especially those who are struggling with a gender identity or expression that is outside traditional social norms.
2. Tell participants that people who identify as transgender or intersex not only face the same SRH concerns as other adolescents, but also may need special treatment or support from their health providers. Very few providers, however, receive any training or information on how to support these clients. Even less for clients who have a disability.

Activity (*Adapted from Amnesty International 2015*)

Time: 45 minutes

3. Place a flipchart at the front of the room. Draw a box on the page and write the words “Act like a man” on the top of the page.
4. Ask participants to share what comes to mind when they hear the words “Act like a man.” Use the following questions to prompt responses and record their responses in the box on the flipchart page.
 - a. What do you need to do to be a “real man”?
 - b. What are you allowed to feel?
 - c. How do men behave? What expectations do your family, community, and friends have of men?
5. Place another flipchart next to the first one (or remove the first page and pin it to the wall where it is visible). On the next flipchart page, draw another box and write the words “Act like a lady” on the top of the page.
6. Ask participants to share what comes to mind when they hear the words “Act like a lady.” Use the following questions to prompt responses and record their responses in the box on the flipchart page.
 - a. What do you need to do to be a “real lady”?

- b. What are you supposed to feel?
 - c. How do women behave? What expectations do your family, community, and friends have of women?
7. In the large group, or in smaller groups of 4-5, ask participants to reflect on what is written on the two flipchart pages.
8. Use the following questions to prompt discussion:
- a. How does it make you feel to look at these gender roles and expectations?
 - b. Do you remember the first time someone told you to “act like a man” or “act like a lady”? When do you think we start teaching children about gender expectations?
 - c. What happens when someone doesn’t behave the way they are expected to because of their gender and disability?
 - d. What would it mean to behave in a way that was “outside the box” when it comes to gender and disability?
9. On a third piece of flip chart paper, draw a horizontal line. Label one side “feminine” and the other side “masculine.”
10. Explain to participants that one way to understand gender identity is to think of gender as a spectrum, from feminine to masculine. While some people have very stereotypically gendered expressions, most people have some combination of “feminine” and “masculine” traits. Ask participants to think about where they would place themselves if you asked them to mark their identity on the spectrum.
11. Draw another horizontal line above the first. Label it “male” and female” on either end. Explain that there is also variation in physical sex, and that some people are born with physical or biological markers that are somewhere between male or female. Draw a vertical dash through the center of the horizontal line and mark it “intersex.”
12. Revisit the definition of “intersex” from the activity in 5.1:
- “Individuals who have genital, chromosomal, or hormonal characteristics which do not correspond to the given standard for “male” or “female” categories of sexual or reproductive anatomy. It may take many forms and covers a wide range of bodily characteristics.”*
- Clarify that intersex identities, or disorders of sex distinction, can take many forms and may or may not be visible in someone’s body.
13. Tell participants that gender identity and expression may or may not be aligned with their physical sex. Ask how they think people around them would react if their gender identity didn’t “match” their physical sex. What if someone wanted to change their physical sex or gender expression to “match” their gender identity?

Time: 30 minutes

14. Begin the presentation with **Content: Defining Gender and Sex** (Slides 6.14-6.21),

below. Tell participants that you'll start by revisiting some of the definitions they've seen before, and then discuss specific care strategies for transgender or intersex adolescents.

- **Trainer's Note:** *Ensure time for questions, clarification, and discussion with each slide. Make sure to correct misinformation, assumptions, or negative stereotypes when they appear, and ask participants to be respectful and open to each other and each other's experiences.*

Content: Defining Gender and Sex

Slide 6.14: Gender Identity and Expression

A person's deeply felt individual experience of gender, may or may not correspond with the sex assigned at birth, or with the way they are expected to express their gender. It includes a personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical, or other means) and other expressions including dress, speech, and mannerisms.

Identity is how you understand and feel your gender. Expression is how you communicate your gender identity to the world around you in terms of dress, appearance, and actions.

Slide 6.15: Intersex and Transgender

Intersex: Individuals who have genital, chromosomal, or hormonal characteristics which do not correspond to the given standard for "male" or "female" categories of sexual or reproductive anatomy. It may take many forms and covers a wide range of bodily characteristics.

Transgender: Individuals whose gender identity and/or gender expression is different from the biological sex they were assigned at birth. Some people may choose to modify their biological sex to match their gender identity, either through surgery or hormonal treatments, and some may not. The term can include a wide range of other identities, such as members of third genders, as well as individuals who identify as more than one gender or no gender at all.

Slide 6.16: Social Pressures on Intersex and Transgender Adolescents

Intersex and transgender adolescents may face different challenges. Intersex adolescents may or may not be aware of their identity, or it may only begin to become apparent when they reach puberty and experience changes in their hormones. Intersex identity is often invisible and intersexed adolescents may fear being discovered as intersex. They may struggle to understand why and how their development differs from their peers.

Transgender adolescents frequently have a strong sense of gender identity and of being “different” from their peers. They may have been subject to violence or abuse in an attempt to “correct” their behaviors or identity and may have internalized social stigma against their gender expression. Transgender adolescents are often bullied or face violence from family, peers, and communities and are often at greater risk of suicide, self-harm, and depression.

15. Pause and ask participants to reflect on their counseling and support role for adolescent clients presenting with confusion or depression related to their gender identity or sex development. Ask participants if and how they would adjust their counseling and support role if the adolescent client has a disability.

Return to the presentation with **Slide 6.17: Health Providers and Parents** below.

Slides 6.17-6.18: Health Providers and Parents

Because violence and discrimination are common within the family, health providers may need to act as a mediator between a client and their parents or caretakers. Even when an adolescent client has a supportive family environment, the health provider may be a trusted source for information about gender and sexual identity. Even when LGBTQI adolescents are accompanied by their parents, providers should refer to the adolescent as their main client and respect their opinion when it comes to decisions related to their sexual and reproductive health. Young persons with disabilities do not represent an exception.

Providers can help parents and caretakers by:

- Reinforcing that intersex identities are common and physically safe for children, adolescents, and adults.
- Reinforcing that transgender identity is no longer considered a physical or mental disorder and cannot be “fixed” through counseling, discipline, or social pressure.
- Helping identify online or community resources for accurate scientific information and support for parents and adolescents (*some are listed at the front of this unit*).

Slide 6.19: Specific Care Strategies: Intersex Adolescents

Source: Frader et al, 2004

- Children born with physical sex differences may or may not need surgery to alter the appearance or function of their external genitalia. Health providers should consider the social and cultural context and acknowledge that surgery will not always protect against discrimination for those adolescents who differ from the “norm.”
- If and when possible, providers should avoid surgery until the patient is old enough to determine their own gender identity and make their own choice for surgery.
- Hormonal or chromosomal differences may need additional treatment with

hormone therapy in adolescence or later in life in to accelerate pubertal development or increase fertility.

- Parents and families should be supported to help their intersex children understand, accept, and embrace their bodies and physical differences.

Slide 6.20-6.21: Specific Care Strategies: Transgender adolescents

Source: Wylie et al, 2016

- Transgender adolescents should, whenever possible, be treated within the primary care structure, no differently from other adolescents.
 - Adolescents presenting with non-normative gender identity or transgender identity should be supported with positive counseling and mental health support for the duration of any treatment.
 - Many online resources and communities exist for transgender adolescents who do not have in-person or community support.
 - Drugs to suppress hormones can be prescribed to delay the onset of puberty or block the maturation of secondary sex characteristics while the adolescent continues to develop their gender identity and role.
 - Hormone therapies can be used to promote feminization or masculinization for transgender adolescents who are planning to transition to their experienced gender identity.
 - Providers should discuss storage of eggs or sperm to ensure opportunities to reproduce in the future.
 - Providers should also discuss potential interactions of hormone therapy with HIV drugs and other medical treatments or procedures before starting any hormone regimen.
 - Gender confirming surgeries, though not currently available in most countries, may be beneficial to adolescents with gender dysphoria, which can improve psychological outcomes.
- 16.** Close the session by reminding participants that while many of them may not have to directly treat intersex or transgender adolescents, the awareness of these issues can help them be more understanding for all adolescents regardless of their gender identity or expression.

SPECIFIC OBJECTIVE 6.4: MODEL INCLUSIVE COUNSELING TECHNIQUES FOR ALL ADOLESCENTS REGARDLESS OF SEXUAL ORIENTATION OR GENDER IDENTITY OR EXPRESSION



TIME

45 minutes



METHODS

- Fishbowl role play



MATERIALS NEEDED

- Trainer's Tool 6b: Client descriptions



STEPS

1. Set chairs in a circle in the center of the room. Pull two chairs into the center of the circle, facing each other.

Time: 45 minutes

2. Ask for two participants to sit in the chairs in the center of the circle. Assign one the role of provider, and one the role of client.
3. Give the client a role description card (see **Trainer's Tool 6b: Client Descriptions** below). Tell the participant playing the client to act according to the description without reading out the description to the audience.
4. Explain to the participant playing the provider and the group that the point of this exercise is to practice providing counseling in a non-judgmental and open manner. They should give accurate information that is helpful to the client.
5. Ask the rest of the participants to observe the interaction between the "client" and the "provider."
6. Have the two participants in the center of the circle spend **five minutes** role playing the interaction while being observed. When they have finished, ask observers to comment on the following questions:
 - a. Did the provider/counselor provide accurate and helpful information to the "client" in a non-judgmental manner?
 - b. If yes, what things did the "provider/counselor" do that led to a positive interaction?
 - c. What could the "provider/counselor" have done to improve the interaction between him/herself and the "client"?
 - d. Ask the "client"—how the character s/he played felt in this situation?
7. Ask for two new volunteers. Give the new "client" a description card and the same

instructions. Repeat the exercise for as many client description cards as you think are relevant or necessary for practice.

- 8.** Close the session by thanking volunteers and the group for their participation.

TRAINER'S TOOL 6B: CLIENT DESCRIPTIONS

Client 1: You are an 18-year-old woman who is attracted to women. You have known this about yourself for years and have tried to establish relationships with men, but it only makes you unhappy. Your family has made it clear that when you finish secondary school at the end of the year, you should be planning to get married. You go to the counselor/health provider for advice: you want to know if she can give you some kind of injection to make you attracted to men instead of women.

Client 2: You are a 23-year-old man with a 4-year-old son. You recently caught him wearing his mother's shoes and putting on lipstick. His mother says that he sometimes does this: it doesn't mean anything, and he will grow out of it in year or two. You are afraid that it means that your son will grow up to be feminine, or even attracted to other men. Your mother says you should beat the behavior out of the boy, so that he knows how to be a man. You visit the health provider to find out if your son is gay.

Client 3: You are a 16-year-old young man who lives on the street with your younger siblings. To make money to buy food, you trade sexual favors (including anal intercourse) with other men. You have heard that HIV is only spread through sex, and you only have sex (vaginal intercourse) with your girlfriend, so you're not worried about catching it. Some of the older boys tease you about being "gay," and you are concerned that if you keep having sex with men for money you will end up gay.

Client 4: You are a 17-year-old woman with a 19-year-old boyfriend. You have been seeing him for two years and having sex for over a year. You love your boyfriend and enjoy having sex with him. You also have a female best friend that you have known since you were a small child. Since you were 13 or 14, you have been kissing and "playing" with her sexually but you never thought it meant anything about you or her being lesbian. Your boyfriend recently caught you kissing your friend and brought you to the health provider to be "fixed."

Client 5: You are 14 years old. When you were born, everyone thought you were female, so you have been told you were a girl your whole life, but it has always sounded wrong to you. As long as you can remember, you have felt like somehow God put you in the wrong body, and you were meant to be a boy. You are different from the other girls in your community: you don't understand them and hate being forced to spend time with them, when you would rather be playing with boys. As you have begun to become more visibly "female"

which includes the onset of menstruation your family has been pressuring you to act more like a “proper young woman.” You want the health provider to stop your body from physically changing so that you can go back to playing with the boys the way you did when you were a child.

Client 6: You are an intersex adolescent with a visual disability and you are not sure yet about your gender identity. When you go to your health provider, your parents tend to discuss and make decisions about your health without consulting you. Your parents think you should have a surgery as soon as possible to ensure you fully develop as a woman, and do not miss the opportunity to get married and have someone who can take care of you when they are gone. They take you to the SRH clinic to discuss about the surgery. You are not sure you feel like a girl and you need more time. You hope the SRH provider will ask how you feel about this.

UNIT 6 SUMMARY



TIME

15 minutes



METHODS

Ice-breaker



MATERIALS NEEDED

None



STEPS

1. Gather participants in a circle. Go around the circle and have participants list one thing they like about being their gender.
2. Go around again and have participants list one thing they would change about being their gender, if they could.
3. Have participants reflect on any commonalities or differences. Remind participants that it is the differences between us that make us interesting.

UNIT 7:

COMMUNICATING WITH THE ADOLESCENT CLIENT

INTRODUCTION:

Clear and effective communication is a key component in programs and services that help an adolescent achieve healthy development and good sexual and reproductive health. Good communication helps establish trust and positive relationships. Adolescents often lack access to appropriate and accurate sources of information whether in the home, the school, or the community. Health care providers who use good communication skills ensure adolescents obtain accurate and unbiased sexual and reproductive health information, which can both educate young people and facilitate their ability to make responsible decisions.

Marginalized young people face additional barriers to accessing accurate and quality information. Among them, young persons with disabilities face additional communication barriers that could vary according to the type of disability. Accommodation is needed to ensure good communication: language interpreters or subtitles in video materials for young persons with hearing disabilities, braille or audio materials for young persons with visual disabilities, and easy to read/simplified materials and pictures for young persons with intellectual and developmental disabilities. In low-resource communities, the use of other simple methods is recommended to ensure good communication: lip reading or exchange of written messages and images with persons with hearing disabilities, reading aloud the information included in written materials inaccessible for persons with visual disabilities, and the use of simplified language and pictures to communicate with persons with intellectual and developmental disabilities. In these circumstances, the most important resource for providers is time, patience, and willingness to establish a good communication with persons with disabilities.

In addition to the instructions included in this module, please refer to the chapter “Adolescents with disabilities” for specific guidance on how to provide inclusive and accessible health information and services to young persons with disabilities and to overcome communication barriers.

Trainer’s Note: This unit is intended to be delivered with trainers who are young. The lesson and activities can be modified for an adult provider-only participant group, but the session is enhanced by young people’s perspectives. It is essential to include the participation of youth trainers with different types of disabilities within the training. Accommodation (sign language interpretation and/or Computer Aided Real-Time Transcription (CART)¹ personal assistants, braille, large print, easy to read materials, etc.) should be provided as needed.

¹ CART is a method to provide access to spoken communication for people with hearing, cognitive or learning disabilities. CART refers to the instant translation of the spoken word into text using a

 **UNIT TRAINING OBJECTIVE:**

To prepare providers to understand the adolescent’s perspective and respond to their specific needs about sexual and reproductive health by using clear, effective and inclusive communication strategies.




 **SPECIFIC LEARNING OBJECTIVES:**

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

1. Explain the importance of establishing a positive, welcoming service environment for the adolescent client.
2. Identify strategies that establish trust with adolescent clients.
3. Demonstrate skills for counseling adolescents on sexuality.

 **TOTAL TIME: 7 HOURS**

UNIT OVERVIEW:

Session	Methods 	Materials 	Time 
2. 7.1	Group brainstorm Communication exercise	Flipcharts and markers Participant Handout 7a	1 hour
7.2	Trainer presentation Small group discussion	Slides 7.1-7.8 Participant Handout 7b	1 hour 45 minutes
7.3	Trainer presentation Values clarification Role play	Slides 7.9-7.14 Participant Handout 7c	2 hours 15 minutes
7.4	Role play Simulated skills practice	Participant Handouts 7d and 7e	1 hour 40 minutes

stenotype machine, notebook computer and real-time software. The text produced by the CART service can be displayed on an individual’s computer monitor, projected onto a screen, or made available using other display systems.

Unit Summary	Group check-in		15 minutes
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WORK FOR TRAINERS TO PREPARE IN ADVANCE:

- Prepare participant handouts 7a-e.
- Review Slides 7.1-7.14
- Review training instructions and create co-training plan with youth facilitators
- SO 7.2: Prepare “Agree” and “Disagree” signs
- SO 7.4: Prepare adolescent client role cards

SPECIFIC OBJECTIVE 7.1: EXPLAIN THE IMPORTANCE OF ESTABLISHING A POSITIVE, WELCOMING SERVICE ENVIRONMENT FOR THE ADOLESCENT CLIENT.



TIME

1 hour



METHODS

- Warm Up
- Group Brainstorm
- Communication Exercise



MATERIALS NEEDED

- Flipchart and markers
- Participant Handout 7a: Verbal and Non-Verbal Communication



STEPS

- *Trainer's note: This program should be delivered by both the lead trainer and a youth counterpart, if available. It is essential to include the participation of youth trainers with different types of disabilities within the training. Accommodation should be provided as needed. The trainers should work together beforehand to decide how best to divide the session activities, with a preference towards the youth trainer delivering more of the content.*

Time: 20 minutes

1. Place chairs in a circle and ask participants to sit facing each other. Ask youth participants to spread themselves out throughout the circle, so that they have a provider on either side. Take a seat in the circle. Ask your co-trainer(s) to also sit in the circle, spaced out from you and each other.
- *Trainers Note: your co-trainers' job in this warm-up is to use their turn to move the story back onto topic if it begins to stray.*
2. Tell participants that you're going to write a story together by coming up with one sentence at a time. This story will be about a 16-year-old girl named "Grace." Explain that you will start the story with a single sentence, and then the person sitting to your left will continue with another single sentence. For example, if you say: "One day I found a wallet on the ground on my way to school" the next person might say: "When I picked it up, a huge wad of cash fell out at my feet." The story would then continue around the circle, clockwise, sentence by sentence, until it came back to you.
 3. Begin the story with: "This morning I woke up with a terrible, terrible burning in a place my mother told me never to talk about."
 4. Let participants continue the story around the circle, making note of any differences in how the providers and youth participants approach the narrative. When the story returns to you, or participants run out of ideas, find a way to resolve the story and

say “The End.”

5. Ask participants if they think the story they came up with was a realistic depiction of what happens to adolescents. What are some real-life examples?
6. Ask participants if they observed any differences in the way providers and youth participants approached the narrative and discuss the reasons for that with the group.
7. Ask the youth participants if they could relate to Grace and in what ways?
8. Ask the whole group what emotions they think Grace was experiencing throughout the story.

Time: 20 minutes

➤ *Have a youth co-trainer lead the next activity.*

9. Place a flipchart at the front of the room. Draw a stick figure on the page, toward the bottom. Draw a raincloud above the head of the stick figure. While drawing, tell participants that the stick figure represents an adolescent, and the cloud represents the feelings and concerns that an adolescent might have that could prevent them from seeking and accessing services.
10. Ask participants to brainstorm some of the feelings adolescents might have that could keep them from accessing services. Write their responses in and around the cloud on the flipchart. You can use the **Supplementary Content: Feelings of the Adolescent** below to supplement their answers if needed.

Supplementary Content: Feelings of the Adolescent

When an adolescent is face-to-face with a provider (or another facility staff member) s/he may feel:

- ***Shy*** about being in a clinic (especially for SRH) and about needing to discuss personal matters.
- ***Embarrassed*** to be seeking SRH care.
- ***Worried/Concerned*** that someone they know might see them and tell their parents, family, or caretakers, or spread rumors about them at school or in the community.
- ***Unprepared*** to describe their concerns, and poorly informed about SRH matters in general.
- ***Anxious or afraid*** that they have a serious condition that has significant consequences (e.g. STI, HIV, unintended 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 they are there against their will.
- **Resistant** to accepting help because of discomfort or fear, or lack of trust in the health provider.
- **Fearful** of being mistreated, judged, or turned away by clinic staff.

In addition to the above, which can be concerns for all young persons, young persons with disabilities often feel:

- **Excluded** if the health provider talks about him/her to his/her parents/guardians without ensuring his/her participation in the conversation.
- **Frustrated** when the information and services are not accessible, and accommodation is not provided.

11. If there are participants in the room who are younger/youth, ask them if they've ever felt any of these emotions in relation to seeking health services and if there is anything missing they would like to add. Make sure you ask the opinion of at least one person present in the room with a disability. Ask a volunteer to share an example of a time when one of these negative emotions kept them or someone they know from seeking information or services that they needed.
12. Ask all participants to think of a time when they've experienced any one of these emotions. Go through some of the emotions listed in the "rain cloud," and ask for volunteers to share a time when they've experienced that emotion and how it might have kept them from doing something they wanted or knew they needed to do. Note: These examples do not need to come from their experiences with health services: for example, someone may have been intimidated to ask for a raise at their work or shy to ask for help in making a purchase.
13. Ask all participants to think of a time when they've experienced one of these emotions but were able to "push through" or overcome their feelings to do what they wanted or needed to do. Ask for a volunteer to share a positive experience and what they did to make it happen, and similarly ask another volunteer to share a negative experience and what prevented them from overcoming their fear or emotion. Have the group compare the two experiences and identify the factors that made the difference in their respective outcomes.
14. Remove the flipchart page with the feelings cloud and post it to a wall in the room.

Time: 20 minutes

15. Tell participants that one of the best ways to ensure that a facility is friendly and welcoming to adolescent clients is to guarantee that ALL facility staff, not just providers, are friendly and welcoming to all adolescent clients including clients with

disabilities. Remind participants that while health providers might receive training in youth-friendly and inclusion techniques, the provider is usually not the first or the only person the adolescent client sees when she or he comes into a clinic. Part of the role of providers is to help all clinic staff – from security guards, to cleaners, to administrative staff to accept and support all adolescents to get the services they need for good health, including adolescents with disabilities.

16. Distribute **Participant Handout 7a: Verbal and Non-Verbal Communication** (below) to participants. Explain that frequently, even when we're saying the "right" thing, our body language can give away our negative feelings or concerns that we may not even know we have.
17. Ask participants to form pairs. In their pairs, explain that one person should talk to the other for **5 minutes** about a personal problem or concern. The problem or concern can be real or fictional. The listening partner should attempt to communicate disinterest, lack of caring, or judgment in any way they wish to, *without speaking*.
18. Have participants switch roles. This time, the partner who was listening before should speak for **5 minutes** about a personal problem or concern, while the partner who spoke before should attempt to communicate interest, understanding, and a desire to help in any way they wish *without speaking*.
19. Discuss the exercise with the entire group. You may use the following questions:
 - a. How did it feel to talk uninterrupted for 5 minutes?
 - b. How did it feel to be prevented from talking?
 - c. Did you feel that your partner understood you? What cues did you get to show their interest or disinterest?
 - d. Did anyone feel helped? Did anyone feel judged? Why or why not?
 - e. Why is silence so difficult to tolerate?
20. Review the handout with the participants. Ask if there are times when our verbal responses don't match our nonverbal messages. Ask: "Do we sometimes show negative emotions or feelings to clients? How do we communicate our discomfort in seeing adolescent clients? Do you communicate differently when the client has a disability?"
21. Close by asking participants for ways they think they can use this information to help create friendlier and more inclusive environments for all adolescent clients throughout their clinics.



PARTICIPANT HANDOUT 7A: VERBAL AND NON-VERBAL COMMUNICATION

Health care providers and health facility staff should explore the many different nonverbal and verbal behaviors they use when communicating with clients. Sometimes, without realizing it, providers and facility staff say one thing, while communicating the opposite message through their body language or non-verbal communication.

Nonverbal communication is complex and is a mix of actions, behaviors, and feelings, which reveal the way we really feel about something even if we are not fully conscious of those feelings. Nonverbal communication is especially important because it communicates to clients our interest, attention, warmth, and understanding.

Positive nonverbal cues include:

- Leaning toward the client.
- Smiling, without showing tension.
- Facial expressions which show interest and concern.
- Maintaining comfortable eye contact with the client.
- Encouraging supportive gestures such as nodding one's head.

Negative nonverbal cues include:

- Not making or maintaining comfortable eye contact.
- Glancing at one's watch or phone obviously and more than once.
- Frowning.
- Fidgeting.
- Sitting with the arms crossed.
- Leaning away from the client.

Providers and facility staff should remember **ROLES** when communicating with adolescent clients:

R = Relax the client by using facial expressions that show interest.

O = Open up the client by using a warm and caring tone of voice.

L = Lean towards the client, not away from him or her.

E = Establish and maintain **eye contact** with the client.

S = Smile

SPECIFIC OBJECTIVE 7.2: IDENTIFY STRATEGIES TO ESTABLISH TRUST WITH ADOLESCENT CLIENTS



TIME

1 hour 45 minutes



METHODS

- Trainer presentation
- Small group discussion



MATERIALS NEEDED

- Slides 7.1-7.8
- Participant Handout 7b: Confidentiality Discussions



STEPS

- *Trainer's note: This program should be delivered by both the lead trainer and a youth counterpart, if available. It is essential to include the participation of youth trainers with different types of disabilities within the training. Accommodation should be provided as needed. The trainers should work together beforehand to decide how best to divide the information, with a preference towards the youth trainer delivering more of the content.*

Time: 40 minutes

1. Introduce the topic by explaining that while all clinic staff must be supportive and helpful to the adolescent, those who provide services may need to take additional steps to encourage trust and rapport and to foster their comfort.
2. Present **Content: Establishing Trust in the Client-Provider Relationship** (Slides 7.1-7.8), below.

Slides 7.1-7.2: Trustworthy Counseling

Several **principles** must be kept in mind when counseling adolescents:

Service providers should not make assumptions about young persons' sexuality based on factors such as disability, HIV status, etc. Providers should first of all listen to what the young person has to say in relation to their sexuality and experience.

If the young person has a disability, the service provider should avoid focusing on the disability, but rather stay focused on the SRH experience/problem that the young person is interested in discussing and asking for support with.

The service provider must **lead a conversation** that enables a young person to analyze and reflect on the issues she/he may be facing, by encouraging them to explore and express feelings and to make their own decisions. This will promote ownership of their decisions, greater self-confidence and self-control.

The counselor must **avoid giving advice**. Rather, the counselor helps the

adolescent to evaluate their own behavior and to generate possible solutions to the situation or problem.

The provider must **respect the adolescent, encouraging their ability** to help themselves, to trust in themselves and to take responsibility for their decisions.

Counselors must **address all adolescents as individuals**, should help them to identify their good qualities and potential, respect their rights as people, and promote their self-confidence and capacity to think and make decisions.

The counselor must **avoid being judgmental**. Accept all adolescents and do not judge them as good or bad.

Slides 7.3-7.4: Tips for Good Communication

Adolescence is a period of dramatic physical, social, and psychological changes, which are at the same time completely normal. Seeking health care, however, may be hard for them to do.

Each staff person who interacts with adolescents should understand and be empathetic to these circumstances and feelings, and must be prepared to assist in a helpful, non-judgmental, respectful, and inclusive way.

The following tips facilitate **good communication**:

- Be genuinely open to and respectful of all adolescents' questions or need for information. Such questions can range from "Where is the toilet?" to "Should I use contraception?"
 - Avoid using words that are judgmental or suggests disapproval of their being at the clinic, of their behavior, appearance, the way they speak, or of their questions or needs. Be conscious of your body language and tone of voice as well!
 - Understand that young people are likely to feel uncomfortable and uncertain. Reassure them, make them feel welcome and comfortable and encourage their confidence.
 - If sensitive issues are being discussed, be sure that conversations are not overheard.
3. Pause to ask participants if they have any additional tips or suggestions for good communication with adolescent clients. Ensure the contribution of young persons with disabilities. Allow **5 minutes** for sharing and discussion, then return to the presentation with **Slide 7.5: Fostering Comfort** (below).

Slides 7.5-7.7: Fostering Comfort

The more an adolescent client can be made comfortable, the more likely s/he will be to express concerns, to participate in determining treatment and follow-up, and to

continue making healthy decisions.

Three factors contribute to the comfort of the adolescent client:

Privacy: Provide a space in the facility where counseling and/or examination can take place without being seen or overheard and where the interaction is free from interruptions.

Confidentiality: Assure the adolescent client that all discussions and matters pertaining to the visit are confidential and will not be discussed with others. All provider and health facility staff should maintain confidentiality of all clients.

Respect: Respect also assumes that all needs are legitimate and deserve a professional response. The provider/counselor must demonstrate recognition of all clients' humanity, dignity and right to be treated as capable of making good decisions.

When should one break confidentiality?

In some instances, the counselor/provider may believe it necessary to share information with others (for example, to report or prevent further sexual abuse). In this instance, the counselor or provider must explain to the adolescent client why it is important and explain to whom, when, and how the information will be shared.

As many services are not accessible, young persons with disabilities are often accompanied by a family member or caregiver to help overcoming physical and communication barriers. In these circumstances, find out if the client would like the accompanying person to stay or to wait outside the consultation room. If the adolescent client asks for the accompanying person to stay, make sure the client with disability remains your main focus and prevent the accompanying person from speaking or making decisions on the behalf of the person with a disability.

Slide 7.8: Building Trust and Rapport

Creating an atmosphere of trust and rapport will facilitate discussion and enhance the likelihood that concerns will be revealed and addressed.

Important conditions for trust and rapport include the following:

- Allow sufficient time for the adolescent client to become comfortable. Once they are comfortable they will be more likely to ask questions and express their thoughts.
- Show understanding of and empathy with the client's situation.
- Demonstrate sincerity and willingness to help.
- Be honest and forthright. This includes the ability to admit when you do not know the answer.
- Provide positive reinforcement for their decision to seek counseling and/or health care
- Express non-judgmental views.
- Be confident and demonstrate professional competence.

4. Ask the participants if they have any additional tips or strategies for developing trust and positive rapport with adolescent clients. Ensure the contribution of young persons with disabilities. Allow **five minutes** for discussion and sharing, then close the presentation by moving to the small group activity.

Time: 1 hour 5 minutes

5. Explain that this exercise will address the importance of confidentiality, circumstances when confidentiality can or should be broken, and the legal climate within the country. Divide the participants into 3 groups. Assign each group a number, 1, 2, or 3.
6. Distribute **Participant Handout 7b: Confidentiality Discussions**. Ask each group to work on the discussion prompt with the same number as their group (Group 1: Prompt 1, Group 2: Prompt 2, Group 3: Prompt 3). Allow **20 minutes** for groups to complete their assigned task.
7. Ask each group to report back its conclusions to the plenary. Lead a discussion with the whole group following each report-back, by asking the other two groups for any additional responses, ideas, or experiences. Allow **10 minutes** for each topic.



*PARTICIPANT HANDOUT 7B: CONFIDENTIALITY DISCUSSIONS
(Modified and updated from Vereau, 1998)*

Prompt 1: Discuss different approaches you can take to reassure adolescents that their concerns will remain confidential. Next, develop two case studies that describe and support your approach. Emphasize the procedures to follow and methods to take to gain the adolescent client's trust.

Prompt 2: Discuss appropriate procedures to inform the adolescent of what types of information will not be kept confidential, and why. Spell out this process in the following three case studies:

- a) An adolescent who is being sexually abused by another adolescent.
- b) An adolescent who is in a coercive sexual relationship with an adult.
- c) An adolescent with disability who is being sexually abused by a family member or caregiver

Prompt 3: Discuss what occurs in the country regarding confidentiality in light of existing laws and socio-cultural norms. List under what circumstances, if any, a provider is required to break client confidentiality and to whom a provider is legally obligated to report. Discuss the main obstacles (if any) to ensuring privacy in counseling sessions and how you have – or should-- address these obstacles.

SPECIFIC OBJECTIVE 7.3: EXPLAIN THE VALUE OF AND DEMONSTRATE SKILLS FOR COUNSELING ADOLESCENTS ON SEXUALITY



TIME

2 hours 15 minutes



METHODS

- Trainer presentation
- Values clarification
- Role play



MATERIALS NEEDED

- Slides 7.9-7.14
- Participant Handout 7c: Clarification Technique Practice
- “Agree” and “Disagree” signs
- Tape



STEPS

- **Trainer’s note:** *This program should be delivered by both the lead trainer and a young trainer, if available. The participation of youth trainers with different types of disabilities is essential to ensure the perspectives of clients with disabilities are included in the training. Accommodation should be provided according to the needs to ensure full participation of young trainers with disabilities. The trainers should work together beforehand to decide how best to divide the information, with a preference towards the youth trainer delivering most of the content.*

Time: 30 minutes

1. Open the session by telling participants that communicating and counseling with adolescents about sexuality can be challenging because it is a sensitive topic for both adolescents and adults.
2. Ask any youth participants in the room to raise their hands if they’ve ever felt, emotional, distrustful, or insecure when discussing sexuality and sexual and reproductive health with an adult. Ask them to keep their hands up while you ask the adult participants to raise their hands if they’ve ever felt embarrassed, unprepared, or insecure when discussing sexuality and sexual and reproductive health with an adolescent. Most hands should be up at this point. Tell participants that they can put their hands down.
3. Introduce the trainer presentation (**Content: Counseling about Sexuality and SRH**, Slides 7.9-7.14, below) by telling participants that as difficult and emotional as these conversations can sometimes be, the importance of high-quality counseling on sexuality and sexual and reproductive health is clear.

Content: Counseling about Sexuality and SRH (Slides 7.9-7.14)

Slide 7.9: Benefits of a Positive Counseling Experience

A client-provider interaction will be more positive when the client feels that s/he was actively involved in health decision-making, including choice of contraceptive method. The chances are greater that they will:

- Be more proactive in making decisions about if, when, how, and with whom to engage in sexual activity.
 - Decide to adopt safe and protective behaviors, including the correct use of contraceptives and condoms to protect from STIs/HIV.
 - Recognize warning signs and symptoms of potential STI/HIV infection.
 - Successfully manage minor side effects of contraceptive methods.
 - Return to see the service provider for information and services, including resupply or switching of methods.
 - Be less likely to believe myths or rumors and may even try to correct them with family members and friends.
 - Encourage others to use health services and products, including contraception.
4. Pause and ask the providers in the room to think of ways these changes could improve their own job experience and satisfaction. Return to the presentation with **Slide 7.10: Communicating about Sexuality** (below).

Slides 7.10-7.11: Communicating about Sexuality

Providers can more effectively communicate with and counsel adolescents on sexuality when they:

- Consider the adolescent's age, disability and level of sexual experience.
- Demonstrate patience and understanding and adapt their communication style to accommodate the need of persons with different types of disabilities (refer to the chapter "Adolescents with disabilities for additional inputs). Adolescents often find it difficult to talk about sex and young persons with disabilities may face additional barriers.
- Assure privacy and confidentiality.
- Show respect for all adolescents, including adolescents with disabilities and their feelings, choices, and decisions.
- Ensure the adolescent feels comfortable to ask questions and communicate concerns and needs.
- Respond to expressed needs for information in understandable and honest ways.
- Explore young people's feelings as well as providing them with facts.
- Encourage the adolescent to identify several possible alternatives when problem solving.
- Help adolescents to analyze the advantages, disadvantages, and consequences of options.
- Assist the client to make an informed decision.

- Help the adolescent plan how to implement their choice.

These approaches help young people to make their own decisions. When the adolescent makes their own decision, with appropriate information, they are more likely to be satisfied with their decision and more capable of adopting changes in their behavior.

Slides 7.12-7.13: Understanding Adolescent Decision-Making

Note: Adolescent clients, like adult clients, will occasionally make decisions with which health providers may disagree. Their reasons may seem unclear. The provider's role is not to make decisions for the adolescent, but to help them to make their own decision with as much information as is available as well as understanding the (positive and/or negative) consequences of their decision.

Adolescents often make significant decisions. These include the following decisions related to sexual and/or reproductive health:

- How to discourage and/or prevent unwanted sexual advances.
- Whether or when to have sex.
- How to prevent pregnancy.
- How to prevent STIs/HIV.
- Whether or when to conceive a child.
- Whether to continue or terminate a pregnancy.
- Where and when to seek antenatal care.
- How to deal with sexual abuse and/or violence.

Most of these decisions can be addressed as part of counseling. Sexual abuse and violence, however, are much more difficult and require additional help. This topic will be covered in Unit 13.

Time: 60 minutes

5. Tell participants that one of the most interesting things about working with adolescent clients— and perhaps the most challenging! is that they are in a state of growth and change with regards to many things, including sexuality, sexual values and sexual behaviors. This dynamic and fluid life stage challenges the adults in their lives, whether parents/caretakers, teachers, or service providers, who must also be willing to consistently revisit and reconsider their own knowledge and values about sexuality.
6. Introduce the values clarification exercise. Have your co-trainer put up signs that say “Agree” and “Disagree” on either side of the space and “Not Sure” in the middle. Explain that the purpose of the exercise is to explore feelings, attitudes, and values regarding sexuality.
7. Explain that you will read a series of statements aloud, one by one. After each one, participants should move towards the side of the room with the sign corresponding

to their response.

➤ **Trainer's note:** after each statement, ask for a few volunteers to explain their viewpoint. Do not force anyone to respond who is uncomfortable doing so. When participants choose to respond, supplement their responses with any additional information or gently correct misinformation. Some possible responses are provided for you under each statement below.

8. Read each of the statements below out loud and allow time between each statement for participants to move and for light discussion. *Supplemental information* is provided under each statement to help you guide discussion as needed.

Content: Clarifying Sexual Values

- i. Men have a greater need to satisfy their sexual desires than do women.

Men and women both experience sexual desire, and both men and women can and should learn how to control and channel that desire appropriately. Both men and women are taught from a young age that men cannot control their desire, and that women should be able to control their own sexual desire as well as that of men.

- ii. Masturbation is a safe way to explore sexual desire and sexual pleasure.

Masturbation is a natural part of growing up and learning about your body. Studies have found that masturbation is frequent in humans of both sexes and all ages.

- iii. A woman should be a virgin at the time of her marriage.

Virginity, or lack thereof, is a social expectation and not related to a woman's health or fertility.

- iv. You can "test" a woman's virginity by seeing if her hymen is intact.

A broken or absent hymen is not an indication of a woman's sexual history. Many women either have minimal or no hymen, or their hymens break during childhood or adolescence due to physical exertion like playing sports.

- v. In an intimate relationship, the woman must set the limits on sexual contact.

In an equal, consensual relationship, both partners communicate and respect each other's limits and preferences.

- vi. A small boy who plays with girl's toys or enjoys dressing up in his mother's clothes will grow up to be homosexual.

It is natural for small children to explore different types of play, regardless of gender. Wanting to play outside of gender norms is not an indication of current or future sexuality.

- vii. Parents should learn to accept their gay, lesbian, or bisexual children, rather than try to "fix" their sexual orientation or attraction.

Sexual orientation is deeply personal and innate and is not the same as sexual behavior. Parents cannot change their children's sexual orientation, either to "turn them gay" or through experiencing conversion therapy to "fix" them. Conversion therapies have been proven to have no effect on sexual orientation but actually contribute to feelings of shame, inadequacy, depression and suicide among gay, lesbian, bisexual, and transgender adolescents.

- viii. How someone should behave is determined by whether they are born male or female.

Gender norms are created by society and culture, not by genetics or biology. There is great variation around the world in the ways masculinity and femininity are expressed.

- ix. The main reason to have sex is for reproduction.

Reproduction is only a small part of why humans and other mammals have sex. Sex also builds intimacy between couples, fosters feelings of connection, relieves tension, is pleasurable, and creates happiness and joy.

- x. If an adolescent asks for contraceptives, they should receive them.

Adolescents have certain rights to health information and services. Your local laws will determine their ability to obtain contraception.

- xi. Only adolescent girls need to know about contraception and sexual health, since they are the ones who get pregnant.

All adolescents need information about contraception and sexual health and all adolescents should take responsibility to prevent unintended pregnancy. Specific outreach and messages may be needed to reach adolescent boys.

- xii. Information about and provision of contraceptive methods should only be given to married people or those about to be married.

Many people all over the world become sexually active before marriage. All sexually active people who want to prevent a pregnancy need information about and the ability to obtain contraception.

- xiii. Giving young people information about sexuality or providing contraception will only encourage them to have sex.

Global reviews of sexuality education programs have shown that comprehensive sexuality education does not result in increased sexual activity. In fact, lack of information or education about sexuality is more likely to lead to risky and unprotected sexual behavior among adolescents.

- xiv. Health care providers should be the main source of sexual health information for adolescents.

The main source for sexual health information for adolescents is frequently the media or their peers. Adolescents should be able to ask for sexual health information from parents, caretakers, teachers, and health workers. Social taboos often prevent open discussion of sexual health, which contributes to the spread of rumors, myths, and misinformation among adolescents.

- xv. Adolescents who contract STIs have too many partners or aren't being careful enough about their health.

No protection method is 100% (even abstinence fails occasionally), and many STIs can be transmitted even while using protection. Having an STI should not be a judgment on an adolescent's character or values.

- xvi. Young persons with disabilities are asexual therefore they do not need to learn about their sexual and reproductive health and rights.

Young persons with disabilities are sexual beings and, as all their peers without disabilities, have intimate and sexual experiences. Young persons with disabilities have the same needs and rights to access

quality sexual and reproductive health information and services as their peers without disabilities.

- xvii. When it comes to sexual and reproductive health, young persons with disabilities are unable to make decisions by themselves and family members or caregivers need to do it on their behalf.

Young persons with disabilities, as their peers without disabilities, are capable of making decisions about their sexual and reproductive health. Accommodation is essential to ensure young persons with different types of disabilities can access information and services, receive the support they need and make decisions about their sexuality independently from family members and caregivers.

9. At the end, explain that the purpose of this exercise is not to persuade others to adopt certain positions, but to listen and reflect on what we think and feel about various issues. Better understanding one's own values, and how they differ from others, enables counselors to be more accepting and less judgmental.

Time: 45 minutes

10. Introduce the next activity. Tell participants that another challenge with counseling adolescents is that we are uncomfortable to break the social taboo on speaking openly with adolescents about sexuality. This taboo is even stronger when the adolescent client has a disability. Sometimes we don't ask the right questions to get the information we need.
11. Show **Slide 7.14: Types of Questions**. Tell participants that the purpose of this exercise is to practice asking the right kind of questions that can clarify unclear or vague statements from adolescent clients and will help them explore their own ideas and feelings. Ask participants to silently review the slide and ask any questions while you distribute **Participant Handout 7c: Clarification Technique** (below).

Slide 7.14: Types of Questions

- CLOSED: lead only to one brief response or brief, precise answers, often "yes" or "no."
 - "How old are you?" "Have you had sexual intercourse?"
- OPEN-ENDED: permit more detailed responses, support reflection and permit the responder to express feelings or concern.
 - "How can I help you?" "What have you heard about contraception?"
- IN-DEPTH: based on responses to previous questions to solicit more information.
 - "Can you tell me what you mean by..."
- LEADING/BIASED: lead the person being questioned to a "correct" response or judgment.

- *“Have you heard that the condom is not a very effective method?”*
12. Ask for 6 volunteers (preferably 3 adults and 3 youth participants, at least one with a disability). Have the pairs sit facing each other, with one member of each pair playing an adolescent and the other playing a counselor.
 13. Have the first “adolescent” read line #1 from the handout to their “counselor.” The counselor should respond, attempting to clarify what the adolescent means, referencing the words in **bold**.
 14. Have the second and third pairs repeat this process with lines #2 and #3. After all three pairs have gone, ask the whole group to critique the “counselors” use of clarifying questions and make suggestions.
 15. Ask the group to divide into pairs and continue with lines #4-10, taking turns being the “adolescent” and the “counselor.
 16. Bring all participants back to plenary to discuss. Ask:
 - a. How did it feel to ask clarifying questions? To be questioned?
 - b. Were any of the lines particularly challenging to question? Why?
 - c. What were some of the better questions you received? Why?



PARTICIPANT HANDOUT 7C: CLARIFICATION TECHNIQUE

Note: The words in **bold** are the ones the counselor must ask the adolescent to define.

1. My parents would **kill me** if they knew I was **seeing** Pedro.
2. **I don't want to know anything** about contraceptives.
3. I am in a relationship, but it's **not serious**. I don't want anything serious right now.
4. I **really like** this boy but everyone says he's just a **player**.
5. Girls don't **pay attention to me**.
6. There's no one else **like me** at my school. I'm **so alone**.
7. When we **make love**, it can get so **sticky** and I don't think I like it very much.
8. Ever since we **had sex** I've been **feeling a bit off, down there**.
9. **Sometimes** I use condoms, but other times I don't.
10. Yes, I have sex, but **I can handle myself**.
11. Unlike me, my boyfriend does not have a disability. He knows **much more** about **sex** and **HIV prevention than I do**.
12. My disability **prevents** me from dating the girls I like. **I feel hopeless**.

SPECIFIC OBJECTIVE 7.4: DEMONSTRATE HOW TO USE POSITIVE AND EMPOWERING COUNSELING TECHNIQUES WITH ADOLESCENTS.



TIME

1 hour 40 minutes



METHODS

- Simulated skills practice
- Group discussion



MATERIALS NEEDED

- Participant Handout 7d: Factors Influencing Counseling and Service Outcomes
- Role Cards: Adolescent Clients
- Participant Handout 7e: Counseling Skills Checklist



STEPS

- **Trainer's note:** *This program should be delivered by both the lead trainer and a youth counterpart, if available. Ensure young persons with disabilities are among the youth trainers. Accommodation should be provided to ensure full participation of young trainers with disabilities. The trainers should work together beforehand to decide how best to divide the information, with a preference towards the youth trainer delivering more of the content.*

Time: 10 minutes

1. Introduce the objective to the participants by telling them that the last activity in this unit is to practice counseling, using the information covered in the previous sessions. Distribute **Participant Handout 7d: Factors Influencing Counseling and Service Outcomes** (below).
2. Spend **5 to 10 minutes** reviewing the previous three sessions (objectives, main points) with the participants, using the handout, flip charts on the walls from previous activities and any slides you think need further review.

Time: 1 hour 30 minutes

3. Distribute **Participant Handout 7e: Counseling Skills Checklist** (below) to all participants. Tell providers that they have **5 minutes** to review while you meet with the youth participants and co-trainers.
 4. Take the youth participants and co-trainers aside or into another room. Distribute **Role Cards: Adolescent Clients** (below). Instruct the youth participants that they will be testing the providers counseling skills, as well as their ability to deal with vague or imprecise language, slang, or unforeseen challenges. Give the youth participants permission to "act out" their character as much as they wish, change the names, or add background information. Give them **2 to 3 minutes** to review their roles.
- **Trainers Note:** *If you have enough youth participants, double up on the Adolescent Client*

Role Cards (so that you have two youth participants assigned to each adolescent role) to ensure that all providers have a chance to practice with or observe each role. When you divide the group into two, divide the youth participants so that each group has one full “set” of roles. One way to do this would be to print the two sets of role cards on two different colored sets of paper, so that you can assign each group a color.

5. Return to the group. Divide participants (providers and youth participants) into two groups. Explain that there will be four adolescent “cases” in each group, and that each participant should practice with at least one case and observe three. Larger groups may need to subdivide again so that multiple role plays can be happening at once to ensure everyone is involved.
 6. When observing, participants should use the **Counseling Skills Checklist** to assess and make notes on each other’s performance. After each role play, observers should provide constructive feedback to the provider. Each participant is expected to actively participate in the role play process, as both a player and an observer, and in the feedback process.
 7. Youth participants should also provide feedback to the provider playing the counseling role after each role play, to let them know how they felt and what the counseling experience felt like to the client.
- **Trainers Note:** *Use constructive criticism to encourage and guide the participants to analyze what was good about the way the counselor handled the counseling and to suggest what could be improved. Remind participants that feedback and critique must not be personal and should address what was done well and ways to improve.*
8. Limit each role play to **5 or 6 minutes** and allow about **15 minutes** for feedback and analysis of the process and content after each role play. The trainers should be circulating and observing during this time: the trainer’s role is to stimulate, guide, and keep up discussion, and to end the exercise when time is up.
 9. Close the session by summarizing any major points observed in the exercise and leave time for questions and feedback from all participants.

*PARTICIPANT HANDOUT 7D: FACTORS THAT INFLUENCE COUNSELING AND SERVICE
OUTCOMES*

In every client-provider counseling session, multiple factors influence counseling. These factors should all be taken into consideration as they can affect counseling outcomes.

Service Providers:

- Provider attitudes and behaviors.
- Provider counseling style (does it apply a mutual participation model, an authoritarian approach, or a provider-controlled discussion).
- Provider knowledge as well as communication and technical skills.
- Provider biases – including towards which methods youth can or should use.
- Provider value system.
- Provider reaction to differences between client and provider in terms of ethnicity, caste, social class, economic status, disability, marital status, language, gender, or education.
- Provider is available and acceptable to client.
- Provider ensures confidentiality.

Clients

- Is able to obtain their method of choice, or second choice if first choice is not available or cannot be used by the client.
- Feels trust and respect for provider.
- Feels privacy and confidentiality are assured.
- Feels s/he is treated with respect and dignity.
- Feels s/he can access and understand information.
- Displays a positive attitude towards counseling and acceptance of counseling outcomes.
- Has had a prior experience with contraceptives.
- Is motivated to seek services.
- Display certain demographic factors (age, marital status, education level, disability, etc).

Programmatic Factors

- Number of methods available.
- Reliability of method supply.
- Privacy and confidentiality of surroundings.
- Social/cultural needs are acknowledged and addressed.
- Image of professionalism conveyed by clinic and provider.
- Accessibility of the clinic (including entrance, waiting room, reception area, consultation rooms/toilets/services) to all, including persons with disabilities.
- Appearance of waiting room/clinic: clean, not overcrowded.
- Convenient hours.
- Friendliness and inclusiveness of health facility staff.
- Good referral system.
- Services are publicly promoted.

- IEC materials are available and are accessible to all, including persons with disabilities.
- Information and services are accessible and accommodation is provided.

PARTICIPANT HANDOUT 7E: COUNSELING SKILLS CHECKLIST

TASK/ACTIVITY	CASES				COMMENTS
	1	2	3	4	
<i>COUNSELING ENVIRONMENT</i>					
PROVIDER ENSURES THAT DISCUSSION CANNOT BE OVERHEARD					
PROVIDER ASSURES CONFIDENTIALITY					
ACCOMMODATION IS PROVIDED FOR PERSONS WITH DISABILITIES					
<i>PROVIDER'S NONVERBAL COMMUNICATION</i>					
FRIENDLY/WELCOMING/SMILING/RESPECTFUL/INCLUSIVE OF ALL CLIENTS?					
NON-JUDGMENTAL/RECEPTIVE?					
LISTENS ATTENTIVELY/NODS HEAD TO ENCOURAGE AND ACKNOWLEDGE CLIENT'S RESPONSES?					
APPEARS PATIENT AND COMFORTABLE?					
<i>PROVIDER'S VERBAL COMMUNICATION</i>					
PHRASES QUESTIONS AND ANSWERS CLEARLY AND APPROPRIATELY? USES NON-TECHNICAL TERMS, AND LANGUAGE THE CLIENT CAN UNDERSTAND? INTEGRATES COMMUNICATION METHODS (IMAGES, WRITTEN MESSAGES, AND GESTURES) TO FACILITATE THE COMMUNICATION WHEN NEEDED?					
ASK OPEN-ENDED QUESTIONS, CLARIFYING QUESTIONS? ASKS IF ANYTHING IS NOT UNDERSTOOD? REPEAT OR REPHRASE QUESTIONS IF NEEDED?					
LISTENS TO CLIENT'S RESPONSES CLOSELY? ALLOWS TIME FOR CLIENT TO FULLY RESPOND WITHOUT INTERRUPTING?					
FULLY EXPLAINS ANY PROCEDURES OR TESTS BEFORE CONDUCTING? OBTAINS CLIENT'S CONSENT BEFORE CONDUCTING ANY TEST OR PROCEDURE? ALLOWS TIME FOR QUESTIONS?					

<i>ESTABLISHING TRUST AND RAPPORT</i>				
DISPLAYS UNDERSTANDING AND EMPATHY TOWARDS THE CLIENT?				
IS HONEST AND PROFESSIONAL? AVOIDS JUDGMENTAL LANGUAGE OR BIASED OR LEADING QUESTIONS?				
SUPPORTS THE CLIENT TO MAKE THEIR OWN DECISIONS?				
ASKS THE CLIENT ABOUT THEMSELVES, INCLUDING THEIR NEEDS AND CONCERNS AND SEXUAL AND REPRODUCTIVE HEALTH GOALS?				
REPEATS INFORMATION AS NECESSARY, DISPLAYS PATIENCE AND PROFESSIONALISM?				

ROLE CARDS: ADOLESCENT CLIENTS

Role 1: Mohammed

Mohammed has come to the clinic today because he had a sore on his penis and his girlfriend insisted that he seek treatment. He is angry, sullen, and silent: he does not want to explain himself and he thinks he doesn't need to be here. He told his girlfriend that the sore doesn't hurt and he's fine: he probably just nicked himself with his zipper. Actually, the sore does hurt quite a bit, and he has been having muscle pain in his legs and a slight fever. He is also feeling generally run-down: school is hard, he works part-time for his uncle at his shop, and he has two girlfriends, who don't know about each other. He feels tired all the time and has been snapping at his friends and family.

Role 2: Maria

Maria, a girl with a visual disability, initially sits in the counseling room with the provider, not talking. When she does start talking, she immediately starts crying and has a hard time explaining herself. She keeps trying to convince the counselor that she is a good girl, she goes to church, she takes care of her younger siblings. When she does reveal why she has come to the clinic, it is because she hasn't had her period in two months and has started feeling ill in the mornings. Maria doesn't have a steady boyfriend. She and her siblings have been living with her aunt for a few years after her mother died, and her uncle has taken a particular liking to her. She has been going along with him because he threatened to turn her and her younger siblings out onto the streets but is now afraid of what he and her aunt will do when they learn she is pregnant.

Role 3: Gabriel

Gabriel, a young person with a physical disability, has come to the clinic for an HIV test. The VCT nurse has asked for help with his counseling, because while he is friendly and willing to test, he refuses to talk to her about his sexual activity, possible risky behaviors he may be engaging in, or why he is here for testing. He will only say that he might be at risk because he sometimes plays around with other boys. He is insistent that this doesn't mean anything about his sexuality, "it's just practice." He is terrified that his parents might find out and "kill him," and says that if his test comes back positive he will kill himself.

Role 4: Amina

Amina is a peer educator. She is well-informed on sexual and reproductive health, and in a serious relationship with one of the other peer educators with whom she works. They've talked about sex and protection, and while they've agreed to wait a bit longer she wants to start contraception now. Specifically, she wants to have an IUD: she has heard that she won't have her period while on her IUD and is concerned about what that means. However, her parents don't know that she is a peer educator or that she is in a relationship: they are

very conservative, and she just tells them that it's an after-school health program. She wants to know how long the procedure will take and how it will affect her so that she can hide it from her parents.

Role 5: Gloria

Gloria is 16 and it is her first time at the local health clinic. Gloria has a hearing disability and she recently started dating Marco. Gloria is very concerned about HIV but feels too shy to share her worries with Marco who is a bit older and, when it comes to sex, "more experienced". The waiting room of the clinic is crowded and clients are given a number and called by the receptionist when it is their turn to see the health worker. Gloria misses her turn twice because, when the receptionist calls her number, she cannot hear her voice. When she finally makes it into the consultation room she is anxious and frustrated.

UNIT 7 SUMMARY



TIME

15 minutes



METHODS

Group check-in



MATERIALS NEEDED

None



STEPS

1. Ask participants to stand in a circle facing each other and reflect on everything they've discussed as part of this unit. After **one minute** of quiet reflection, ask participants to think of one word to express how they are feeling at the end of this session.
 2. Go around the circle and ask participants to say their one word. When everyone has had a chance to say their word, reflect with the group on the overall trend: are people tired? Interested? Happy? Frustrated?
- **Trainer's Note:** *If there seems to be an overall tired or unhappy trend, take a moment to let the group express their concerns or frustrations. Ask for volunteers to explain what frustrated them and ask the group for idea of how the facilitation can be improved to lessen confusion or frustration.*
3. Give the group another moment to reflect, this time on one thing they can do in the next day for fun. Go around the group again and have participants share what they plan to do for fun that evening or within the next day.

UNIT 8:

THE SRH CLINICAL VISIT AND THE ADOLESCENT CLIENT

INTRODUCTION:

Many of the health concerns adolescents will bring to a clinic are similar or even identical to those of adult clients, although some of the health and human rights issues raised by adolescent clients require special attention. Both screening and history taking must be tailored to the adolescent client, to include their rights to privacy, confidentiality, and informed choice. This unit explores what should be addressed in screening and history taking as well as ways in which the SRH visit can be made less stressful for both the service provider and the adolescent client.

TRAINER'S NOTE: *This unit is designed to be delivered with youth trainers. The lesson and activities can be modified for an adult provider-only participant group, but trainers are strongly encouraged to include youth trainers. It is essential to ensure the participation of youth trainers with different types of disabilities within the training. Accommodation (sign language interpretation and/or Computer Aided Real-Time Transcription (CART)² personal assistants, braille, large print, easy to read materials, etc.) should be provided as needed to ensure full participation of young trainers with disabilities.*


UNIT TRAINING OBJECTIVE:

To prepare providers to serve the needs of the adolescent client during the SRH visit with special attention to screening and history taking.

SPECIFIC LEARNING OBJECTIVES:




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

9. Identify the elements that should be included in screening and history taking for adolescent sexual and reproductive health service provision.
10. Explain the physical exam and how it can be tailored to the needs of the adolescent client.
11. Discuss specific issues for adolescent client education, such as the menstrual cycle, sexual pleasure, and shared responsibility for sexual health.

 **TOTAL TIME: 3 HOURS 10 MINUTES**

² CART is a method to provide access to spoken communication for people with hearing, cognitive or learning disabilities. CART refers to the instant translation of the spoken word into text using a stenotype machine, notebook computer, and real-time software. The text produced by the CART service can be displayed on an individual's computer monitor, projected onto a screen, or made available using other display systems.

UNIT OVERVIEW:

Session	Methods 	Materials 	Time 
8.1	Trainer presentation Role Plays	Slides 8.1-8.22 Participant Handouts 8a <i>Optional</i> : Participant Handout 8b	1 hour 50 minutes
8.2	Trainer presentation	Flipcharts and markers Slides 8.23-8.29	30 minutes
8.3	Group discussion	Trainer Tool 8a Flipcharts and markers	45 minutes
Unit Summary	Take home research	Participant Handouts 8a and 8b	5 minutes



WORK FOR TRAINERS TO DO IN ADVANCE:

- Review Slides 8.1-8.29
- Work with youth co-trainers to plan delivery of session activities
- SO 8.1 Prepare copies of Participant Handouts.
- SO 8.1 Find/Obtain copies of local Ministry of Health history taking form for participants.
- SO 8.3 Print sample letters from adolescents and cut them into separate strips of paper.



MAJOR REFERENCES AND TRAINING MATERIALS:

FHI360. 2015. *How to be reasonably sure a client is not pregnant. A Checklist*:
<https://www.fhi360.org/sites/default/files/media/documents/checklist-pregnancy-english.pdf>

HEEADSSS: A Psychosocial Interview Format for Adolescents, Adapted from Contemporary Pediatrics, Getting Into Adolescent Heads, July 1988, John Goldenring, MD, MPH and Eric Cohen, MD.

World Health Organization. 2010. *Adolescent Job Aid: A handy desk reference tool for primary level health workers*. Geneva: WHO.

SPECIFIC OBJECTIVE 8.1: IDENTIFY THE ELEMENTS THAT SHOULD BE INCLUDED IN SCREENING AND HISTORY TAKING FOR ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH SERVICE PROVISION



TIME

1 hour 50 minutes



METHODS

- Trainer presentation
- Role play activity



MATERIALS NEEDED

- Slides 8.1-8.22
- Participant Handout 8a: HEEDSSS Psychosocial Interview for Adolescents
- *Optional:* Participant Handout 8b: MoH History Form



STEPS

- **Trainer's note:** *This program should be delivered by both the lead trainer and a youth counterpart, if available. IT IS ESSENTIAL TO ENSURE the participation of youth trainers with different types of disabilities WITHIN THE TRAINING. Accommodation should be provided as needed to ensure the full participation of young trainers with disabilities. The trainers should work together beforehand to decide how best to divide the information, with a preference towards the youth trainer delivering more of the content.*

Time: 20 minutes

1. Introduce the content of the presentation by explaining that there are issues to be aware of when planning services for adolescent clients. Present the **Content: Tips for Providing Clinical SRH Services to Adolescents** (Slides 8.1-8.6) below.

Content: Tips for Providing Clinical SRH Services to Adolescents

Slide 8.1-8.2: Clinical Screening

Conducting a clinical screening for adolescents, especially for SRH services, can be uncomfortable and even challenging for both the adolescent as well as the provider. This is in part due to cultural or social perspectives and norms on adolescent sexuality and their use of health services and contraceptive methods. Many providers feel awkward discussing sexuality, sexual activity, and contraception with unmarried adolescents, perhaps because they don't want to be perceived as endorsing or encouraging adolescent sexual activity. As a result of stigma, prejudice, attitudinal and communication barriers, providers may feel even more uncomfortable when the client is an adolescent with a disability. Young people often sense this and may interpret provider discomfort as judgment or disapproval.

Ask participants to reflect on previous sessions which discussed adolescence and key

communication skills that should be used with an adolescent client and on the communication tips specifically related to clients with disabilities (also refer to the chapter “Adolescents with disabilities”). Ask what topic and/or service would they be most uncomfortable discussing with or providing to an adolescent client. Tell them to make a mental note of the topic or service that creates the greatest discomfort.

2. Explain to participants that there are a few tips to conducting an assessment of an adolescent client which can help ease anxieties for both the provider and the adolescent client.
3. Return to the presentation with **Slide 8.3: Tips for Conducting an Assessment of an Adolescent Client** below.

Slides 8.3-8.6: Tips for Conducting an Assessment of an Adolescent Client

- *Ensure the adolescent’s privacy and confidentiality.* Parents, family members or other adults/caregivers should not be present when conducting an assessment unless the adolescent specifically gives permission or asks for an individual to be present. This rule is valid for all adolescent clients including clients with disabilities.
- *Be aware of your own beliefs and biases.* A provider may be confronted with difficult situations which conflict with your beliefs and values.
 - Avoid making common assumptions, such as assuming that your adolescent client lives at home, has two parents, goes to school, gets along well with teachers and peers, and is heterosexual.
 - Be prepared to engage with youth in a non-judgmental and inclusive way as a respectful, caring health care provider, not as a parent or friend.
- *Start by introducing yourself.* If a parent is present, introduce yourself to the adolescent first and have the adolescent introduce you to his/her parent. This sends a message that you as the provider are interested in the adolescent.
- *Explain that what is said to the provider is confidential.* Ask the adolescent what they understand about confidentiality, acknowledge his/her response and then add your own views.
- *Ask non-threatening questions.* At first, avoid asking direct questions about whether an adolescent is sexually active. Instead, ask some questions that help you get to know the adolescent client and that put the client at ease. For example, ask some questions about their living environment, school, leisure activities or work.
 - When you’re ready to ask more direct questions about the client’s sexual and reproductive health, use **indirect lines of inquiry**. In other words, ask questions using the third person. For example, rather than asking an unmarried adolescent if s/he is sexually active, ask about the activities of his/her friends or peers: “Are any of your friends in relationships? Are they having sex?” Then ask how the client feels about their friends’ activities. You can then begin to ask if the adolescent client is also in a relationship, and so on...
 - If your client is married, ask how long she has been married, if she has friends who are married, and how she is settling into married life. Let her know you are willing to answer any questions or concerns she may have.
- *Use verbal and non-verbal language that normalizes rather than stigmatizes their behavior.* Ensure that both your verbal and body language is friendly and non-judgmental at all times (see previous Unit 7). Unmarried sexually active adolescents

often face immense social stigma – both external and internal, and they may feel powerful shame or embarrassment. Sometimes a simple “I have seen and helped many young people with this same concern or problem” can ease their discomfort.

- Married adolescents may be experiencing powerful pressure from family members and communities to bear children but may feel uncertain or unprepared for pregnancy and childbearing or may want to better space their next pregnancy. The provider can help by acknowledging this pressure they may be facing, supporting them to articulate their feelings and concerns, and exploring coping strategies.

Source: WHO Adolescent Job Aid

4. Ask participants: What are the most common complaints among the adolescents you see in your practice? Do you sometimes feel that there are other concerns behind their initial complaint? How do you address that?

Time: 45 minutes

5. Pass out **Participant Handout 8a: HEEADSSS Assessment** and ask participants to follow along as you go through the next few slides.

Content: HEEADSSS Assessment (Slides 8.7-8.22)

Slide 8.7: Client Background

As noted, adolescence is a challenging time of emotional, social and physical change. Many adolescents make it through adolescence without major problems, but this is still a time of vulnerabilities, risks and experimentation.

Many people, adolescents included, only seek help when they are experiencing a particular health issue or symptom.

- Clients often only volunteer information that seems most relevant to the problem they think they have. Providers are often forced to fill in the gaps to be able to provide quality care to their client.
- Adolescents also have many myths, misconceptions, and gaps in information about sexual and reproductive health and contraception.
- Providers may wish to use a more rigorous and systematic approach to assessing adolescent clients to ensure they are able to fully discuss potential health and social risks and provide high-quality information and care.

Slide 8.8: HEEADSSS Assessment

The HEEADSSS assessment helps the provider to obtain a full picture of the adolescent, including behaviors, social factors, and potential warning signs in the adolescent’s environment that could affect their health and wellbeing. HEEADSSS stands for:

- Home and Environment
- Education/Employment
- Eating and Exercise
- Activities
- Drugs/Substances

- Sexuality
- Suicide/Depression
- Safety

➤ **Trainer's Note:** For the following slides on each component of the HEEADSSS Assessment, pause before showing the questions and ask participants to brainstorm what types of questions should be asked. Then, show the slide with the recommended HEEADSSS questions. Ask participants to keep the following in mind: How can they use the responses to assess:

- The adolescent's evolving capacity.
- Their general health needs.
- Their sexual and reproductive health needs.

Ask participants to evaluate in each section which questions, if any, are essential to ask even if they have limited time.

Slide 8.9: Living environment

Potential first line questions about clients' living environment	Where do you live? Who lives with you there?
	What are relationships like?
	Can you talk to anyone about stress? Who?
	Is there anyone new? Has someone left recently?
	Is there anything you would like to change about your living environment?

➤ *Pause for questions.*

Other questions to be asked if there is adequate time:

- Have you moved recently?
- If the client lives at home: Have you ever had to live away from home? Why?
- Have you ever run away? Why?
- Is there any physical violence where you live?

Slide 8.10: Education/Employment

Education/ Employment	Do you go to school?
	<u>If the answer is yes:</u>
	Tell me about school

For adolescents with disabilities: do they attend a disability-specific school or a mainstream school?

Is your school a safe place? Why? Have you been bullied or harassed at school? On the way to school?

Do you feel connected to your school? Do you feel you belong?

Are there adults at school that you could talk to about something important? Who?

Have there been any recent changes in your schoolwork? Are you failing any of your subjects?

What are your future education plans and goals?

Are you working? Where? How much?

What are your future employment plans and goals?

➤ *Pause for questions*

Other questions to be asked if the client goes to school and if there is adequate time:

- How many days of school have you missed this month/this semester? Why?
- Have you changed schools in the past few years?
- Tell me about your friends at school.
- Have you ever had to repeat a class or a grade?
- Have you ever been suspended from school? Have you ever considered dropping out?
- How well do you get along with your classmates?
- Have your work responsibilities increased?
- What are your favorite subjects in school? Least favorite?

Slide 8.11: Eating and Exercise

Eating Does your weight or body shape cause you any stress? If so, tell me about it. What do you like or not like about your body?

Have there been any recent changes in your weight?

How would you describe your eating habits?

Tell me about any exercise you do or get in your daily routine.

➤ *Pause for questions*

- What do you think is a healthy diet? Do you think you maintain a healthy diet?
- How many meals do you have on a normal day? What do you eat at each meal? Have you done anything to manage your weight?
- What would it be like if you gained 5 kilos? Lost 5 kilos?
- Do you ever feel like your eating is out of control?

Slide 8.12: Activities

Activities What do you do for fun? What things do you do with your friends? Your family?

What do you do in your free time?

Are most of your friends from school or the community? Are they the same age as you?

➤ *Pause for questions*

Other questions to be asked if there is adequate time:

- Do you spend time with mainly people of your same sex, or with a mixed group of young men and women?
- Do you have one best friend or a few friends or a lot of friends?
- Do you see your friends at school? After school? On weekends?
- Do you do any regular sports or exercise? What are your hobbies or interests?
- Do you attend church or mosque?
- Do you watch a lot of television? How much? What are your favorite shows?
- Do you spend a lot of time on your phone? The internet? How much?
- Do you read for fun? What do you read?

Slide 8.13: Drugs and substances

Drugs Some young people try cigarettes, alcohol, marijuana or other drugs. Have you or your friends ever tried any of these?

Do any of your family members drink, smoke or use drugs? If so, how do you feel about this? is it a problem for you?

➤ *Pause for questions*

Other questions to be asked if there is adequate time:

- Have you or your friends ever tried any other drugs? Specifically, what? Have you ever used a needle to inject drugs?
- How do you pay for cigarettes, alcohol, drugs?

- Is there any history of alcohol or drug problems in your family?
- Do you ever drink or use drugs when you are alone?

Slides 8.14-8.16: Sexuality

Sexuality (For girls) When did you first get your period (at what age?) When was your last menstrual period? How often do you get your period? Do you have any questions about your periods?

How do you care for yourself during your menstruation?

What do you do to manage menstrual flow?

(For boys) Have you been circumcised? (If yes) at what age were you circumcised? Do you have any questions or concerns about the circumcision? Explain that voluntary medical male circumcision (VMMC) contributes to HIV prevention, along with the use of condoms and other safer sex practices. Ask if they are interested in VMMC.

Are your friends in relationships? Have your friends had sex?

Are you now involved in a relationship? Have you been involved in a relationship? How was that experience for you?

How long have you been/were you in a relationship?

Have any of your relationships been sexual – that is, involved kissing or touching?

Are you attracted to anyone now?

Are you interested in boys? Girls? Not yet sure?

Have you had sex? Was it a good experience? Are you comfortable with sexual activity?

(Girls) Have you ever been pregnant? If yes, what was the outcome?

(Boys) Have you ever gotten someone pregnant? If yes, what was the outcome?

What things do you do to prevent pregnancy? (Use this opportunity to correct any myths or misinformation about ineffective pregnancy prevention practices, such as douching.)

Do you currently use a contraceptive method? What method are you using now? Have you used any other methods?

Do you regularly use condoms?

What are some of the challenges you have experienced in using a contraceptive method? Condoms?

Do you have any questions or concerns about your current method of contraception?

If client is not currently using a method, ask if they are interested in using a contraceptive method, and if they have a method preference.

Have you ever had any kind of discharge or sore that you are concerned about? Have you ever been tested for a sexually transmitted infection? Have you ever been treated for an STI?

Are your vaccinations up to date? Have you been given the HPV vaccine?

Have you ever been tested for HIV? What was the result?

Have you had an experience in the past where someone did something to you that you did not feel comfortable with or that made you feel disrespected? What did you do?

Have you ever been pressured or forced into doing something sexual that you didn't want to do?

If someone abused you or hurt you, who would you talk to?

➤ *Pause for questions*

It is important to make sure that their immunizations are up to date, and at the very least, providers should ask if they have received the HPV vaccine. Adolescents can get the HPV vaccine even if they have already initiated sexual activity.

Other questions to be asked (where relevant) and where there is adequate time:

Menstruation

- How many days do your periods last when they come?
- How many pads (or cloths or equivalent) do you use a day – at the beginning of your period? At the end?
- Do you have pain with your periods? Is the pain constant throughout your period?
- Does the pain prevent you from carrying out your daily activities?
- What do you do to ease the pain?

Slide 8.17: Suicide/Depression

Mental health is emerging as a major health concern among adolescents. The assessment should seek to identify elements that correlate with anxiety or depression. If the screening

is positive, adequate referral for detection should be scheduled. It is also important to check for potential violence and abuse situations.

Suicide/ Have you felt more stressed or anxious than usual?

Depression

Do you feel sad or down more than usual?

Do you ever have thoughts about hurting yourself or wishing you didn't exist?
How have you handled these types of thoughts/feelings?

Are you having trouble sleeping?

Have you lost interest in activities that previously you deemed enjoyable?

Have you lost interest in food?

Do you feel it is difficult to cope with normal social interactions at a level you were previously used to?

Tell me about a time when someone bullied you or made you feel uncomfortable. What did you do?

➤ *Pause for questions*

Other questions to be asked if there is adequate time:

- Do you find yourself spending less time with friends and people you care about?
- Would you rather just be by yourself most of the time?
- Tell me about how you feel when you use social media, like Facebook. Does it make you feel sad?
- Do you feel like you've lost interest in things you used to like to do? If so, can you tell me more?
- Do you ever use alcohol or drugs to help you calm down or feel better?
- Have you ever hurt yourself by cutting yourself to calm down or feel better?

Slide 8.18: Safety

Safety Have you ever been seriously injured? How?

Have you ever made a decision that could have put you at risk of being hurt/harmed?

How do you decide if a person or a situation is safe for you?

Are you able to use a seatbelt in the car?

Do you wear a helmet when riding a motorbike?

Have you ever ridden in a car or on a motorbike with someone who was drunk or high?

Is there a lot of violence where you live? School? Neighborhood? Workplace? Among friends?

➤ *Pause for questions*

Other questions to be asked if there is adequate time:

- Have you ever been picked on or bullied? Is that currently a problem?
- Have you ever gotten in a physical fight at school or your neighborhood?
- Have you ever felt like you needed to carry a weapon to protect yourself?
- Have you ever met in person someone you first met online? Do you have plans to meet someone that you met online?
- Do you ever text and drive?

Slides 8.19-8.20: Wrap Up

To wrap up the assessment,

- Have the adolescent sum up their life in one word or give a “weather report” for their life. (e.g. sunny with a few clouds, cloudy and rainy, etc).
- Ask them what they see when they look in the mirror each day. Look for adolescents who say they are bored. Boredom could suggest depression.
- Ask them to tell you who they can trust and in whom they can confide if there are problems. Have them tell you why they trust this person. Tell the adolescent that s/he can also trust in you, the provider, to help with problems and answer questions.
- Let the adolescent know you are interested in them as a whole person, and that you are someone who wants to help them lead a full, healthy life.
- Give them an opportunity to express any concerns you have not covered. Ask for feedback about the interview. Let them know they can call or come back anytime.
- For adolescents who report significant risk factors, let them know you are concerned. Ask if they are willing to make some changes or if they are interested in help to deal with their problems. Many adolescents may not recognize unhealthy lifestyles or patterns of behavior, because they see their actions not as problems but as solutions. As a provider, you can help them see health risk-taking behaviors and to develop better strategies for dealing with them.
- Discuss what the providers’ next steps would be if they identify health risk-taking behavior and ensure providers understand the importance of referring and supporting the client, who has decided to open up about violence, bullying, or if the provider has identified elements that correlate with anxiety or depression.
- If the adolescent’s life is going well, say so. Identify strengths and weaknesses and discuss how the adolescent can build on strengths and address weaknesses.

Slide 8.21: Assessing SRH is an important aspect of adolescent history taking

The HEADSSS assessment includes questions regarding sexuality and SRH and it is important that these issues not be omitted when conducting history taking with an adolescent client. Young people may feel reluctant to seek specific SRH services but may be willing to seek care for other less sensitive concerns. This may also provide the adolescent with an opportunity to assess the “friendliness” of the provider and to determine if they can approach the provider for SRH information and care.

Any history-taking, inclusive of SRH, should be personalized according to the gender, age, disability, marital status, and sexual orientation of the individual client, and all clients should be asked about their sexual activity and relationships, reproductive goals and intentions, and use of or interest in contraception and condoms.

Slide 8.22: Screening for SGBV is essential

Young people, especially young women, but also young men too often experience violence in the home, sexual coercion, forced sex, rape/sexual assault, intimate partner violence and gender and disability-based violence which can be committed by family members, neighbors, teachers, and peers, among others. Adolescent girls are 3 to 4 times more likely to experience violence or abuse. Young women may also be at risk for or have experienced harmful traditional practices, such as female genital mutilation/cutting.

These topics will be addressed more fully in Unit 13 on Sexual and Gender Based Violence.

Time: 45 minutes

6. Introduce the Activity. Ensure that all participants have copies of the HEADSSS Assessment tool. If copies of the Ministry of Health intake/history taking form are available, distribute these as well.
7. Ask participants to break into pairs. Explain that they will practice conducting a HEADSSS Assessment. If you have young people participating, disperse them among the pairs to provide additional context, but instruct participants that each will have an opportunity to play both the adolescent client and the service provider.
8. Ask each participant to take a few moments to think of an adolescent client, such as a typical client they see for services or a client that they found interesting or challenging. Remind participants that this is a great opportunity for them to pick the case of a client with a disability, the potential challenges of supporting them and how to address and overcome these challenges. Once all participants have a client in mind, move on to the next instructions.
9. Ask them to take turns taking each other’s history using questions from the HEADSSS Assessment and the Ministry of Health history form (if available).
10. Remind participants: During the initial history taking, it is important that providers use neutral, non-judgmental, respectful and inclusive language, and be aware of their

assumptions (e.g. that the client is heterosexual) and non-verbal reactions and communications.

- 11.** Give the pairs **10 minutes** for their first history, then ask them to switch roles.
- 12.** Give participants **10 minutes** for the second history. Ask them to come back to the larger group when finished.
- 13.** Debrief the activity. Ask for volunteers to respond to the following questions:
 - How did it feel to be the “provider” asking questions?
 - How did it feel to be the adolescent client answering the questions?
 - Did it feel like there was enough time or did it feel rushed?
 - Did it feel like there was too much time or too many questions?
 - For those who portrayed adolescent clients, did you think the provider got all the information they needed to understand your character and your concern?
 - Did anyone feel like their provider didn’t ask for key or crucial pieces of information? What other questions should have been asked?
- 14.** If you have youth participants in the room, ask them if they felt like this exercise reflects the typical adolescent experience with service providers. In what ways was it different? If you have youth participants with disabilities in the room, take this opportunity to ask for their feedback and share this experience with all the participants.
- 15.** Wrap up the activity by asking participants to discuss how providers can balance the need for time and efficiency against the need to gather crucial information from adolescent clients?

TABLE 1 The HEADSSS psychosocial interview for adolescents

	Potential first-line questions	Questions if time permits or if situation warrants exploration
Home	Who lives with you? Where do you live? What are relationships like at home? Can you talk to anyone at home about stress? (Who?) Is there anyone new at home? Has someone left recently? Do you have a smart phone or computer at home? In your room? What do you use it for? (May ask this in the activities section.)	Have you moved recently? Have you ever had to live away from home? (Why?) Have you ever run away? (Why?) Is there any physical violence at home?
Education and employment	Tell me about school. Is your school a safe place? (Why?) Have you been bullied at school? Do you feel connected to your school? Do you feel as if you belong? Are there adults at school you feel you could talk to about something important? (Who?) Do you have any failing grades? Any recent changes? What are your future education/employment plans/goals? Are you working? Where? How much?	How many days have you missed from school this month/quarter/semester? Have you changed schools in the past few years? Tell me about your friends at school. Have you ever had to repeat a class/grade? Have you ever been suspended? Expelled? Have you ever considered dropping out? How well do you get along with the people at school? Work? Have your responsibilities at work increased? What are your favorite subjects at school? Your least favorite subjects?
Eating	Does your weight or body shape cause you any stress? If so, tell me about it. Have there been any recent changes in your weight? Have you dieted in the last year? How? How often?	What do you like and not like about your body? Have you done anything else to try to manage your weight? Tell me about your exercise routine. What do you think would be a healthy diet? How does that compare to your current eating patterns? What would it be like if you gained (lost) 10 lb? Does it ever seem as though your eating is out of control? Have you ever taken diet pills?
Activities	What do you do for fun? How do you spend time with friends? Family? (With whom, where, when?) Some teenagers tell me that they spend much of their free time online. What types of things do you use the Internet for? How many hours do you spend on any given day in front of a screen, such as a computer, TV, or phone? Do you wish you spent less time on these things?	Do you participate in any sports? Do you regularly attend religious or spiritual activities? Have you messaged photos or texts that you have later regretted? Can you think of a friend who was harmed by spending time online? How often do you view pornography (or nude images or videos) online? What types of books do you read for fun? How do you feel after playing video games? What music do you like to listen to?
Drugs	Do any of your friends or family members use tobacco? Alcohol? Other drugs? Do you use tobacco or electronic cigarettes? Alcohol? Other drugs, energy drinks, steroids, or medications not prescribed to you?	Is there any history of alcohol or drug problems in your family? Does anyone at home use tobacco? Do you ever drink or use drugs when you're alone? (Assess frequency, intensity, patterns of use or abuse, and how patient obtains or pays for drugs, alcohol, or tobacco.) (Ask the CRAFFT questions in Table 5, page 25.)

SPECIFIC OBJECTIVE 8.2: EXPLAIN THE PHYSICAL EXAM AND HOW IT CAN BE TAILORED TO THE NEEDS OF THE ADOLESCENT CLIENT



TIME

30 minutes



METHODS

- Trainer presentation



MATERIALS NEEDED

- Slides 8.23-8.29
- Flipcharts and markers.
- Handout 8C: How to Be Reasonably Sure a Client is Not Pregnant



STEPS

1. Ask participants how they can help make adolescents more comfortable during a physical exam. Ask if any of them have strategies or techniques for making adolescent clients more comfortable before, during, or after physical exams. Write suggestions on flip charts.
2. Introduce the presentation. Say: Physical exams can be stressful for all kinds of clients, regardless of their age. For adolescent clients, there are some ways to address their discomfort and ensure that both the adolescent and the provider are protected and at ease during the clinical exam. Present **Content: Adolescent Physical Exams** (Slides 8.23-8.29) below.

Content: Adolescent Physical Exams (Slides 8.23-8.29)

Slide 8.23: Before the Physical Exam

Explain why the physical examination is important.

Respect the adolescent's need for privacy. If the adolescent is accompanied by a friend, parent, husband or other person, reach an agreement about whether they want this person to be present during the examination.

Inform the adolescent about what the nature, purpose, and content of the examination is. Reassure the adolescent that any results of the exam will remain confidential.

Offer to have the exam performed by a provider of the same sex. If this is not possible, make sure there is a same sex attendant in the room during the exam.

Obtain the adolescent's consent to perform the examination. If the adolescent is below the legal age of consent for medical services, you will need to obtain consent from a parent or guardian. However, even if you have obtained consent

from a parent or guardian, you should not proceed with the examination unless the adolescent agrees.

A good rapport between the provider and client is essential.

Slide 8.24: Assess for Pregnancy

A pregnancy test can be administered, but if there are no pregnancy test kits, you can use the pregnancy checklist with the client. The checklist consists of six questions that providers ask clients while taking their medical history. If the client answers “yes” to any of these questions, and there are no signs or symptoms of pregnancy, then a provider can be reasonably sure that the woman is not pregnant.

3. Distribute Handout 8C *The pregnancy checklist*. Review the pregnancy checklist questions with the participants.

Ask participants: Would it be difficult to use this checklist with adolescents? Why or why not? Would you trust the results of the checklist? Why or why not?

Slide 8.25: Assessing the need for a pelvic exam

A pelvic exam is not needed to obtain contraception. In many countries, routine pelvic exams are not common. If the adolescent is not pregnant and does not report current physical symptoms of or risk factors for an STI, there is no need for a pelvic exam.

Slide 8.26: Prepare for the Physical Exam

Protect her/his physical privacy as much as possible. Make sure curtains are drawn, doors are shut, and that no unauthorized person enters the room during the examination. 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.

Provide reassurance throughout the exam. Explain what you are doing before you begin each step of the examination. Provide an opportunity for the adolescent to ask questions or relay concerns.

Provide constant feedback in a non-judgmental, respectful and inclusive manner. "I see you have a small sore here, does it hurt?"

Watch for signs of discomfort or pain and be prepared to stop the examination if needed.

Slides 8.27-8.29: General Elements of a Physical Exam

In the event you believe a physical exam is warranted, consider these elements of a good physical exam. Take great care to carry out all parts of the exam gently and smoothly to minimize discomfort and anxiety.

Examine the external genitalia, including the anus, for ulcers, warts, discharge, trauma, or pubic lice.

Conduct a dermatology exam, which can be as simple as an expanded examination of the buttocks and the perineum.

Include an oral exam to look for any oral lesions or ulcers.

If the client is a young man who is not circumcised, gently retract the foreskin to look for ulcers on the glans penis.

If a vaginal examination is necessary, provide a chance for questions. Adolescent girls may fear that an object placed in the vagina will tear the hymen/affect her virginity. 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. As you insert the speculum, ask her to bear down and take slow, deep breaths.

The breast examination should become part of the general medical evaluation once girls have breasts. 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.

Although breast cancer is rare during the adolescent years, girls should learn how to conduct breast self-examination. Similarly, boys should be taught to do testicular self-examination. Explain to the adolescent what healthy breast or testicular tissue feels like and what to look for when conducting a self-examination.

Have the adolescent conduct a self-examination on their own breasts or testicles and ask questions about what they find.

4. Close the presentation by providing space and time for questions from the participants.

How to be Reasonably Sure a Client is Not Pregnant

Ask the client questions 1–6. As soon as the client answers **YES** to *any question*, stop, and follow the instructions.

NO	1. Did your last menstrual period start within the past 7 days?*	YES
NO	2. Have you abstained from sexual intercourse since your last menstrual period or delivery?	YES
NO	3. Have you been using a reliable contraceptive method consistently and correctly since your last menstrual period or delivery?	YES
NO	4. Have you had a baby in the last 4 weeks?	YES
NO	5. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	YES
NO	6. Have you had a miscarriage or abortion in the past 7 days?*	YES

* If the client is planning to use an IUD, the 7 day window is expanded to 12 days.

If the client answered **NO** to *all of the questions*, pregnancy cannot be ruled out using the checklist.†
Rule out pregnancy by other means. Give her condoms to use until pregnancy can be ruled out.

If the client answered **YES** to *at least one of the questions* and she is free of signs or symptoms of pregnancy, you can be reasonably sure she is not pregnant.

† If the client is concerned about an unintended pregnancy, offer emergency contraception if every unprotected sex act since last menses occurred within the last 5 days.

SPECIFIC OBJECTIVE 8.3: DISCUSS SPECIFIC ISSUES OF CONCERN FOR ADOLESCENT CLIENTS, SUCH AS THE MENSTRUAL CYCLE, SEXUAL PLEASURE, AND SHARED RESPONSIBILITY FOR REPRODUCTIVE AND SEXUAL HEALTH



TIME

45 minutes



METHODS

- Group brainstorm



MATERIALS NEEDED

- Sample letters from adolescents (**Trainer Tool 8a: Sample Letters** below)
- Flipcharts and markers



STEPS

1. Introduce the activity. Tell participants that there are issues related to puberty and being an adolescent that they'll need to be prepared to respond to, and that they're going to practice those responses together now.
2. Distribute **Sample Letters from Adolescents** to participants. Ask for a volunteer to read the first letter out loud.
3. Ask participants to identify the issues raised by the letter. Note their responses on the flip chart.
4. Next, ask participants to brainstorm responses for the issues they identified. Note these on a separate flip chart.
5. Ask for a volunteer to compose out loud for the group a letter to respond to the adolescent in the first sample letter. Let the group comment on the response.
6. Repeat steps 2-5 for each of the sample letters.
7. If there is adequate time, ask participants to share any of their own experiences in answering the questions of adolescent clients.



TRAINER TOOL 8C: SAMPLE LETTERS FROM ADOLESCENTS

Adapted from Positively Informed, International Women's Health Coalition

I'm a 15-year-old boy with a hearing disability and sometimes when I wake up in the morning, my pajama bottoms are sticky with a white substance. Is there something the matter with me or am I normal?

Several days before I get my period, I get irritable and cry a lot. I also get a bad backache. My grandma keeps telling me that it's "all in my head" and that if I had a better attitude and tried harder, I wouldn't have such a bad time each month. Is she right? Am I causing myself to feel bad?

My boyfriend is really pressuring me to have sex with him. I'm not really comfortable with having sex yet, but I really love my boyfriend. He told me that if I love him, I will have sex with him, and if I don't there are plenty of other girls who will. I want to keep my boyfriend, how can I keep him without having sex?

Can you explain to me why some students in my class still look like children and some look like adults? We're all the same age! All my friends have their periods and are taller and I still look like a little girl. But I'm almost 14! My mother says my day will come... but I want to know when? And will I end up looking like everyone else eventually?

I'm not circumcised, and I can't pull my foreskin all the way back to wash properly. I'm scared to tell anyone because I think it would be very painful to be circumcised. What can I do?

My girlfriend says we should talk about contraception because she doesn't want to get pregnant, but I don't think there's anything I can do. Isn't it the girl's job to stop pregnancy?

My friends all tell me that there are "safe" days every month where I can have sex and I won't get pregnant, but I'm still scared every time I have sex. One friend said I should have sex when I'm having my monthly bleeding, because there's no way I can get pregnant then. That sounds awful! Wouldn't blood get everywhere?

I'm 16 and went through puberty about three years ago. But my penis is still quite small. When I'm erect, it is about five inches long, which seems short, considering some of the movies I've seen. When it is soft, it shrinks down to practically nothing. This is very embarrassing, especially when I'm bathing in public. I even try to get erect before I get into a shower, just so it looks bigger. I'm still a virgin, and I'm afraid that when I do have sex, I'll be too small. Will that be a problem?

I really enjoy sex, but I'm afraid to tell my boyfriend how much I like it or what I like most. My friends say that boys can't know that you like sex or they'll want it all the time and will always be bothering me for sex. But I do want to have sex! Are my friends right? How can I hide from my boyfriend how much I like it?

My friends all tell me that you can catch all kinds of diseases from performing oral sex on a woman, and that it makes you weak and unmanly. But I think I want to try? My girlfriend thinks I'm strange for even thinking about it. How can I explain to her that I want her to enjoy herself too?

I am 16. I have a spinal-cord injury as a result of a car accident. Can I have sex and have children as all my female friends?

I am 15, I have a visual disability and I have a boyfriend. I want to learn about love, sex and relationship. Can you teach me?

Unit 8 Summary



TIME

5 minutes



METHODS

Homework



MATERIALS NEEDED

- Participant Handout 8a: HEEADSSS Assessment
- *Optional:* Participant Handout 8b: MoH History Form
- Participant Handout 8c: Pregnancy Checklist



STEPS

1. Assign homework: Ask participants to take their handouts home.
 - If they have a Ministry of Health form, make revisions to supplement what they think will help them get more and better information from their adolescent clients.
 - If they don't have a Ministry of Health form, to create their own form or assessment worksheet to help them streamline their services.
2. Ask participants to bring back their sample forms on the day you've planned Unit 15: Designing Adolescent Services.

UNIT 9:

CONTRACEPTION AND RISK REDUCTION COUNSELING FOR ADOLESCENTS

INTRODUCTION:

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

Protection against infection and pregnancy involve many of the same strategies and services. Adolescents need to be able to first assess their risk of STI/HIV or of an unintended pregnancy, and then identify steps they can take to protect their sexual health and mitigate risk. Providers need to be able to comfortably discuss sexual health and sexual activity with adolescents, and to provide accurate information on risks that may be associated with sexual activity as well as actions young people can take to reduce their risk. One important action that providers can take is to dispel myths and correct misinformation about contraception such as commonly held concerns around the side effects of contraceptive methods. This can help to ensure that the adolescent client will choose to use a method of contraception and continue to use it properly.

Trainer's Note: *This unit is designed to be delivered with youth trainers. The lesson and activities can be modified for an adult provider-only participant group, but trainers are strongly encouraged to include youth participants. The participation of youth trainers with different types of disabilities is essential to ensure the perspectives of clients with disabilities are included in the training. Accommodation (sign language interpretation and/or Computer Aided Real-Time Transcription (CART)³ personal assistants, braille, large print, easy to read materials, etc.) should be provided according to the needs to ensure full participation of young trainers with disabilities*

UNIT TRAINING OBJECTIVE:


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

SPECIFIC LEARNING OBJECTIVES:




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

12. Identify reasons why adolescents may not use protection and effectively dispel misinformation and rumors.
13. Discuss safer sex messages and actions to prevent STIs, HIV, and unintended pregnancy, including contraceptive options available to adolescents.
14. Demonstrate how to counsel adolescents, including young men, about contraception and dual protection strategies to prevent STIs, HIV, and unintended pregnancy.

³ CART is a method to provide access to spoken communication for people with hearing, cognitive or learning disabilities. CART refers to the instant translation of the spoken word into text using a stenotype machine, notebook computer and real-time software. The text produced by the CART service can be displayed on an individual's computer monitor, projected onto a screen, or made available using other display systems.

 **TOTAL TIME: 3 HOURS 45 MINUTES**

UNIT OVERVIEW:

Session	Methods 	Materials 	Time 
9.1	Brainstorm Trainer presentation	Slides 9.1-9.5 Index cards Flipcharts and markers	40 minutes
9.2	Trainer presentation Group discussion	Slides 9.6-9.21 Participant Handouts 9a Contraceptive cue cards	1 hour 15 minutes
9.3	Role plays	Participant Handouts 9a and 9b Contraceptive cue cards IEC materials (if available)	1 hour 30 minutes
Unit Summary	Feedback discussion		20 minutes



WORK FOR TRAINERS TO PREPARE IN ADVANCE:

- Review Slides 9.1-9.21
- Work with youth co-trainers to plan delivery
- SO 9.1 Index cards (5 per participant)
- SO 9.2 Prepare copies of Pathfinder’s Cue Cards for Counseling Adolescents on Contraception for each participant. The cue cards can be downloaded here: <http://www.pathfinder.org/publications/cue-cards-for-counseling-adolescents-on-contraception/>. They can also be found in hard copy in Handout 9b.

- SO 9.2 Prepare Participant Handout 9a: BCS+ Algorithm
- SO 9.3 Prepare Participant Handout 9b: ASRH Counseling Role Plays
- SO 9.3 Collect or ask participants to bring in existing IEC materials on contraceptives from their clinics.



MAJOR REFERENCES AND TRAINING MATERIALS:

Jones, N., Presler-Marshall, E. and Stavropoulou, M. 2018. Adolescents with disabilities. Enhancing resilience and delivering inclusive development. London: Gender and Adolescence: Global Evidence

Population Council, 2015. *Balanced Counseling Strategy Plus: A Toolkit for Family Planning Service Providers Working in High STI/HIV Prevalence Settings; Trainer's Guide, Third Edition*. Washington, DC: Population Council.

UNAIDS. 2017. *Disability and HIV*. UNAIDS. Available at https://www.unaids.org/sites/default/files/media_asset/JC2905_disability-and-HIV_en.pdf

WHO medical eligibility criteria wheel for contraceptive use – 2015 update.
http://apps.who.int/iris/bitstream/handle/10665/173585/9789241549257_eng.pdf?sequence=1

SPECIFIC OBJECTIVE 9.1: IDENTIFY REASONS WHY ADOLESCENTS MAY NOT USE PROTECTION AND DISPEL MISINFORMATION AND RUMORS



TIME

40 minutes



METHODS

- Group brainstorm activity
- Trainer presentation



MATERIALS NEEDED

- Index cards (5 per participant)
- Flipcharts and markers
- Slides 9.1-9.5



STEPS

Time: 20 minutes

1. Introduce the activity by explaining to participants that there are many reasons why adolescents are particularly at risk for STIs/HIV and unintended pregnancy. There are also many reasons why it is particularly important to help adolescents avoid STIs, including HIV, and unintended pregnancy. Say that some adolescents will seek services because they want to prevent pregnancy, while others may want to prevent HIV. Explain that every service session with an adolescent is a chance to integrate information on STIs, HIV, and pregnancy prevention and to promote dual protection: protection against infection and pregnancy.

➤ **Trainer's Note:** *If there is a youth co-trainer, have them lead/facilitate this activity.*

2. Pass out 5 index cards to each participant. Tell them that first we're going to try to put ourselves in the mindset of an adolescent, because we can better plan for counseling adolescents if we understand the context in which they make decisions about sexual behavior.
3. Have participants write one reason why adolescents have unprotected sex on each of their index cards. Give them **5 minutes** to complete their cards.
4. Collect the cards and group them according to similar responses. The youth facilitator should at this point supplement participants' responses with their own responses, and any missing content you judge important from **Supplemental Content: Reasons Why Adolescents May Have Unprotected Sex**.

Supplemental Content: Reasons Why Adolescents May Have Unprotected Sex

- May 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 sexuality or protection.
- Sexuality education is often non-existent or inadequate in both schools and the community.
- Parents and others are reluctant to provide practical information and may believe that providing information encourages sexual activity. (Research shows this is not true: sexuality education actually facilitates safer behaviors.)
- Media promotes unrealistic notions of sexuality (“sex sells”) and usually omits any mention of risk or protection.
- Don’t know what methods are available.
- Don’t know where, how, or when to get methods.
- May not be aware of the need for protection during every sex act (i.e. may think that oral or anal sex are “safe” alternatives to vaginal sex).
- Believe their peers are not using contraception or protection.
- In addition to the above mentioned factors, which can be common to all adolescents, adolescents with disabilities face additional barriers in accessing information about methods and need for protection, which increase their risk of engaging in unsafe behavior. These include not only communication barriers but also attitudinal barriers at the service providers, school, community or family level based on the widespread lack of understanding of sexuality and disability and the misconception that adolescents with disabilities are not sexually active and, therefore, do not need to access SRH information.

Misinformation or Misconceptions

- May have misinformation or myths about methods and their side effects. Myths about the dangers of contraception are common and difficult to correct.
- 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" (for example, commercial sex workers, poor people, "other" ethnic groups) and not among others (for example persons with disabilities).
- May be under social pressure to “prove” their fertility.
- May believe that social norms associate use of contraceptives with “planning for sex” and promiscuity.
- May be using ineffective or potential harmful traditional remedies for pregnancy or STIs.
- Believe that sexual desire is uncontrollable or could result in injury or illness if not fulfilled.

Denial

- "Sex just happened."
- "I only had sex once."
- Believe "sex should be spontaneous" or are under social pressure to behave as though sex is/was spontaneous.
- They don't think they will get pregnant or contract a STI.

Lack of Access

- Access to contraceptive services (including protection) for adolescents is limited by law, custom, or clinic/institutional policy.
- Availability and high cost of certain methods.
- Irregular supply of methods.
- Social pressure that associates contraceptives with promiscuity.
- Adolescents believe/ behave as though sex is spontaneous so are less likely to have a method available when sex happens.
- Judgmental attitudes or personal beliefs of the provider may prevent them from distributing certain methods to adolescents.
- Some vulnerable or marginalized groups of adolescents often face additional barriers to accessing contraceptive information and services. In the case of adolescents with disabilities, these include but are not limited to physical, communication and attitudinal barriers. See the chapter "Adolescents with Disabilities" for additional information on disability-based barriers.

Coercion

- Partner or family wants pregnancy.
- Partner won't let her/him use protection or insists that use of contraceptives is a sign of mistrust.
- Sex is forced or coerced.
- Belief that condoms ruin sex or are unromantic.
- Partner agrees to use contraceptives or protection but then refuses to follow through.

Fear

- Rejection by partner.
- Lack of confidentiality at the place where they obtain methods.
- Fear of the unknown - of using something that they have never used before.
- Side effects.
- Limited understanding of how to properly use protective methods.
- Where to keep protective methods so that no one sees/discovers them.
- Something may go wrong if they start using certain methods or products in adolescence.
- Their parents will find out they are having/planning to have sex.
- Their peers will know they are sexually active.
- Concerns over a physical examination, especially pelvic exam.
- Being asked questions by medical staff.
- Being labeled as "cheap" or "loose" or "bad."
- Being seen entering a clinic.

Embarrassment

- Service providers are sometimes judgmental and/or moralistic about adolescent sexual activity. This is particularly true in the case of adolescents with disabilities because of the widespread misconceptions and lack of knowledge on sexuality and disability.
- Embarrassed to buy condoms.
- Retail outlets often place protective methods behind the counters so that customers must request them.
- May be embarrassed to use a method at the time of sex.

Other factors

- Stopped using contraceptives because of the side effects.
- Sex may be spontaneous or unplanned.
- In some instances, adolescents want to conceive. Girls/young women may see pregnancy as a way to keep a relationship or a boyfriend; for a boy/young man, pregnancy may be seen as a way to prove manhood.
- May lack the communication and negotiation skills to discuss contraception/protection.
- Thinks the partner "is taking care of contraception."
- Feels ambivalent about becoming pregnant.
- Does not know how to dispose of condoms.

5. Have the group discuss the following questions in plenary (*Ensure that youth facilitators/participants with and without disabilities are leading the discussion and are encouraged to respond to any assumptions or misconceptions expressed by participants*):
 - a. Which of these reasons are internal to the adolescent (that is, based on their own self-awareness or self-perception)?
 - b. Which are external (that is, based on social norms or cultural barriers)?
 - c. What are some counseling strategies you could use to help an adolescent express his or her concerns or misconceptions? (*Trainer's note: select individual cards and ask for specific strategies or techniques. Use a flip chart during this question and the next to create a record for participants.*)
 - d. What other support could you provide?
6. Close the discussion by asking youth participants/facilitators for their reactions and advice for providers. Ask participants/facilitators with disabilities in the room for their specific insights and experiences on disability-based barriers and advice for providers.

Time: 20 minutes

7. Move to the trainer's presentation. *This presentation should be delivered by both the lead trainer and a youth counterpart, if available. The trainers should work together beforehand to decide how best to divide the information, with a preference towards the youth trainer delivering more of the content.*
8. Start the presentation by explaining that rumors and misconceptions about contraception, about how they will be treated at clinics, and how the community perceives their actions, are some of the reasons why adolescents and even adult clients fail to access available services. Service

providers working with adolescents need to be prepared to address the myths, misconceptions, and rumors that clients may express to best counsel them on dual protection.

9. Present **Content: Rumors** (Slides 9.1-9.5) below.

Content: Rumors (Slides 9.1-9.5)

Slide 9.1: Rumors

Rumors are **unconfirmed stories** that are **transferred** from one person to another **by word of mouth**. Increasingly, rumors are spread on social media. Rumors are common among adolescents. 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 incorrect information.
- The original source is seen to be credible.
- Social taboos prevent adolescents from seeking correct information from trusted adults.
- People are motivated to spread them for political or social reasons.

10. Pause and ask participants to think of some common rumors in their community.

11. Return to the presentation with **Slide 9.2: Misconceptions** below.

Slides 9.2-9.3: Misconceptions

A **misconception** is a **mistaken interpretation of ideas or information**. If a misconception is filled with details and becomes a fanciful story, then it acquires the characteristics of a rumor. Rumors can play a big role among adolescents' perceptions and beliefs because they are often cut off from or denied information about sexual and reproductive health and are eager to fill "in the blanks."

Rumors and misinformation can also come from other sources in the community: the media is often a source of misinformation or incomplete information for all members of the community. Parents, faith leaders, teachers, and community leaders may not possess correct information on or understanding of adolescents and sexual and reproductive health and may perpetuate potentially dangerous stereotypes and misconceptions about adolescent sexuality and sexual risk. Rumors or misconceptions may even be spread by health workers who may be misinformed about adolescents and their abilities to use certain methods. They may hold beliefs pertaining to contraception and adolescent sexuality that are influenced by their culture or religion which they allow to affect 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 sense to clients and potential clients, especially to young people.

Slides 9.4-9.5: Methods for Counteracting Rumors and Misconceptions

When a client mentions a rumor, **always listen politely. Don't laugh. Take the rumors seriously.**

Define what a rumor or misconception is. **Normalize** the rumor or misconception through statements like "A lot of people have that belief" or "I can see why you'd think so, but..."

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 contraceptives and sexual risk to counteract misinformation.

Always **tell the truth**. Never try to hide side effects or problems that might occur with various methods. **Never overstate or exaggerate** the level of risk associated with sexual behaviors.

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 offering STI/HIV and/or pregnancy testing or routine sexual and reproductive health exams and discuss the findings.

Counsel the client about all available contraceptive methods.

Use visual aids and actual contraceptives to explain the facts. Remember to provide the accommodations needed by the persons with disabilities in the room to ensure full participation.

12. Conclude your presentation by asking participants to look back at the flip charts from the previous discussion with strategies for counteracting rumors. Ask them to think about which they've used, and if there are any new strategies they'd like to try when they go back to their clinics.

SPECIFIC OBJECTIVE 9.2: DISCUSS SAFER SEX MESSAGES AND TECHNIQUES IN THE PREVENTION OF STIS AND UNINTENDED PREGNANCY, INCLUDING CONTRACEPTIVE OPTIONS AVAILABLE TO ADOLESCENTS



TIME

1 hour 15 minutes



METHODS

- Trainer presentation



MATERIALS NEEDED

- Slides 9.6-9.21
- Participant Handout 9a: BCS+ Algorithm
- Participant Handout 9b: Contraceptive Cue Cards



STEPS

- **Trainer's Note:** *This presentation should be delivered by both the lead trainer and a youth counterpart, if available. The trainers should work together beforehand to decide how best to divide the information, with a preference towards the youth trainer delivering more of the content. The participation of youth trainers with different types of disabilities is essential to ensure the perspectives of clients with disabilities are included in the training. Accommodation should be provided according to the needs to ensure full participation of young trainers with disabilities.*

Time: 45 minutes

1. Start by reminding participants that addressing adolescent clients' misconceptions is only the beginning of the service relationship. Explain that this session will contain a lot of information, and in the next session the group will practice putting both their strategies for addressing misconceptions and the information and methods contained in this session into practice.
2. Begin the presentation **Content: Adolescent SRH Landscape** (Slides 9.6-9.21) below.

Slide 9.6-9.8: Global Statistics

Adolescents seek services for multiple reasons: maybe they are concerned about HIV infection, or preventing unintended pregnancy. Maybe they're experiencing symptoms that could be an STI or a similar infection. Some adolescents will come for ante-natal visits or because they are already pregnant or have given birth. Some will come for post-abortion care or because they have an infection from an unsafe abortion. According to WHO:

- About one half of all people infected with HIV are under the age of 25.
- About half of all new HIV infections occur among young people aged 15-24.
- 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 15-19 years old.

- Anywhere from 40-70% of women have become pregnant or mothers by the end of their teens in many African countries.
- In many Latin American countries, 35% of women hospitalized for septic abortion are under age 20.
- In some countries, maternal deaths are 2-3 times greater in women 15-19 years old than in women 20-24 years old.
- Condom use among young people is greater than among older people.
- Similar SRH global data disaggregated by age and disability are not yet available. On HIV, the data available from sub-Saharan Africa suggests an increased risk of HIV infection of 1.48 times in men with disabilities and 2.21 times in women with disabilities compared with men without disabilities. It is possible to assume that adolescents with disabilities are exposed to the same or even a higher increased risk.

These statistics show that young people are vulnerable when it comes to their sexual and reproductive health. Every interaction with an adolescent client is an opportunity for service integration, in particular when it comes to protection against infection and unintended pregnancy. Because young women already seek care because of pregnancy and abortion care, we may have the opportunity to educate, prevent and treat STIs in this setting. Young men may be more likely to come for STI/HIV testing and should be counseled on contraception and sexual health.

3. Pause and ask participants to reflect on the following terms. Go around the group in a circle and ask them to share the first thing that pops into their head when you say each of the terms. Encourage participants to freely say the first thing that pops into their heads and not worry about “right” or “wrong” answers:
 - Unprotected sex
 - Risk behavior
 - Safe sex
 - Protected sex
4. Ask the group if they noticed any trends in the answers. Were there positive responses associated with safe sex? Protected sex? What about unprotected sex? Were there negative responses associated with safe or protective sex? If so, ask why participants think the responses were so varied. If responses weren’t varied, ask why not. Is there a dominant cultural norm associated with these terms?
5. Return to the presentation.

Slides 9.9-9.11

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. Sexual protection is anything that can be done to lower the risk of sexually transmitted infections,

including HIV, and pregnancy. Sexual protection reduces risks and can be practiced without reducing pleasure.

Many programs and governments promote abstinence until marriage as the only sexual protection option appropriate for adolescents, referring to abstinence as 100% effective. This is a false statement. Total abstinence from sexual activity will of course protect anyone from STIs and unintended pregnancy, but just like any other method of protection, abstinence has a failure rate. The failure rate for abstinence is higher for typical use than other contraceptive methods. For example, some programs narrowly define abstinence as abstaining from penetrative vaginal sex, which leaves adolescents with the mistaken impression that oral or anal sex, because they cannot result in a pregnancy, are “safe.” For an unacceptably high number of adolescent girls, sexual activity is forced or coerced, and public promotion of abstinence as the only method that is morally appropriate for young people can create feelings of shame and stigma. Abstinence is also an impractical standard to hold adolescents to; it can be encouraged for those who feel they are not yet ready for sexual activity but should not be held up as the **only** option for protection against STIs, HIV, and unintended pregnancy.

The promotion of abstinence until marriage also discriminates against and excludes adolescents from sexual minority groups who may not legally be allowed to marry the partner of their choosing. Other programs promote "Safer Sex," which describes a range of ways that sexually active people can protect themselves from most STIs, including HIV. Practicing safer sex also provides protection from pregnancy. Counseling adolescents on safer sex and sexual protection focuses on first helping young people to assess the relative risk of various sexual practices.

Slide 9.12: No Risk

There are many ways to explore your sexuality that are **not risky**. Some of them include hugging, holding hands, massaging, rubbing against each other with clothes on, sharing fantasies, masturbating your partner or masturbating together, as long as men do not ejaculate near any opening or broken skin on their partners.

Slide 9.13: Low Risk

There are other activities that are **mostly safe** such as using a latex or polyurethane condom or other barrier for **every** penetrative act of sexual intercourse (penis, fingers, or other objects in vagina, anus, or mouth), and using a barrier (such as a latex dental dam, a cut-open condom or plastic wrap) for oral sex on a woman or for any mouth to anus contact. Most kissing is also safe, provided neither partner has any cuts or sores on, in, or around their mouths.

Slide 9.14: Medium Risk

There are activities that carry some additional 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.

Slide 9.15: High Risk

There are activities that are **very risky**, because they lead to exposure to the body fluids in which most STIs, including HIV, live. These include having any kind of sexual intercourse without using a condom or having oral sex without a latex barrier. Sex which is coerced or non-consensual and forceful may also carry additional risk due to likelihood of small cuts or tears resulting from violence.

Slide 9.16: Dual Protection

Dual protection is the consistent use of a male or female condom alone or in combination with a second contraceptive method (e.g. hormonal or permanent). Adolescents who seek contraception may only be provided with a method that protects them 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.

Time: 30 minutes

6. Pause for questions. While taking questions, distribute **Participant Handout 9a: BCS+ Algorithm**.
7. Introduce the handout. Explain that this session will cover the basics of the Balanced Counseling Strategy +, which is a counseling method developed by the Population Council and their partners, and one that Pathfinder recommends for service providers.



There are more tools available on Population Council's website:
<http://www.popcouncil.org/research/the-balanced-counseling-strategy-plus-a-toolkit-for-family-planning-service>

8. Present **Slide 9.17: The BCS+ Approach**

Slide 9.17: The BCS+ Approach

The BCS+ approach is divided into 4 stages:

- **Pre-Choice Stage** The service provider establishes a relationship with the client and learns about their current and desired family size, timing, and contraceptive choices.
- **Method Choice Stage** The provider counsels the client on available methods and empowers them to choose their preferred contraceptive option.
- **Post-Choice Stage** The provider reviews the client's method of choice in detail, discusses side effects, and helps the client set a follow-up plan for continued contraceptive use.
- **Systematic Screening for Other Services Stage** The provider reviews the client's risk for STIs, including HIV, discusses dual protection strategies, and addresses other reproductive health concerns.

It is important to remember that adolescents particularly benefit from dual protection information and strategies. Allow adequate opportunity for them to ask questions and provide quality, non-judgmental information.

9. Pause for questions and to give participants time to review the handout. While discussing any questions, distribute Adolescent Contraceptive Cue Cards to participants.
10. State: Pathfinder believes that sexually active adolescents should have access to the full range of contraceptive methods, including LARCs. The World Health Organization Medical Eligibility for Contraceptive Use supports this belief, stating that age and parity are not contraindications for any method. In fact, users of short-acting methods, particularly adolescents aged 15 to 19, are more prone to contraceptive failure than users of LARCs.
11. Say: These Contraceptive Cue Cards describe the various forms of contraception that are commonly available and should be discussed with adolescents. However, we know that not all of these methods may be available in your clinics or community, and in some cases there may be legal or policy restrictions on which methods adolescents may obtain.

12. Present Slide 9.18: Contraceptive Methods.

Slide 9.18: Contraceptive Methods

Contraceptive methods are generally classified into one of three categories:

- Short-acting
- Long-acting reversible contraceptives (LARCS)
- Permanent methods

Both short-acting and LARCs are appropriate for adolescent use. There is a growing international medical and advocacy consensus that adolescents should be able to obtain and use LARCs, given their effectiveness at preventing unwanted or unintended pregnancy.

13. Say: the BCS+ method requires you to be aware of which methods are available **and** which methods are best for adolescents based on their current and future pregnancy desires. Counseling and discussion will reveal which contraceptive methods are likely to be best suited for individual adolescent clients, but you should be aware of the following general recommendations:
 - All adolescents need to be counseled on the importance of using dual protection against STIs, HIV, and unintended pregnancy. Condoms can prevent pregnancy, STIs and HIV, or adolescents can choose to use a contraceptive method for effective prevention of pregnancy and a barrier method (condoms).
 - LARCS are a medically acceptable and recommended strategy for adolescents, which can be used to both delay and space pregnancy.

- All adolescents regardless of gender should be counseled on their risks and responsibilities for their sexual and reproductive health, including prevention strategies for STIs and unintended pregnancy.

14. Return to the presentation with **Slide 9.19: Side Effects and Their Effect on Clients.**

Slidess 9.19-9.21: Side Effects and Their Effect on Clients

Research has shown that the leading reason women, and especially young women, don't use or discontinue use of a contraceptive method is due to misinformation about or mismanagement of side effects. Providers must fully inform their clients about potential side effects of their chosen method, how best to manage side effects and when to follow up with the provider for support in managing side effects or to switch methods.

It is important to emphasize that **most side effects from modern family planning methods pose no health risk to clients.** However, providers should take them seriously because they can be uncomfortable, annoying, or worrisome to adolescent clients.

For example: A young woman who is using DMPA may experience spotting or amenorrhea. This side effect may lead her to believe that she is pregnant or, conversely that that she will not be able to become pregnant.

Some young women tolerate side effects better than others. Every woman's experience (pain, discomfort, weight gain, etc) is very individual.

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). Changes in menstrual patterns may bother some young women, while others may see it as a benefit.

Side effects are the major reason that clients stop using a method. Providers must:

- ✓ Not be dismissive of the adolescent clients concerns.
- ✓ Be patient and empathetic with all client complaints.
- ✓ Offer clients an opportunity to discuss their concerns.
- ✓ Reassure that side effects usually resolve in a few months.
- ✓ Differentiate side effects from complications.
- ✓ Offer clients good technical and practical information, and advice about how to deal with side effects.
- ✓ Provide information/handouts for the client on side effects in local languages.
- ✓ Recommend follow-up.

- 15.** Ask participants to list some of the side effects that clients have expressed concern about. In small groups, have participants discuss and compare the side effects for the methods of contraception available in their clinics, using the Contraceptive Cue Cards. Ask if there are any side effects they are unfamiliar with, or methods they would like to review in further detail. Take time to discuss any concerns or questions.

- 16.** Conclude the presentation by informing participants that the next session will be focused on practicing using the information learned so far.

Algorithm for Using the Balanced Counseling Strategy Plus

THIRD EDITION, 2015



PRE-CHOICE STAGE

- 1 Establish and maintain a warm, cordial relationship.
- 2 Inform client (and partner, if present) that there will be opportunities to address both health needs and family planning needs during this consultation.
- 3 Ask client about current family size and current contraceptive practices. Counsel client on Healthy Timing and Spacing of Pregnancy using counseling card.
 - a) If client is currently using a family planning method or delaying pregnancy, ask about her/his satisfaction with it and interest in continuing or changing the method.
 - b) If partner is present, use the male services and support card.
- 4 Rule out pregnancy using the Checklist to Make Reasonably Sure a Woman is not Pregnant card to be reasonably sure the woman is not pregnant.
- 5 Display all of the method cards. Ask client if she/he wants a particular method.
- 6 Ask all of the following questions. Set aside method cards based on the client's responses.
 - a) Do you wish to have children in the future?
If "Yes," set aside vasectomy and tubal ligation cards. Explain Why.
If "No," keep all cards and continue.
 - b) Have you given birth in the last 48 hours?
If "Yes," set aside combined oral contraceptives (the Pill) and combined injectables. Explain why.
If "No," continue with the next question.
 - c) Are you breastfeeding an infant less than 6 months old?
If "Yes," set aside the combined oral contraceptives (the Pill) and combined injectable cards. Explain why.
If "No," or she has begun her monthly bleeding again, set aside the lactational amenorrhea (LAM) card. Explain why.
 - d) Does your partner support you in family planning?
If "Yes," continue with the next question
If "No," set aside the following cards: female condom, male condom, Standard Days Method®, Two Days Method®, and withdrawal. Explain why.
 - e) Do you have any medical conditions? Are you taking any medications?
If "Yes," ask further about which conditions or medications. Refer to WHO Medical Eligibility Criteria Wheel or current national guidelines and set aside all contraindicated method cards. Explain why.
If "No," keep all the cards and continue.
 - f) Are there any methods that you do not want to use or have not tolerated in the past?
If "Yes," set aside the cards the client does not want.
If "No," keep the rest of the cards.



METHOD CHOICE STAGE

- 7 Briefly review the methods that have not been set aside and indicate their effectiveness.
 - a) Arrange the remaining cards in order of effectiveness (see back of each card).
 - b) In order of effectiveness (highly effective to not effective), briefly review the attributes on each method card.
- 8 Ask the client to choose the method that is most convenient for her/him.
 - a) If client is adolescent use the counseling card to inform her that she can get any method
- 9 Using the method-specific brochure, check whether the client has any condition for which the method is not advised.
 - a) Review "Method not advised if you..." section in the brochure
 - b) If the method is not advisable, ask the client to select another method from the cards that remain. Repeat the process from **Step 8**.



POST-CHOICE STAGE

- 10 Discuss the method chosen with the client, using the method-specific brochure as a counseling tool. Determine the client's comprehension and reinforce key information.
- 11 Make sure the client has made a definite decision. Give her/him the method chosen, a referral, and a back-up method depending on the method selected.
- 12 Encourage the client to involve partner(s) in decisions about/practice of contraception through discussion or a visit to the clinic.



SYSTEMATIC SCREENING FOR OTHER SERVICES STAGE

- 13 Using information collected previously, determine client's need for postpartum, newborn, infant care, well-child services or post abortion care.
 - a) If client reported giving birth recently, review the Promoting Healthy Postpartum Period and Promoting Newborn and Infant Health card with client. Provide or refer for services, if needed.
 - b) For clients with children less than 5 years of age, ask if children have been taken to well-child services. Provide or refer for immunizations and growth monitoring services, if needed.
 - c) If client reported a recent abortion, review the Post Abortion Care card with the client. Provide or refer post abortion care services, if needed.
- 14 Ask client when she had her last screening for cervical cancer (VIA/VILI or pap smear) or breast cancer.
 - a) If her last Cervical Cancer screening was more than 3 years ago (*6-12 months if she is HIV positive) or she doesn't know, ask if she would like to have a screening today. Review the Screening for Cervical Cancer card. Provide or refer for services.
 - b) If her last Cervical Cancer screening was less than 3 years ago continue with next question.
 - c) Review Breast Cancer Information and Awareness counseling card with client.
- 15 Discuss STI/HIV Transmission & Prevention and dual protection with client using counseling cards. Offer condoms and instructions on correct and consistent use.
- 16 Conduct STI and HIV risk assessment using the counseling card. If symptoms are identified, treat her/him syndromically.
- 17 Ask client whether s/he knows her/his HIV status.
 - a) If client knows s/he is living with HIV,
 - Review Positive Health, Dignity, & Prevention counseling card with client.
 - Refer client to center for wellness care and treatment.
 - b) If client knows s/he is HIV negative,
 - Discuss a time frame for repeat testing.
 - c) If client does not know her/his status,
 - Discuss HIV Counseling and Testing (HCT) with client, using counseling card.
 - Offer or initiate testing with client, according to national protocols.
 - Counsel client on test results. If client is living with HIV, review Positive Health, Dignity, & Prevention counseling card and refer client to center for wellness care and treatment.
 - d) Counsel client using Women's Support & Safety Card.
 - If client shows any major Intimate Partner Violence (IPV) triggers, refer her for specialized services.
- 18 Give follow-up instructions, a condom brochure, and the brochure for the method chosen. Set a date for next visit.
- 19 Thank her/him for the visit. Complete the counseling session.



HANDOUT 9B: CONTRACEPTIVE CUE CARDS

The contraceptive cue cards were updated in 2020 to include DMPA-SC and to ensure they appropriate reflect most up-to-date global guidance. They can also be downloaded at <https://www.pathfinder.org/publications/cue-cards-for-counseling-adolescents-on-contraception/>

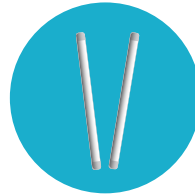
Cue Cards for Counseling Adolescents on Contraception

About the Cue Cards

This set of contraceptive counseling cue cards was developed to support a range of providers (such as facility-based providers, community health workers, pharmacists, outreach workers, counselors, and peer providers) in counseling young people on their contraceptive options. The cue cards provide information that is particularly relevant to adolescents (10–19 years), but can also be used with young people over age 19. The cards can be adapted to meet local circumstances and contexts.

One side of the card serves to remind the provider of important information about the contraceptive method, such as the effectiveness, advantages, and disadvantages. The provider should use this information to guide a dialogue with an adolescent client about the full range of available methods and support the adolescent client in choosing a method that is right for her/him. After the client chooses a method, the provider can turn to the other side of the card to give the client specific instructions on her/his method of choice. This side of the card includes information that the provider should tell the adolescent client about how to use the method, possible side effects, and reasons to return to the provider.

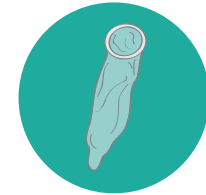
The cue cards cover the following methods:



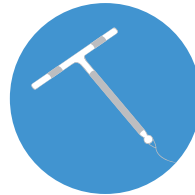
Implants



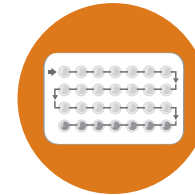
Lactational Amenorrhea Method (LAM)



Male Condom



**Intrauterine Device (IUD)
both hormonal and TCU**



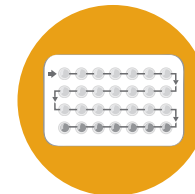
Combined Oral Contraceptives (COCs)



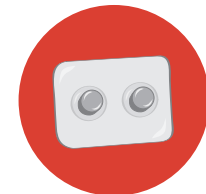
Female Condom



**DMPA (injectables)
both DMPA-IM and DMPA-SC**



Progestin-Only Pills (POPs)



Emergency Contraceptive Pills (ECPs)

Cue Cards for Counseling Adolescents on Contraception

Counseling Tips

- **It is important to remember that adolescents—regardless of age, relationship, marital, or childbearing status—are eligible for the full range of contraceptive methods.** The World Health Organization’s (WHO) Medical Eligibility Criteria states that age alone is not a contraindication for any contraceptive method included in this set of cue cards, including long-acting methods. Providers have an obligation to provide adolescents with evidence-based and unbiased information about a full range of methods that might meet their needs. However, the provider should verify that the adolescent does not have any other condition that precludes use of a particular method per the WHO’s Medical Eligibility Criteria.
- **The cue cards can be used in any order based on the stated preferences and medical eligibility of the client.** They are arranged in order of method effectiveness (from most effective to least effective) to encourage you to include method effectiveness as a key component of client counseling and to reinforce the fact that long-acting methods are an appropriate option for adolescents.
- **Adolescent clients should have full information on a method, including potential side effects.** This can help minimize an adolescent’s concern if she/he does experience a side effect. However, adolescent clients also have more misinformation than adults about contraception and, as a result, often have greater fears about side effects. **Therefore, when counseling adolescent clients on possible side effects, be sure to start by mentioning that most adolescent clients do not experience any side effects.**
- **Make sure to emphasize that *only* male and female condoms offer protection from sexually transmitted infections (STIs), HIV, and pregnancy.** Therefore, if the client chooses a contraceptive method other than condoms, a condom must also be used to prevent pregnancy and STIs/HIV (often referred to as dual method use, double protection or dual protection).

As you counsel adolescents remember to:

- ✓ Ensure privacy and confidentiality
- ✓ Be respectful of the client’s choices, culture, religion, and sexuality
- ✓ Listen actively and show interest
- ✓ Be attentive to the client’s questions and specific needs
- ✓ Use clear language the client can understand
- ✓ Avoid one-way communication and ask open-ended questions
- ✓ Avoid judgmental attitudes and behaviors—don’t lecture, scold, or tell the adolescent what he/she should do
- ✓ Provide unbiased, evidence-based information using the cue cards to ensure the adolescent has a choice of methods

Implants

What are they?

Implants are small flexible rods that contain the hormone progestin. The capsules are placed under the skin of a woman's upper arm and can prevent pregnancy for 3–5 years, depending on the type. There are several types of implants:

- **Jadelle:** 2 rods, effective for 5 years
- **Implanon:** 1 rod, effective for 3 years
- **Sinoplant:** 2 rods, effective for 5 years

How effective are they?

Implants are 99% effective which means if 100 women use an implant, typically less than 1 becomes pregnant during the first year. Over the 3–5 years (depending on type), up to 1 pregnancy occurs per 100 women using an implant.

How do implants work?

Implants work by thickening cervical mucus, blocking sperm from meeting an egg, and by preventing the release of the egg from the ovary.

Not recommended for clients who:

- Have unexplained vaginal bleeding (requires examination)

Check medical eligibility criteria if adolescent has other serious health problems.



Advantages

- Safe and effective
- Long lasting (3–5 years) and no daily action required
- Monthly bleeding becomes very light and often disappears after a year
- Can become pregnant again immediately after removing the implants
- Can be used while breastfeeding
- Doesn't interfere with sex
- May improve anemia
- Can be used discreetly

Disadvantages

- Menstrual pattern will probably change
- Doesn't protect against STIs/HIV
- Requires a health provider to insert and remove
- May be the most expensive option

Implants



Show the implants, let the client touch them and explain the following:

How to use implants

- The small rods or capsules are inserted under the skin of the client's upper arm.
- If implant is inserted within 7 days of the start of monthly bleeding, there is no need for a back-up method.
- If implant is inserted more than 7 days after the start of monthly bleeding (or more than 5 days for Implanon), the client will need a back-up method for the first 7 days. Once inserted, an implant may be effective for 3-5 years. However, it can be removed at any time. If not removed sooner, the implant will need to be removed after 3–5 years depending on implant type and client's weight.
- If a woman is heavier than 80 kg, advise her that Jadelle will become less effective after 4 years of use.

Possible side effects may include:

- Changes in monthly bleeding: irregular spotting or prolonged light to moderate bleeding in the beginning. Later, bleeding is likely to be lighter, less frequent, or stop altogether.
- Weight gain, breast tenderness, headaches, dizziness, nausea, mood changes.

Reasons to return to the provider

- If the client wants to remove the implant.
- Pus, heat, redness, or pain at the insertion site that worsens or does not go away (could indicate an infection at the site)
- Migraine headaches with blurred vision
- Implant seems to be coming out
- In the event of significant weight gain, as this may reduce the long-term effectiveness of the implant
- Any time there is a problem or if either partner has been exposed to an STI
- A resupply of condoms is needed (never run out before returning)



Implants do not protect against STIs/HIV:
To protect against pregnancy and STIs/HIV,
use a condom every time you have sex.

Have the client repeat this information back to you.

Intrauterine Device (IUD) (information for the TCU 380A and Levonorgestrel 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?

IUDs are 99% effective which means if 100 women use an IUD for 1 year, typically less than 1 woman becomes pregnant.

How does the IUD work?

The IUD works by preventing sperm from joining with the egg. There are four ways: 1) IUD thickens the cervical mucus; 2) Changes the endometrial lining; 3) Interferes with the movement of the egg from the ovaries before the egg arrive in the uterine cavity and 4) Interferes with the ability of sperm to pass through the uterine cavity.

Not recommended for clients who:

- Are 48 hours to 4 weeks postpartum
- Have postpartum sepsis or post-septic abortion
- Have unexplained vaginal bleeding (must do an examination before initiating method)
- Have active pelvic inflammatory disease, chlamydia, or gonorrhea (initiation only, continuation of method is acceptable)
- Have multiple sexual partners or whose partner has other sexual partners (at increased risk of STIs)
- Have AIDS and are not clinically well (initiation of IUD only)

Check medical eligibility criteria if adolescent has other serious health problems.

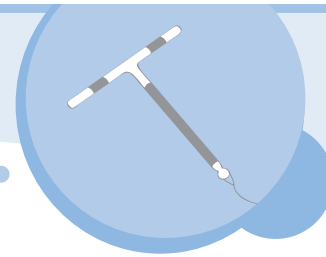
Advantages

- Safe, effective, and long-acting (up to 12- years (for TCU 380A) and 5 years (for Levonorgestrel IUD))
- Easy to remove (by the provider) if the client wants to become pregnant
- Rapid return to fertility
- No daily action required
- Doesn't interfere with sex
- Can be used discreetly—no visible clues that it is used (occasionally a partner may feel the strings during sex)
- Can be inserted immediately postpartum
- Doesn't interfere with breastfeeding
- Can be used by young women, including those who have never been pregnant
- The copper IUD can also be used as emergency contraception to prevent pregnancy if inserted within 5 days of unprotected sex.
- It is inexpensive, less than \$1 USD in most places.

Disadvantages

- Slight pain during the first few days after IUD insertion
- Heavier and/or longer periods, which normally decrease during the first and second years
- Doesn't protect against STIs/HIV
- Requires a health care provider to insert and remove

Intrauterine Device (IUD) (information for the TCU 380A and Levonorgestrel IUD)



Show and let the client touch the IUD and explain the following:

How to use the IUD

- The IUD is inserted by the provider once and can stay for up to 5 years (Levonorgestrel IUD) and 12 years (TCu 380A IUD). No additional follow-up is required after insertion (unless there is a problem).
- The client should come for a check-up 3–6 weeks after insertion, but no additional follow-up is required (unless there is a problem).
- Checking the strings is optional. The strings may be checked during the first few months and after monthly bleeding to see if the IUD is still in place. *Explain how to check strings.*

Possible side effects may include:

- Heavier, longer, and/or irregular bleeding (usually decreases after first 3–6 months)
- More cramps and pain during monthly bleeding
- Increased vaginal discharge
- Pelvic inflammatory disease (PID) may occur if the woman has chlamydia or gonorrhea at the time of IUD insertion
- Possible infection
- Pain and cramping during insertion and the first few days after IUD insertion

Reasons to return to provider

- Abnormal bleeding or discharge
- Pain (abdominal or pain with intercourse)
- Fever
- Strings are missing or you feel the hard plastic of an IUD that has partially come out.
- Any time there is a problem or if either partner has been exposed to an STI
- Any time a re-supply of condoms is needed (never run out completely before returning)

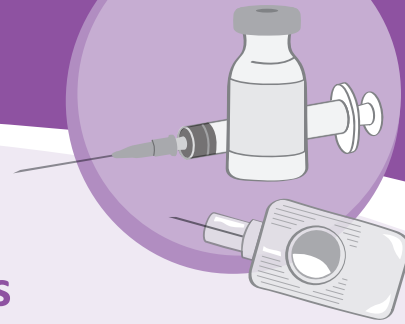


The IUD does not protect against STIs/HIV:
To protect against pregnancy and STIs/HIV,
use a condom every time you have sex.

Have the client repeat this information back to you.

DMPA: Injectable Contraceptives

Depot Medroxyprogesterone Acetate
(DMPA-IM and DMPA-SC).



What is it?

There are different types of injectable contraceptive. This card refers to DMPA-IM and DMPA-SC not NET-EN or monthly combined injectables. DMPA, sometimes known as “the shot” or “Depo,” is an injection containing the hormone progestin. The injection is given every 3 months.

How effective is it?

DMPA is 97% effective which means if 100 women use DMPA for 1 year, typically 3 become pregnant.

How does DMPA work?

DMPA works by preventing the release of the egg from the ovary. Without an egg, a woman cannot become pregnant.

Not recommended for clients who:

- Have unexplained vaginal bleeding (before evaluation)

Check medical eligibility criteria if adolescent has other serious health problems.

Advantages

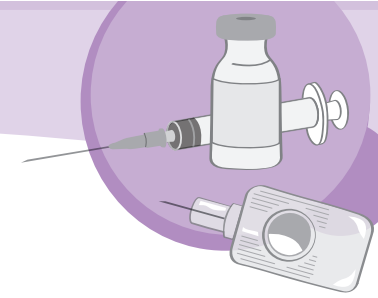
- Safe and effective
- Can be administered by non-physician trained health care workers
- Lasts for 3 months, no daily action required
- Discreet
- Monthly bleedings become very light and often disappear after a year of use
- Completely reversible—can become pregnant again after stopping DMPA, but there might be a delay of several months
- Can be used while breastfeeding
- Doesn't interfere with sex
- May improve anemia

Disadvantages

- Monthly bleeding pattern will probably change
- Increased appetite may cause weight gain
- On average, a 4-month longer delay in ability to get pregnant after stopping DMPA compared to other methods
- Doesn't protect against STIs/HIV

DMPA: Injectable Contraceptives

Depot Medroxyprogesterone Acetate
(DMPA-IM and DMPA-SC).



Show and have the client touch the vial of DMPA and explain the following:

How to use DMPA

- DMPA is given by injection every 3 months.
- Never be more than 4 weeks late for a repeat injection.
- DMPA is now available in a special formulation, called DMPA-SC, that is meant only for subcutaneous injection (just under the skin) and not for injection into muscle. This product may be particularly useful for community-based programs. Also, women can easily learn to give themselves subcutaneous injections with this system.
- Effective immediately if starting within 7 days after the start of monthly bleeding
- If starting more than 7 days after the first day of monthly bleeding, a back-up method (e.g., condoms) is needed for the first 7 days.

Missed injection – What to do?

- Come immediately to get an injection and use a back-up method immediately until 7 days after the injection.
- If you can't come at the appointed time, but you can come earlier, it is possible to come up to 4 weeks early for your next injection.

Possible side effects may include:

- Irregular spotting
- Prolonged light to moderate bleeding
- Bleeding is likely to become lighter, less frequent, or stop altogether.
- Possible weight gain, headaches, dizziness, mood changes

Reasons to return to provider

- Heavy vaginal bleeding
- Excessive weight gain
- Extreme headaches with blurred vision
- Any time there is a problem or if either partner has been exposed to an STI
- Another 3-month injection or a resupply of condoms is needed (never run out completely before returning)



DMPA does not protect against STIs/HIV:
To protect against pregnancy and STIs/HIV,
use a condom every time you have sex.

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 contraceptive method. (“Lactational” means related to breastfeeding and “amenorrhea” means not having menstrual bleeding.)

How effective is it?

LAM is 98% effective which means if 100 women use LAM correctly in the first 6 months after childbirth, typically 2 become pregnant. Women who choose to use this method are protected against pregnancy as long as they exclusively breastfed their babies in the first 6 months.

How does LAM work?

LAM works by preventing ovulation because breastfeeding changes the rate of release of natural hormones.

Advantages

- Effective in preventing pregnancy for at least 6 months
- Encourages the best breastfeeding patterns with health benefits for the mother and baby
- Can be used immediately after childbirth
- Doesn’t interfere with sex
- No direct cost for contraception or for feeding the baby
- No supplies or procedures needed to prevent pregnancy

Disadvantages

- Reduced effectiveness after 6 months
- Requires frequent breastfeeding (day and night), which may be difficult for some mothers
- Does not provide protection against STIs, including HIV
- If the mother has HIV there is a chance that breast milk will pass HIV to the baby. It is recommended for mothers to exclusively breastfeed to reduce this risk.

Lactational Amenorrhea Method (LAM)



Explain the following to the client:

LAM *can* be used if all the conditions below are met:

- Monthly bleeding has not returned.
- The baby is not receiving other food besides breast milk and does not go for long periods (more than 4–6 hours) without breastfeeding, either during the day or night.
- The baby is less than 6 months old.

Note: A complementary form of contraception can also be used at any point.

LAM *cannot* be used if any of the following conditions exist:

- Baby is 6 months of age or older
- Monthly bleeding begins
- Baby is receiving supplemental foods

! LAM does not protect against STIs/HIV:
To protect against pregnancy and STIs/HIV,
use a condom every time you have sex.

How to make breastfeeding effective?

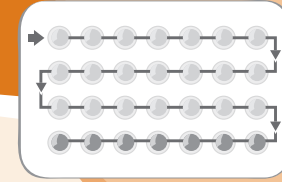
- Breastfeed whenever the baby wants to be fed, day and night.
- Feed from both breasts.
- Avoid intervals of more than 4 hours between any daytime feeds and more than 6 hours between any nighttime feeds.
- Breastfeed for 6 months.
- Don't use pacifiers, nipples, or bottles.
- Express breast milk if separated from the baby.
- Don't give the baby water or teas.

Reasons to return to provider

- No longer fully breastfeeding and need another contraceptive method
- Any time there is a problem or if either partner has been exposed to an STI
- A resupply of condoms is needed (never run out completely before returning)

Have the client repeat this information back to you.

Combined Oral Contraceptives (COCs)



What are they?

COCs (also known as “the pill”) are tablets containing the hormones estrogen and progestin. A woman takes 1 pill daily to prevent pregnancy.

How effective are they?

COCs are 92% effective, which means if 100 women use COCs correctly for 1 year, typically 8 become pregnant. There is a higher failure rate for adolescents than for all other ages because 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 releasing an egg, a woman cannot become pregnant.

Not recommended for clients who:

- Gave birth less than 4 weeks ago (if not breastfeeding)
- Are breastfeeding a baby less than 6 months old
- Have migraine headaches with aura
- Have viral hepatitis with severe or acute flare-up
- Take Ritonavir-boosted protease inhibitor ARVs (If using any ARV, use COCs with at least 30 ug EE.)
- Take rifampicin or rifabutin for TB (If using rifampicin or rifabutin, use COCs with at least 30 ug EE.)

Check medical eligibility criteria if adolescent has other serious health problems.

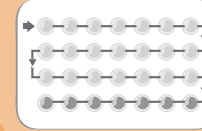
Advantages

- Safe, effective, and easy to use
- Controlled by the woman
- Can be used before the onset of monthly bleeding
- Lighter, regular monthly bleeding with less cramping
- Possible to become pregnant again immediately after stopping COCs
- Don’t interfere with sex
- May be beneficial for adolescents who have irregular or heavy monthly bleeding, severe cramping, or acne
- Decrease risk of cancer of the female reproductive organs

Disadvantages

- Must be taken every day to be effective, which can make it difficult or lead to discontinuation or incorrect use by some adolescents and young women.
- Not always discreet (someone could see the pills)
- Weight gain or unexpected bleeding/spotting in some adolescents
- Don’t protect against STIs including HIV

Combined Oral Contraceptives (COCs)



Show and let the client touch the pill packet and explain the following:

How to use COCs?

- Take first pill on the first day of monthly bleeding or any of the next 4 days.
- If taking the pill more than 5 days after the start of your monthly bleeding, use a back-up method for the first 7 days.
- Take 1 pill every day, at the same time of day. Keep the pills in a place that will help you remember, such as near where you wash at night.
- 28-day packet: After finishing the packet, begin next packet the following day. The last 7 pills do not contain hormones, but they are there to remind you to keep taking the pill.
- 21-day packet: After finishing the packet, wait 7 days and then begin the next packet.

Missed pills – What to do?

- Missed pills may result in pregnancy.
- If you miss pills, ALWAYS take one as soon as you remember and continue to take the rest of the pills each day at the regular time.
- If you miss 3 or more pills, or start a pack more than 3 days late, continue taking the rest of the pills at the regular time *and* use a condom or avoid sex for the next 7 days.
- If you miss 3 or more pills in the third week of the pill packet, skip the inactive pills and start a new packet. Use a condom or avoid sex for the next 7 days.

Possible side effects may include:

- Nausea, weight gain, breast tenderness, headaches, dizziness, mood changes
- Changes in monthly bleeding patterns, including unexpected bleeding or spotting

Reasons to return to provider:

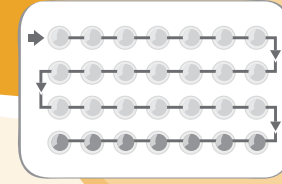
- Severe headaches (including headaches with blurred vision)
- Severe, constant pain in belly, chest, or legs
- Jaundice or yellowing of the skin
- Brief loss of vision, seeing flashing lights or zigzag lines (with or without bad headaches)
- Brief trouble speaking or moving arms or legs
- Any time there is a problem or if either partner has been exposed to an STI
- When a resupply of COCs (always have at least 1 back-up pack) or condoms is needed



COCs do not protect against STIs/HIV:
To protect against pregnancy and STIs/HIV,
use a condom every time you have sex.

Have the client repeat this information back to you.

Progestin-only Pills (POPs)



What are they?

POPs (also known as the “mini-pill”) are oral contraceptive pills containing only a very small amount of one hormone (a progestin). A woman takes 1 tablet daily to prevent pregnancy.

How effective are they?

- POPs are very effective for breastfeeding women. POPs are 99% effective, which means if 100 breastfeeding women use POPs correctly for 1 year, typically 1 becomes pregnant.
- As typically used, they are less effective for non-breastfeeding women. If 100 non-breastfeeding women use POPs for 1 year, typically 3–10 women become pregnant.
- There is a higher failure rate for adolescents since adolescents have trouble remembering to take pills regularly.

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 all menstrual cycles.

Not recommended for adolescents who are:

- Taking ritonavir-boosted protease inhibitor ARVs
- Taking rifampicin or rifabutin therapy for TB

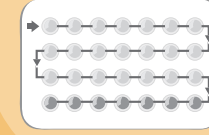
Advantages

- Can be used while breastfeeding
- Good option for adolescents who can't use estrogen but want to use pills
- Can become pregnant again immediately after stopping
- Don't interfere with sex
- No need for health care provider or medical exam

Disadvantages

- For adolescents (not breastfeeding), monthly bleeding patterns may change (including spotting and amenorrhea)
- Must be taken at the same time every day, which can be difficult for adolescents to remember—a delay of 3 hours is similar to missing a pill
- Not always discreet (someone could see the pills)
- Don't protect against STIs/HIV

Progestin-only Pills (POPs)



Show and let the client touch the pill packet and explain the following:

How to use POPs?

- If breastfeeding and monthly bleeding has not returned, can start POPs at any time without a back-up method.
- If monthly bleeding has returned, POPs can be started within the first 5 days after the start of monthly bleeding without a back-up method.
- If it has been more than 6 months since giving birth or if monthly bleeding has returned, but it is not within the first 5 days after the start of monthly bleeding, POPs can be started any time if you are reasonably certain you are not pregnant. But a back-up method, like a condom, should be used for the first 2 days.
- Take 1 pill every day, at the same time of day. When a packet finishes, start another pack the very next day.
- Don't miss a day or take the pill late. You may want to take the pill when you do something that you do every day, like washing your face or brushing your teeth.

Missed pills – What to do?

- Take pill or pills as soon as you remember. You may take 2 pills at the same time or the same day.
- Continue taking the next pill at the usual time.
- Use a back-up method, like a condom, for the next 2 days.

Possible side effects may include:

- Changes in monthly bleeding patterns, including amenorrhea, spotting, irregular or prolonged bleeding (for adolescents who are not breastfeeding)
- Breast tenderness, headaches, dizziness, mood changes, abdominal pain, nausea
- Breastfeeding adolescents may have a longer delay in return of monthly bleeding after childbirth.

Reasons to return to provider

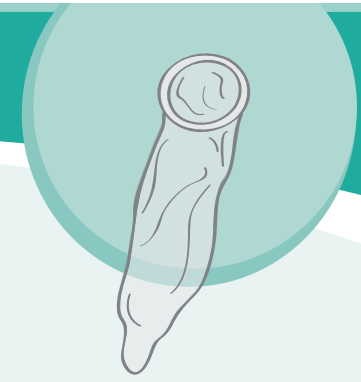
- Stopped breastfeeding and would like to switch methods
- Took a pill more than 3 hours late or missed one completely, and also had sex during this time, and want to consider ECPs (for women who have monthly bleeding)
- Severe headaches with blurred vision
- Any time there is a problem or if either partner has been exposed to an STI
- A resupply of POPs or condoms is needed (always have at least 1 back-up pack)



**POPs do not protect against STIs/HIV:
To protect against pregnancy and STIs/HIV,
use a condom every time you have sex.**

Have the client repeat this information back to you.

Male Condom



What is it?

The male condom is a thin sheath worn over the erect penis and used when a couple is having sex.

How effective is it?

- The condom is 85% effective, which means if 100 couples use condoms for 1 year, typically 15 become pregnant.
- If used correctly with every act of intercourse, condoms are highly effective in protecting against most STIs (except herpes simplex and other genital ulcer diseases), including HIV.

How do condoms work?

The condom catches the man's sperm so that no sperm can enter the vagina.

Not recommended for clients who:

- Have a severe allergy to latex rubber

! **Note: Condoms are always recommended to prevent STIs/HIV.**
If the adolescent feels s/he may not *always* be able to negotiate condom use, it is recommended that s/he also use an additional contraceptive method.

Advantages

- Safe
- Doesn't require a prescription or medical examination
- Effective and easy to use
- Protects against STIs/HIV

Disadvantages

- Interrupts the sex act
- May decrease sexual sensitivity in some men and women
- Requires communication and consent from both partners
- A new condom must be used each time the couple has sex
- A supply of condoms must be available before sex occurs

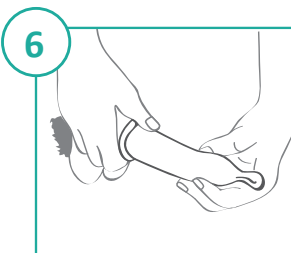
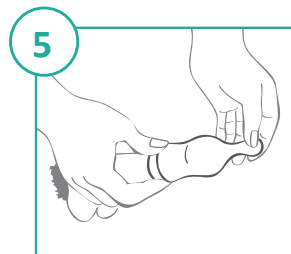
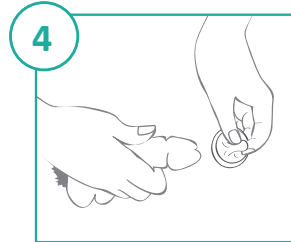
Male Condom



Show and let the client touch the condom and explain the following:

How to use a condom?

1. Check the expiration date on the condom package.
2. Open the package carefully so the condom doesn't tear.
3. Don't unroll the condom before putting it on.
4. Place the unrolled condom on the tip of the hard penis.
5. Hold the tip of the condom with the thumb and forefinger.
6. Unroll the condom until it covers the penis.
7. Leave enough space at the tip of the condom for the semen.
8. After ejaculation, hold the rim of the condom and pull the penis out of the vagina before it becomes soft.
9. Only use one condom at a time.
10. Always keep a supply of condoms readily available.



Care of condoms

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

Possible side effects may include:

- A condom may break or come off during sex.
- A few men and women experience itching, burning, or swelling due to latex allergy.

Reasons to return to provider:

- Any time 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 an STI

Have the client repeat this information back to you.

Female Condom



What is it?

The female condom is a thin lubricated sheath or lining made of a soft plastic film that fits loosely inside a woman's vagina. It has flexible rings at both ends. The ring at one end is closed and covers the cervix. A woman uses the female condom during intercourse to prevent pregnancy.

How effective is it?

- The female condom is about 98% effective, which means if 100 women use the female condom for 1 year, typically 21 become pregnant.
- The female condom also effectively prevents many STIs including HIV when used correctly every time a woman and her partner have sexual intercourse.

How does the female condom work?

The condom catches the man's sperm so that no sperm can enter the vagina.

Note: Condoms are always recommended to prevent STIs/HIV.

If the adolescent feels s/he may not *always* be able to negotiate condom use, it is recommended that s/he also use an additional contraceptive method.

Advantages

- Safe
- Effective
- Can be inserted up to 8 hours before sex
- Can be used with oil-based lubricants
- Can feel more natural during sex than male condoms
- Protects against STIs/HIV
- Reduces the chance of irritation or allergic reaction compared to latex condoms

Disadvantages

- Costs more than the male condom
- May be noisy or awkward
- Is female initiated, but requires cooperation and consent of the male partner
- Can be difficult to insert

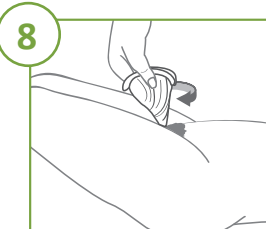
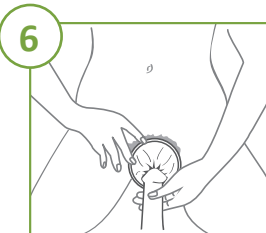
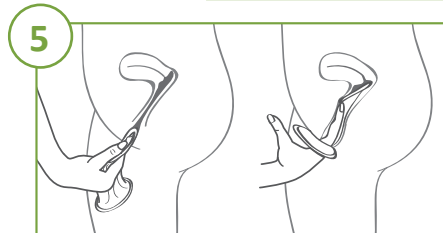
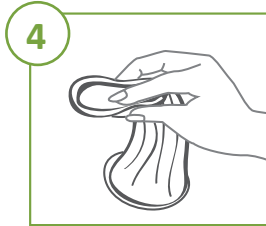
Female Condom



Show the client the female condom and explain the following:

How to use the female condom?

1. Check the expiration date on the condom package.
2. Open the package carefully so the condom doesn't tear.
3. Find the inner ring, which is at the closed end of the condom.
4. Squeeze the inner ring together.
5. Put the inner ring in the vagina and push up into the vagina with the finger. (The outer ring stays outside the vagina.)
6. During sex, guide the penis through the outer ring. (If it is outside the ring, it will not offer protection from pregnancy or STIs/HIV.)
7. Remove condom immediately after sex, before standing up.
8. Squeeze and twist the outer ring to keep the sperm inside the pouch.
9. Pull the pouch out gently.
10. Burn or bury the condom—do not put it down the toilet.



Suggest that the client practice inserting and removing the condom before having sex with it for the first time and try different positions to see which way insertion is easiest.

Care of female condoms

- Store condoms in a cool, dry place. Don't carry them close to the body because heat can destroy them.
- Use each condom only once.
- Don't use a condom if the package is broken or if the condom is dry or sticky or the color has changed.
- Always keep a supply of condoms readily available.

Possible side effects may include:

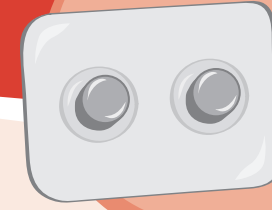
- Usually there are no side effects. Occasionally, a condom may break or slip out during intercourse.
- Very few adolescents may have itching, burning, or redness around the vagina (or partner's penis).

Reasons to return to provider:

- Any time there is a problem (condom breaks or unhappy with method)
- A resupply of condoms is needed (never run out completely)
- Either partner thinks s/he may have been exposed to an STI

Have the client repeat this information back to you.

Emergency Contraceptive Pills (ECPs)



What are they?

ECPs are a hormonal method of contraception that can be used to prevent pregnancy up to 120 hours (5 days) following an act of unprotected sexual intercourse.

How effective are they?

- ECPs are 98-99% effective which means:
- If 100 women use progestin-only ECPs, typically 1 becomes pregnant.
- If 100 women use combined (estrogen and progestin) ECPs, typically 2 become pregnant.
- ECPs are most effective when used shortly after unprotected sex.

How do ECPs work?

- ECPs prevent a pregnancy from occurring. They do not disrupt an implanted pregnancy. ECPs prevent the egg from leaving the ovary and may thicken cervical mucus to prevent the sperm from meeting the egg.
- ECPs only prevent pregnancy from unprotected sex that occurs before the pills are taken. They do not prevent pregnancy from sex that occurs after the ECPs are taken.

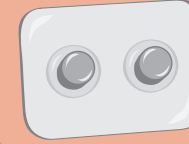
Advantages

- Safe for women of all ages, including adolescents who may be less likely to prepare for a first sexual encounter
- Reduce risk of unintended pregnancy and need for abortion
- 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

- Don't protect against STIs/HIV
- Don't provide ongoing protection against pregnancy
- Must be used within 120 hours after unprotected sex (and should be taken as soon as possible to be most effective)
- May change the time of the woman's next monthly bleeding
- Inappropriate for regular use (high cumulative pregnancy rate)

Emergency Contraceptive Pills (ECPs)



Show and let the client touch the ECPs and explain the following:

How to use ECPs

- For progestin-only ECP (dedicated product): When possible, take 2 pills at the same time within 120 hours of unprotected sex, or take 1 pill within 120 hours and 1 pill 12 hours later.
- For combined oral contraceptives (COCs): 1 dose of 0.1 mg ethinyl estradiol plus 0.5 mg levonorgestrel followed by a second identical dose 12 hours later.
- If vomiting occurs within 2 hours of taking ECPs, take another dose as soon as possible. If vomiting occurs after 2 hours, no additional dose is needed.
- To reduce nausea, take the tablets after eating or use anti-nausea medication.
- Do not to take any extra ECPs unless vomiting occurs. More pills will not decrease risk of pregnancy.

Possible side effects may include:*

- Nausea and vomiting
- Headaches or dizziness
- Cramping/abdominal pain
- Breast tenderness
- Changes in monthly bleeding or slight irregular bleeding for 1–2 days after taking ECPs

* Most do not last for more than 24 hours.

What to expect after using ECPs?

There will not be any immediate signs showing whether the ECPs worked. The next monthly bleeding should come on time (or a few days early or late).

Reasons to return to provider:

- If next monthly bleeding is more than 1 week later than expected
- Any time there is a problem or if either partner has been exposed to an STI

Contraceptive methods after taking ECPs

- Now may be good time to begin a regular contraceptive method. COCs and POPs can be started the day after ECPs are taken.
- DMPA, IUD, and male and female condoms can be started on the same day as the ECP.
- For the implant, you must return after the next monthly bleeding.



**ECPs do not protect against STIs/HIV:
To protect against pregnancy and STIs/HIV,
use a condom every time you have sex.**

Have the client repeat this information back to you.

SPECIFIC OBJECTIVE 9.3: DEMONSTRATE HOW TO COUNSEL ADOLESCENTS, INCLUDING YOUNG MEN, ABOUT CONTRACEPTION AND DUAL PROTECTION TO PREVENT STIs AND UNINTENDED PREGNANCY



TIME

1 hour 30 minutes



METHODS

- Role plays



MATERIALS NEEDED

- Participant Handout 9a: BCS+ Algorithm
- Participant Handout 9b: Contraceptive Cue Cards
- Participant Handout 9c: AYSRH Role Plays



STEPS:

- **Trainer's Note:** *Work with the youth trainer or another trainer. The two trainers should use role play to demonstrate examples of what constitutes "poor" counseling and an "improved" counseling process. It is essential to ensure the participation of youth trainers with different types of disabilities within the training. Accommodation should be provided as needed.*

Time: 10 minutes

1. Set up two chairs at the front of the room. Demonstrate a role play with your youth co-trainer of a "poor" counseling and an "improved" counseling experience for an adolescent client. The demonstration of a poor procedure should come first, followed by analysis and feedback.
2. When performing the *improved* counseling role play, apply the BCS+ method, so that participants can observe an example of how that approach should work.
3. Ask participants to analyze the demonstration and provide feedback on what was positive or negative, what was missing, and whether there was wrong or incomplete information presented.
4. After the trainer demonstration, divide the participants into small groups of 3-5 for simultaneous role plays. Keep the number of groups to a size where the trainer(s) can observe role plays easily by moving around the room. For example, if there is one trainer, divide participants into fewer, larger groups. If there are multiple trainers and youth trainers, divide the participants into groups of three.

Time: 1 hour 20 minutes

5. Ask the participants to perform role plays, using information from **Participant Handout 9c:** AYSRH Counseling Role Plays, **Participant Handout 9a:** the BCS+ Algorithm, and **Participants Handout 9b:** Contraceptive Cue Cards, and local IEC materials if available. Each participant should participate in three role plays and play each of the following roles at least once (more if the trainer feels a participant needs more practice):
 - Client

- Provider
- Observer

➤ **Trainer's Note:** *If an exam or medical procedure would normally be done when providing a contraceptive method, participants should announce to the observers what they would do if they were in the clinic (i.e. now I would take the Blood Pressure).*

6. Each participant is expected to participate actively in the role play process, as both a player and observer, and in group discussions and feedback.
7. Trainers should rotate groups after the first one or two role plays to get as many trainer observations of individual participants' counseling skills as possible.
8. **Observe and assess each participant** for both counseling content, process, and participation in the exercise.
9. Allow *actors/players* about **10 minutes** to prepare, limit each role play to **5 minutes**, and allow about **15 minutes** for feedback and analysis of the process and content.
10. **Encourage and guide the participants in using constructive critique**, analyzing what was good about the way the **counselor** handled the counseling and suggesting what could be improved.
11. Remind participants not to confuse the actual participant with the **actor's** role, and that feedback and critique must not be personalized.
12. The trainer's role during feedback/ discussion should be to stimulate, guide, keep up discussion, and end the exercise when time is up.
13. The trainer may wish to provide general feedback at the end of participant discussion.
14. Summarize the major points observed in the exercise and respond to participant questions with the entire group.

*PARTICIPANT HANDOUT 9C: ADOLESCENT AND YOUTH SEXUAL AND REPRODUCTIVE HEALTH ROLE
PLAYS*

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

Role Play 2: A 16-year-old woman with a three-month-old baby who is breastfeeding wants to postpone her next pregnancy. Her sister uses combined oral contraceptives (pills) and likes that method very much. She says she wants to use pills. How will the clinician respond?

Role Play 3: A 17-year-old young man comes to the clinic because he is concerned about an itchy discharge from his penis. He reveals that he and his girlfriend are regularly having sex but are not using condoms. How will the clinician respond?

Role Play 4: A young couple accompanied by the husband's mother comes to see the clinician. The couple has been married three months. The mother-in-law insists that they should have a child – preferably a son -- as soon as possible. The young woman is still in school and appears to want to postpone pregnancy for at least two years. How will the clinician respond?

Role Play 5: A 19-year-old young man comes for an HIV test. He reveals that he has both a female partner and a male partner, and that he regularly has unprotected sex with each of them. How will the clinician respond?

Role Play 6: A 15-year-old unmarried adolescent girl with a physical disability comes to the clinic. She reveals that she is having sex with a boyfriend and she does not want to become pregnant. How will the clinician respond?

Role Play 7: A 17-year-old young man comes for information. He is being pressured by his friends to have sex with his girlfriend. His girlfriend is also starting to say that he is not a real man because he wants to wait to have sex. He is worried about pregnancy, but he also has strong sexual feelings for her. How will the clinician respond?

Role Play 8: A young couple comes to the clinic because the young man has a discharge and a burning sensation when he urinates. The young woman attends the clinic regularly to obtain injectable contraceptives, but says they are not using condoms because she is already using contraception. The clinician suspects that he may have gonorrhea or chlamydia. How will the clinician respond?

Role Play 9: A 15-year-old woman with Down Syndrome comes to the clinic looking for information on contraception as she is planning to have sex with her boyfriend. How will the clinician respond?

UNIT 9 SUMMARY



TIME

20 minutes



METHODS

Feedback discussion



MATERIALS NEEDED

None



STEPS

1. Ask participants to reflect on everything they've discussed as part of this unit. In plenary, ask youth co-trainers to provide feedback to participants using the following questions:
 - Did this session and training accurately reflect the experiences of young people in seeking health services? Are there key differences that providers should be aware of? Anything specific related to the need of clients with disabilities?
 - What would you like to see change as a result of this training?

UNIT 10:

Safe Abortion and Post-Abortion Care for Adolescents

INTRODUCTION:

Adolescents face many barriers to obtaining sexual and reproductive health services. When it comes to safe abortion and post-abortion care, they must also deal with larger social taboos and concerns. Service providers may feel unclear about which services they can provide, when they can provide, and to whom they can provide services. Service providers may be caught between the client's need for services and law(s) that determine how they can provide services. This is particularly true in the case of women and girls with disabilities, whose sexual and reproductive autonomy is often denied and their ability to decide if and when to have and raise children is questioned. Where abortion is illegal or access is restricted, women may seek unsafe abortions which jeopardizes their health and even their lives. Although many countries restrict or limit the provision of safe abortion services, women in nearly all countries can legally obtain comprehensive post-abortion care (cPAC).

El Salvador's repressive abortion legislation

El Salvador's penal code mandates a 12-year sentence for women convicted of having an abortion. Women seeking post-abortion care for a spontaneous or induced abortion are also at serious risk of criminal prosecution. A woman can be prosecuted for aggravated homicide in the case of an abortion, miscarriage, or stillborn fetus if the fetus is deemed viable by courts. In one case a woman received a 40-year prison term for miscarrying at 18 weeks.

UNIT TRAINING OBJECTIVE:

To clarify values and attitudes related to safe abortion and post-abortion care for adolescent women.

To establish appropriate clinical and counseling approaches.




SPECIFIC LEARNING OBJECTIVES:

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

15. Identify their values related to adolescent sexuality, pregnancy, safe abortion, and cPAC.
16. Explain the importance of safe abortion and cPAC for adolescents.
17. Demonstrate appropriate medical and counseling approaches for adolescents who may seek safe abortion and cPAC services.

TOTAL TIME: 5 HOURS 10 MINUTES

UNIT OVERVIEW:

Session	Methods 	Materials 	Time 
10.1	Values clarification	Flipcharts and markers “A lot,” “a little,” and “not at all” signs Tape	1 hour 45 minutes
10.2	Trainer presentation Case studies Group discussion	Participant Handout 10a Prepared flipchart Slides 10.1-10.8 Flipcharts and markers	1 hour 20 minutes
10.3	Trainer presentation Role plays	Participant Handout 10b Slides 10.9-10.12 Prepared flipcharts	1 hour 35 minutes
Unit Summary	Small group work	Participant Handout 10c	30 minutes



WORK FOR TRAINERS TO PREPARE IN ADVANCE:

- Review national or local laws and policies related to safe abortion, comprehensive post-abortion services, and parental consent and notification laws. Find out if these or other laws and policies specifically refer to women and girls with disabilities and become familiar with their content. Revise content of activities as necessary.
- Review *The Nairobi Principles on Abortion, Prenatal Testing, and Disability* to understand the position of selected women’s rights organizations—including those led by women with disabilities—on abortion and disability and prepare for discussion with participants on the subject.
- Review Pathfinder’s **Abortion Policy Scan for Advocacy**, available at: <https://www.pathfinder.org/publications/abortion-policy-scan-for-advocacy/>
- Review slides 10.1-10.12
- Review and prepare Participant Handouts 10a-c.
- SO 10.1: Prepare three signs saying “A little,” “A lot,” and “Not at all” for the comfort continuum activity and sheets of paper with questions for reasons why activity.
- SO 10.2: Prepare flipchart page with case study discussion questions.

- SO 10.3: Prepare flipcharts on procedural considerations, strategies for pain management, and post-procedure considerations.
- Unit Summary: Review and prepare Participant Handout 10c Service Readiness Assessment Checklist. Work with adolescent and young women from your community in the review if possible.



MAJOR REFERENCES AND TRAINING MATERIALS:

Ipas. 2011. *Abortion Attitude Transformation: Values clarification activities adapted for young women*. Chapel Hill, NC: Ipas.

IPPF. 2014. *Youth and Abortion: Key Strategies and Promising Practices for Increasing Young Women's Access to Abortion Services*. London: IPPF.

Pathfinder International. 2008. *Assessment of Youth-Friendly Postabortion Care Services: A Global Tool for Assessing Postabortion Care for Youth*. Watertown, MA: Pathfinder International.

Pathfinder International. 2014 *Abortion Policy Scan for Advocacy*. Watertown, MA: Pathfinder International.

Postabortion Care Consortium (PAC). 2012. *Youth-Friendly Postabortion Care Supplemental Training Module: Trainer's Manual*. Washington, DC: PAC.

Postabortion Care Consortium (PAC) Youth-Friendly Working Group. 2006. *Technical Guidance on Youth-friendly PAC*. Washington, DC: Pathfinder International.

The Nairobi Principles on Abortion, Prenatal Testing and Disability. 2018. CREA.
<https://nairobiprinciples.creaworld.org/>

Turner, K. L., E. Borjesson, A. Huber, and C. Mulligan. 2011. *Abortion Care for Young Women: A Training Toolkit*. Chapel Hill, NC: Ipas.

USAID: Extending Service Delivery (ESD). 2008. *Youth-Friendly Postabortion Care Cue Cards*. Washington, DC: Pathfinder International.

More resources available at <http://pac-consortium.org/resources/youth/>.

SPECIFIC OBJECTIVE 10.1: REFLECT ON VALUES RELATED TO ADOLESCENT SEXUALITY, PREGNANCY, SAFE ABORTION AND PAC



TIME

1 hour 45 minutes



METHODS

- Values clarification activities
- Group discussion



MATERIALS NEEDED

- Signs: “A little,” “A lot,” and “Not at all.”
- Flipcharts and markers



STEPS

1. Set up the room by placing three signs in a row that establishes a continuum from “Not at all” to “A lot.”

Time: 1 hour

2. Introduce the activity by telling participants that this activity is intended to help providers assess their comfort in providing safe abortion and comprehensive post-abortion care services to young women. Remind participants of the ground rules regarding confidentiality and respect for each other’s opinions and feelings.
3. Tell participants that when you read a statement, they should move to the sign that best reflects their feelings. Encourage participants to be honest about their own feelings and to try to not pay attention to other participants.
4. Read the first statement from **Content: Comfort Continuum Statements** below. Have participants move to a place on the continuum. Ask for a few volunteers to explain their position. If, based on someone else’s explanation, participants want to move to a different place on the continuum, encourage them to do so.
5. Continue through the rest of the statements, discussing participant’s placement after each one.

Content: Comfort Continuum Statements

- How comfortable are you with the idea of providing safe and legal induced abortion services in your country?
- How comfortable are you in discussing abortion with colleagues at work?
- How comfortable are you in discussing abortion outside of a work setting?
- How comfortable are you in discussing comprehensive post-abortion care for unsafe or illegal abortions with your colleagues?
- How knowledgeable are you about your country’s laws and policies on abortion services?

- What do you know about the legality of access to comprehensive post-abortion care in your country, regardless of the legal status of abortion?
 - How comfortable are you working in a place where women are treated for complications from unsafe abortions?
 - How comfortable are you or would you be in working in a facility where abortions are performed?
 - How much disapproval would you expect from your family and/or friends if you provided (or assisted with) comprehensive post-abortion care or abortion services?
 - How comfortable would you be treating a woman who was suffering from complications from an unsafe abortion?
 - How comfortable are you or would you be in performing (or assisting with) an abortion in the first trimester?
 - How comfortable are you or would you be in performing (or assisting with) an abortion in the second trimester?
 - How comfortable are you with the idea of every woman having the right to access safe abortion and comprehensive post-abortion care services?
 - How comfortable are you with the idea of every adolescent women having the right to access safe abortion and comprehensive post-abortion care services?
 - How comfortable are you or would you be in providing (or assisting with) abortion for every woman that obtains one, regardless of her reasons?
6. Once you have read through and discussed each of the statements, have participants return to their seats. Have two participants share their feelings about the activity.
7. Facilitate a conversation with the whole group about the different responses and levels of comfort in the room using the discussion prompts below. Refer to the reasons participants gave when taking their place on the continuum.
- What do you observe about your responses to the statements? Other people's responses?
 - Were there times when you wanted to be with the majority of the group? Did you move? Why or why not? How did that feel?
 - Did any of your responses surprise you? How about other people's responses?
 - What did you learn about your own and others' comfort levels with abortion?
 - What observations do you have about the group's overall comfort level with abortion?
8. Ask the participants to reflect on the experiences that have influenced their comfort and discomfort around abortion or comprehensive post-abortion care. Invite them to imagine how a different set of life circumstances might have led to a different perception of abortion. Is disability an element that brings additional comfort or discomfort? If yes, is this related to the disability of the mother or of the child? Ask a few participants to share their reflections.
9. Discuss how these different levels of comfort with abortion affect social attitudes and norms on abortion, how women may feel about themselves if they have an abortion, and how providers might feel about providing abortions or comprehensive post abortion care.
10. Ask participants to reflect on how their comfort or discomfort with abortion and/or adolescents affects their ability to provide quality abortion care. How does provider comfort or discomfort with abortion affect the services that are provided, such as counseling or clinical care? What

about a provider's level of comfort with treating an adolescent client who is unmarried and sexually active? How does a provider's level of comfort affect their ability to provide care to an adolescent who has sought a second trimester abortion? What if the adolescent client has a disability? Would the level of comfort or discomfort vary according to the type of disability? What does non-judgmental care look like? Emphasize that provider attitudes have a big effect on their ability to provide quality, non-judgmental services, and that provider attitudes also affect women's experiences and satisfaction with those services.

➤ **Trainer's Note:** *If questions arise during the discussion on abortion laws and policies in the country, be prepared to gently correct misinformation or provide correct information once participants have finished the discussion. When it comes to abortion and disability, remember to refer participants to the Nairobi Principles on Abortion, Prenatal Testing, and Disability included in the references list of this unit and use them to guide the discussion.*

11. Leave time for any outstanding questions, concerns, or comments. Thank the group for their participation.

Time: 60 minutes

12. Divide participants into groups of three to five. Give each group a flip chart and markers. Assign each group one or more of the questions from **Content: Reason's Why Statements** below.

Content: Reasons Why Statements

1. What are all the reasons women have sex?
2. What are all the reasons adolescent women have unprotected sex?
3. What are all the reasons women become pregnant?
4. What are all the reasons women have an unintended pregnancy?
5. What are all the reasons women terminate a pregnancy?
6. What are all the reasons women continue an unintended pregnancy?
7. What are all the reasons women may make decisions about their unintended pregnancy that they really don't want to make?
8. What are all the reasons adolescent women feel like they can't make their own decisions about sexual activity, contraceptive use, pregnancy, and abortion?
9. What are all the reasons governments regulate women's sexual activity, contraceptive use, pregnancies, and abortion?

13. Give each group **10 minutes** to brainstorm all of the possible responses to the questions they have been given. Encourage them to think as deeply and broadly as possible about the range of women they see in their clinics including women with disabilities and the difference in their lives and circumstances. Have each group record their responses on flip chart paper highlighting all the relevant points related to women with disabilities that emerged from their answers.

14. Have each group present their responses to the larger group. Once all the groups have presented, ask the group as a whole to add any extra responses to the presentations. Invite participants to take some time to walk around the flip charts and review the responses.

15. Use the following discussion questions to facilitate a group discussion about their comfort levels.

- What are some reasons for having sex that make you feel uncomfortable?
 - Is there anything about persons with disabilities having sex that makes you feel uncomfortable? If yes, what?
 - What are some reasons for unintended pregnancy that make you feel uncomfortable?
 - What reasons for abortion make you feel uncomfortable? Why do these reasons make you uncomfortable?
 - How do your personal values influence your level of discomfort with certain reasons for having sex, using contraception, experiencing unintended pregnancy, and obtaining an abortion?
 - How does your own discomfort with abortion affect your ability to provide non-judgmental services to women who have had an abortion?
 - In what way might your discomfort with adolescents who are unmarried and sexually active and who have obtained an abortion affect your ability to provide quality care?
 - Does disability play a role in deepening your discomfort?
 - How do you feel about women having to make a decision about their unintended pregnancy that they really don't want to make?
 - How do you feel about parents/guardians who want to make decisions about the reproductive lives of adolescent clients for them? What if the client has a disability? An intellectual and developmental disability?
 - What are the reasons that governments may regulate women's pregnancies and abortion? Are these more regulated than other medical conditions and procedures?
 - How does our discomfort on the following affect our ability to provide sexual and reproductive health care to young people, especially quality abortion or post-abortion care?
 - Having non-marital sex
 - Using contraception, especially hormonal methods
 - Experiencing unintended pregnancy
 - Seeking abortion
 - How does our discomfort with the following affect our ability to provide sexual and reproductive health care to young persons with disabilities, especially quality abortion or post-abortion care?
 - Having non-marital sex,
 - Using contraception, especially hormonal methods
 - Experiencing unintended pregnancy
 - Seeking abortion
 - Might clients sense this discomfort? What effect could this have on the quality of health care we provide?
- 16.** Close the activity by discussing how individuals' discomfort with some women's reasons (for having sex, using contraception, getting pregnant or seeking an abortion) can result in services and systems that deny women access to safe, high-quality abortion and comprehensive post-abortion care services. This can lead some women to have to risk their health and lives to obtain an unsafe abortion.
- 17.** Allow time for any final questions, comments, or concerns.

SPECIFIC OBJECTIVE 10.2: EXPLAIN THE IMPORTANCE OF ACCESS TO SAFE ABORTION AND PAC FOR ADOLESCENTS



TIME

1 hour 20 minutes



METHODS

- Trainer presentation
- Case studies
- Group discussion



MATERIALS NEEDED

- Slides 10.1-10.8
- Flipcharts and markers
- Prepared flipchart with Case Study Discussion Questions
- Participant Handout 10a: Safe Abortion Access Case Studies



STEPS

1. Introduce the topic. Remind participants of the discussions about barriers to seeking abortion in Units 3 and 7, and the previous discussion about the values component of safe abortion and comprehensive post-abortion care in this unit.
2. Say: *In this session we are going to discuss the specific challenges that adolescent clients face in seeking safe abortion and post-abortion care services.*

Time: 20 minutes

3. Ask participants to brainstorm some reasons that young people seek unsafe and late abortions. Remind participants to think about reasons specific to vulnerable and marginalized groups of young people, including young persons with disabilities. After some ideas have been shared, begin the presentation with **Content: Adolescent and Youth-Specific Barriers** (Slides 10.1-10.8) below.

Content: Adolescent and Youth-Specific Barriers (Slides 10.1-10.8)

Slides 10.1-10.2: Reasons that Adolescents Seek Unsafe or Late Abortion

- They deny the pregnancy.
- They are unaware they are pregnant.
- They fear the reactions of their parents, in-laws, partners, peers, and/or communities.
- They are unaware of where to seek safe abortion services.
- There are no legal, safe abortion options.
- Their access to abortion services is restricted due to age, marital status, disability or dependent on a parent's or partner's consent.
- They lack financial resources.
- They lack transportation (or cannot afford it) /services are far away.

- They lack accessible transportation (for young persons with disabilities) and services are far away.
- Services are inaccessible or unwelcoming due to physical, attitudinal, or communication barriers (for young persons with disabilities) and accommodation is not provided.
- They are misinformed about safe abortion and seek out “home” or traditional approaches.
- They do not know whom or how to ask for help.

Source: PAC Consortium YFPAC Training Module

Slide 10.3: Summary of Barriers

- Adolescents often seek late and unsafe abortion services. As a result, adolescents may end up with more serious complications (including death) than adults.
- Many adolescents also present late at health facilities when they are pregnant or because of complications of either a spontaneous or unsafe abortion.

Source: PAC Consortium YFPAC Training Module

4. Pause and ask participants to brainstorm some ways to reduce barriers and encourage adolescent clients to seek early care for pregnancy, abortion, and/or comprehensive post abortion care. Remind participants to consider barriers that may be specific to distinct groups of adolescents, including young persons with disabilities. Once participants have responded, return to the presentation with **Slide 10.4: Addressing Barriers** below. Remind participants that these suggestions are not comprehensive, merely some ideas for them to start from.

Slide 10.4: Addressing Social Barriers

- Provide information to community leaders.
- Engage religious leaders.
- Provide education to parents/guardians/caregivers.
- Set up informal or formal social support networks.
- Organize values clarification workshops for health-care providers and staff.

Source: PAC Consortium/IPAS

Slide 10.5 Addressing Economic and Logistical Barriers

- Lower the cost of abortion care or establish sliding cost scales for adolescents.
- Request accessible and affordable public transport routes or establish facility transport service (e.g. with local taxi services).
- Create a community-run transportation network.
- Use a community fund to assist in covering costs for services or transportation.

Slide 10.6 Addressing Legal and Policy Barriers

- Ensure that facilities provide abortion services to the fullest extent of the law to all clients, including women and girls with disabilities.
- Create and/or adopt good clinical standards and guidelines if they do not exist, and

remove language barriers in those that do exist. Ensure that those standards and guidelines are disability-inclusive.

- Understand the parameters of the law and the legal indications of what is permissible for any client who seeks abortion care.
- See Pathfinder International's *Abortion Policy Scan for Advocacy*.

Slides 10.7-10.8: Addressing Health System Barriers

- Provide abortion care for young women in easily accessible locations.
 - Support clinics to keep an extensive schedule/remain open as late as possible.
 - Ensure that misoprostol medical abortions are available locally and provide them.
 - Ensure the entire facility (including the waiting room, the counselling rooms, the examination and procedure rooms, the recovery rooms and the bathrooms) is accessible to persons with disabilities and provides both visual and auditory privacy. Where possible, provide private rooms and separate toilets for abortion clients.
 - Ensure effective communication between the client and the provider by providing accommodations as needed by young persons with different types of disabilities.
 - Ensure confidentiality for all clients, including young people and clients with disabilities.
 - Use data collection forms that are neutral and non-judgmental, disability-sensitive, and do not require clients to complete excessive or unnecessary paperwork. If possible, make data collection forms available in an accessible format (i.e., braille, large print, easy to read etc.). Ensure the reception staff is trained and available to support persons with disabilities to complete data collection forms if necessary.
 - Do not require unnecessary return visits as recommended by international protocols.
 - Frame counseling about sexual and reproductive health using positive, respectful, and disability inclusive language and terms.
 - Interpret legal indications broadly.
 - Avoid any actions that might traumatize the client and ensure that providers assess and address the needs of all clients.
5. Conclude the presentation by asking for questions or clarifications from participants. If there is time, ask participants to share positive experiences of providing safe abortion and comprehensive post-abortion care services to young women, including women with disabilities.

Time: 1 hour

6. Explain to participants that you will be dividing them into small groups to discuss case studies on reducing barriers to safe abortion and comprehensive post-abortion care.
7. Divide participants into six small groups. Provide each group with a flipchart.
8. Distribute **Participant Handout 10a: Safe Abortion Access Case Studies**. Assign each group a different case study. Post the flipchart with the case study discussion questions (below) at the front of the room and review with participants. Ask groups to read their assigned case study, then take **20 minutes** to brainstorm and record answers to the discussion questions.

Content: Case Study Discussion Questions

- a. What are the challenges identified in the case study?
 - b. What possible strategies exist to address the challenge?
 - c. How could you determine which is the best strategy to implement? How would you involve young people in determining the strategy?
 - d. Which do you think is the best strategy?
 - e. What would be the first steps you would take to implement the strategy?
 - f. How would you involve young people in implementing the strategy?
 - g. How do you think health officers and/or facility administrators would react to the proposed strategy?
- 9.** When the groups have completed their discussion, have them report back to the plenary by having a representative first read their case study, and then present the strategy the group created to address the challenge.
- 10.** In plenary, compare how different groups addressed similar issues. Ask participants to identify any common elements that appear in the strategies, and brainstorm any elements that may be lacking, such as strong partnerships with young people, or focus on young persons with disabilities.
- 11.** Facilitate a group discussion using the following questions:
- a. How did it feel to create a strategy that addresses some of the challenges that young women face in obtaining abortion care?
 - b. What, if any, were the challenges your group faced in creating that strategy?
 - c. Do you think you face any of these challenges in your community? How would these strategies help you there?
 - d. What steps might you take when you get to your facility to address these challenges?
- 12.** Close the activity by leaving time for any additional questions or comments. Remind participants that each facility is different, both in their challenges and their approaches to addressing those challenges. Remind them of the resources available to them, both those listed at the start of this unit and those in the community, including young women themselves.



PARTICIPANT HANDOUT 10A: SAFE ABORTION ACCESS CASE STUDIES

Adapted from IPAS/PAC Consortium

Case Study 1: Community Resistance

Parents and religious leaders in the community are not happy that their local community health facility provides abortion services, especially to young women. They feel like the clinic is promoting promiscuity, teaching the girls to hide things from their family, and going against the teachings of the church. In fact, young women are more likely to be admitted to the clinic with complications from unsafe abortion. Very few actually come for safe abortion services.

Case Study 2: Cost and Transportation

A district hospital serves a large rural area and provides safe abortion services. Not many young women come to the hospital for safe abortion services. If they do, they often only have barely enough money to cover the cost of the service. They have very little money for transportation and certainly no money for food or a hotel. They usually come alone and need to return home on the same day they come for the abortion. The trip can take several hours, over bad roads.

Case Study 3: Consent Law

A private clinic provides safe abortions. Recently they began enforcing a new law that requires young women below the age of 17 to seek a parent's consent to the abortion. If the parent is not available, they will need to obtain a judge's consent. In just a few months, the number of young women who request an abortion has reduced by half, but the number of post-abortion care cases has dramatically increased.

Case Study 4: Privacy, Confidentiality, and Informed Consent.

Many young women with disabilities say they prefer not to come to the facility for abortion services, because they are afraid that they will see someone that they know. There is also a persistent rumor that people working in the facility share stories with their families and neighbors about women who come for abortions and that women with disabilities are forcibly sterilized thereafter.

Case Study 5: Provider Attitudes

When a young woman comes to a public health facility in her community, the receptionist loudly asks if the young woman is here for an abortion, asks her age twice, then sucks her teeth and shakes her head. She loudly announces to the doctor that the young woman is there to have an abortion and has come alone. When the young woman meets the doctor, he asks her age and then asks about her husband and wants to know if her husband knows she is getting an abortion. The provider tells her he cannot provide the abortion to her. He does not tell her why.

Case Study 6: Low Service Use Among Young Women

A referral hospital discovers that its abortion patient load is mostly women over the age of 30. Yet other data shows that many young women present with complications of unsafe abortion and there have even been several deaths.

SPECIFIC OBJECTIVE 10.3: DEMONSTRATE APPROPRIATE MEDICAL AND COUNSELING TECHNIQUES FOR ADOLESCENT SAFE ABORTION AND PAC SERVICES

TIME

METHODS

- Trainer presentation
- Role plays



MATERIALS NEEDED

- Participant Handout 10b: YFPAC Cue Cards
- Flipchart: Procedural Considerations
- Flipchart: Strategies for Pain Management
- Flipchart: Post-Procedure Considerations



STEPS

Time: 10 minutes

1. Introduce the content. Tell participants that the group has had a chance to explore some of their values related to safe abortion and post-abortion care and brainstorm strategies for making safe abortion and post-abortion care more accessible to all young women, including young women with disabilities. The next session will review some of the specific counseling and clinical needs of young women seeking these services.
2. Present **Content: Considerations for Counseling Adolescent Clients** (Slides 10.9-10.12) below. Remind participants that the group has previously discussed adolescent-friendly counseling in Units 3, 7, and 8.
3. Say: *Our behavior reflects our attitudes, beliefs, and emotions, even when we're not aware of it. All of the non-judgmental language and counseling techniques we've discussed for general SRH services also need to be applied to young women seeking safe abortion and post-abortion care.*

Content: Considerations for Counseling Adolescent Clients (Slides 10.9-10.12)

Slide 10.9: Before the Facility

When a young woman comes to a facility for treatment of an incomplete abortion, she has already had contact with, and will have contact with, more than just the health provider. These may include:

- Parents/guardians/caregivers
- Traditional Healers
- “Quacks”
- Friends/Peers
- Partners
- Community
- Faith Leaders
- Other clinic staff

She may have gotten conflicting information and had a range of experiences – likely negative -- with any of these people. She may be feeling defensive, frightened, anxious, and/or frustrated.

Slide 10.10: Provider Attitude

It is essential that the provider demonstrate supportive attitudes. This is essential not just for the quality of the clinical care provided, but to allow the young woman to relax, communicate effectively, and relay her fears. Adolescent clients who are afraid or have experienced judgmental attitudes from service providers, service facility staff, or others, will be reluctant to share information, and in particular, may be afraid to talk about what kinds of unsafe abortion strategies they’ve attempted. This can be particularly true for adolescent clients with disabilities who often face additional attitudinal barriers in accessing care.

Counseling during safe abortion and post-abortion care is essential: it is key to positive physical and emotional health outcomes. Ensuring that counseling is available and accessible to all adolescent clients, including young persons with disabilities, is therefore a priority.

Source: Adapted from PAC Consortium YF PAC Training

Slides 10.11-10.12: Safe Abortion and PAC Counseling

Safe abortion and post-abortion care counseling can:

- Provide adequate, clear and accessible information to help the adolescent make an informed decision.
- Help the adolescent evaluate her feelings and opinions.
- Act as an emotional support for the adolescent.
- Help the adolescent anticipate consequences.
- Support the adolescent in making informed and conscious health decisions, including the adoption of contraception to avoid future unintended pregnancy.

Safe abortion and post-abortion care counseling does not:

- Enforce a pre-determined solution to the adolescent’s problems.
- Make decisions for the adolescent.
- Promote a life plan that has been successful in the past or with other clients.
- Express the counselor’s judgment about the adolescent’s behavior.

It is important to keep in mind that all the above mentioned “do and don’ts” apply for all clients accessing safe abortion and post-abortion care counseling without any restriction on the basis of

education level, disability, or financial status.

Source: PAC Consortium YF PAC Training

4. Take time for participant questions at the end of this presentation. While participants are discussing, set up 3 Flip Charts in separate parts of the room. Divide participants into three groups and assign each group to one flip chart.

Time: 45 Minutes

Content: Activity Introduction

Source: PAC Consortium YFPAC Training

Introduce the activity by telling participants that clinical procedures for safe abortion and post-abortion care are the same for both adult and adolescent clients. Methods can include using manual vacuum aspiration, misoprostol and electric vacuum aspiration. Where various methods for safe abortion or post abortion care are available, and when providers are equally skilled in the use of different methods, the least invasive method should be used. Dilation and curettage (D&C) should not be used unless the other methods are not available or it is the only appropriate method for that particular case.

5. Dilation and curettage is also used when other safe methods are not available or as indicated. There are some additional aspects of care that should be considered when treating adolescents, which the group will review in this activity.
6. Tell participants that they will start at the flip chart to which they have been assigned. They should read the content on the flip chart, discuss, and mark what their group thinks are the two most important points. This should take **10 minutes**.
7. After **10 minutes**, the groups should rotate to a new flip chart station and read the content on that flip chart. They should again discuss the content and mark the two most important points which have not been marked by the previous group.
8. After another **10 minutes**, groups should rotate to the last flip chart station and again discuss the content and mark an additional two points.
9. When groups have completed all three flip charts, allow participants **5 minutes** to walk individually around the room and look again at each flip chart to see what other groups have marked as important.
10. In plenary, review the key points each group chose and answer any remaining questions.

Time: 40 minutes

11. Distribute **Participant Handout 10c: YFPAC Cue Cards**. Give participants **5 minutes** to review the cue cards, explaining that they may want to use them during the next activity.

12. Ask participants to form pairs: each pair should take turns playing a provider and client. Explain that you will read a case study out loud, and that the pairs will then have **10 minutes** to practice role playing appropriate counseling and clinical techniques.

13. Read **Content: Role Play 1** below.

(Role plays adapted from PAC Consortium YFPAC Training)

Content: Role Play 1

Lucy is a 16-year-old young woman from a rural village who now works as a house girl in a wealthy family's home in the capital. She doesn't have much free time, but she does see a young man from down the street occasionally. Sometimes he stops and talks to Lucy when she is working outside. Lucy enjoys his company and they have begun spending some time together, going for walks or to the movies. Recently they had sex for the first time. Lucy left school when she was very young and being far from home, she doesn't have anyone to talk to about sex or pregnancy or contraception. She didn't know that you could get pregnant the first time you have sex and was unaware of the signs and symptoms of pregnancy. She began feeling nauseous and tired, and when she had missed her third period she asked her employer if she could go the doctor. Her employer, a woman, was furious with her for "being so stupid" and threatened to kick her out of the house. She talked to her male friend, and he told her how she could end the pregnancy using a cassava stick. Later that night, her employer found Lucy bleeding and brought her in for treatment.

14. After pairs have finished the role play, ask the participant who played Lucy to provide some feedback to the participant who played the provider on how they felt.
15. Tell participants to swap roles for the next role play. Read **Content: Role Play 2** (below) and allow an additional **10 minutes** for the second role play.

Content: Role Play 2

Nisha is a 19-year-old woman with a visual disability who works in a small shop in the provincial capital. She lives with her uncle, who she rarely sees. She sends most of her wages back to her family in a rural village which is a few hours from the city. Nisha started seeing Mathew about six months ago. He has been kind and generous to her, buying her meals and presents and they have started having sex occasionally. They do not use condoms or contraception. When she missed her period, she asked a friend for help, and her friend gave her some pills to take to "bring down her period." When Nisha fell ill, her friend took her to the hospital where she was admitted for treatment.

16. After the role play, ask the participant who played Nisha to give their partner feedback on how they felt during the counseling and "treatment."
17. In the plenary, ask the group to discuss the following questions:
 - a. When you were in the client role, what behaviors did you notice that were not

comforting? What behaviors were comforting?

- b.** When you were in the provider role, what behaviors felt natural? Which did you have to think more about or use the cue cards for?
 - c.** What counseling techniques were most helpful? What types of questions did you ask?
 - d.** Was it difficult to separate the client from her circumstances?
 - e.** How did you make a transition from post-abortion care to talking about contraception or dual protection? Was the transition easy?
- 18.** Allow time for any closing questions or comments. Thank participants for their participation and their willingness to explore this topic.

PARTICIPANT HANDOUT 10B: YFPAC CUE CARDS

Source: Adapted from the Extending Service Delivery Project YFPAC Cue Cards.

<https://www.k4health.org/toolkits/http/youth-friendly-postabortion-care-yfpac-job-aids-english>

Preamble

The Government of Kenya is committed to reducing inequalities in health care and reversing the downward trend in health related impact and outcome indicators by:

- Increasing equitable access to health services
- Improving the quality and responsiveness of services
- Improving the efficiency and effectiveness of service delivery

The Kenya Essential Package for Health integrates all health programmes into a single package that focuses on improving health at different stages of the life cycle.

The KEPH prioritizes threats to adolescent health such as sexually transmitted infections, HIV/AIDS, risk of early pregnancy, drug and substance abuse, which are especially affected as a result of risky behaviours. One in five women admitted to public sector facilities for abortion complications are under the age of 20. Quality, comprehensive postabortion care is a key service as part of the KEPH, and incorporating an enhanced response to the needs of adolescent PAC clients will contribute to efforts to reduce the numbers of unsafe abortions to young women. These job aids will assist providers to provide high quality and comprehensive PAC services to young

1 - BEFORE PROCEDURE (a)

- ❖ Welcome the client and make her comfortable.
- ❖ Ensure privacy and confidentiality.
- ❖ Introduce client to assistant
- ❖ Assess/ triage and manage emergency
- ❖ Take history and include risk assessment for STI/HIV and GBV.
- ❖ Assess client to ensure:
 - Vital signs do not indicate shock
 - Vaginal bleeding is not excessive
 - No abdominal injury is present
 - No signs of STI

1 - BEFORE PROCEDURE (b)

If needed, make arrangements with available trained health provider for the procedure, or refer to a higher level facility.

- ❖ If client desires, involve a support person (e.g., friend, partner, and parent) in all counselling.
- ❖ Remember: Ask/ Observe/ Examine client as appropriate.
- ❖ Confirm that all equipment is sterilized and ready.
- ❖ Explain the procedure to the client and answer any questions she may have.
- ❖ Obtain informed consent for the procedure and for pain management.
- ❖ Ensure the client gets adequate pain medication:
 - IV/IM: 15-30 minutes before procedure
 - By mouth: 30 to 60 minutes before procedure

2 - DURING PROCEDURE

- ❖ Ensure complete privacy.
- ❖ Ask the client to undress and lie on the examination table only when you are ready to begin the procedure.
- ❖ Monitor vital signs and provide verbal support.
- ❖ Monitor the client closely for pain; give pain management counselling and use additional pain medication that is safe for the client, if needed.
- ❖ Reassure the client during the procedure.
- ❖ Follow all infection prevention procedures.
- ❖ Inspect complete uterine evacuation, gritty sensation, well-contracted uterus, frothy red if aspirate.
- ❖ Caution: FP counselling until the procedure is completed.

3 - AFTER PROCEDURE (a)

- ❖ Observe the client for 1 to 2 hours; check vital signs and vaginal bleeding every 30 minutes.
- ❖ Provide pain medication when required.
- ❖ Continue to ensure confidentiality.
- ❖ If the client agrees, include a support person (e.g. friend, partner and/or parent) when giving instructions/ counselling.

3 - AFTER THE PROCEDURE (b)

Advise the client on:

- ❖ Adequate rest
- ❖ Personal hygiene
- ❖ Nothing to be inserted in the vagina
- ❖ No sex until after 72 hours after vagina bleeding has stopped
- ❖ Completion of medication
- ❖ Proper nutrition; eat foods rich in iron and protein.
- ❖ Post abortion family planning

Counsel/refer client, as needed, for:

- ❖ Malaria prevention
- ❖ Tetanus prophylaxis
- ❖ HIV counselling and testing
- ❖ STI evaluation
- ❖ GBV
- ❖ Cervical cancer screening

3 - AFTER PROCEDURE (c)

- ❖ Advise the client to avoid pregnancy until after 3 months.
- ❖ Counsel on the health benefits related to delaying the next pregnancy and birth timing.
- ❖ Counsel and provide FP based on YFS guidelines.
- ❖ Remind her that if she does not use a family planning method, she can get pregnant within 10-14 days after the procedure before she has her next period. Counsel her on abstinence as appropriate and at a minimum, provide condoms.
- ❖ Counsel the youth on issues related to sexual abuse and/or abstinence as appropriate and relevant.

3 - AFTER PROCEDURE (d)

- ❖ If client is unsure of FP choice, reschedule for a visit within a week.
- ❖ Discharge the client after 1 to 2 hours if she is comfortable, stable, and able to walk without assistance.
- ❖ Record all findings in the client record.
- ❖ Complete the PAC register.
- ❖ Encourage client to come for review after two weeks

6 – DANGER SIGNS (a)

Watch for warning signs that indicate the need for medical attention, including:

- ❖ Severe abdominal pain
- ❖ Fever
- ❖ Bleeding heavier than a normal period
- ❖ Foul odour from vagina
- ❖ Bleeding that lasts more than two weeks
- ❖ Vomiting or nausea

6 – DANGER SIGNS (b)

Signs of Shock	Signs of Infection	Signs of Abdominal Injury
<ul style="list-style-type: none"> ❖ Cold clammy skin ❖ Rapid thready pulse > 110 ❖ RR >30 ❖ Low or unrecordable BP ≤ 90/60 <p><i>Consider:</i></p> <ul style="list-style-type: none"> - Ruptured ectopic pregnancy - Uterine perforation <p><i>Management:</i></p> <ul style="list-style-type: none"> - Infuse IV fluids: 1 liter over 20 minutes and a total 1500 ml in 1 hour - Keep warm - Stabilize and refer to higher level of care if necessary 	<ul style="list-style-type: none"> ❖ Fever [Temp ≥ 38°] ❖ Foul smelling vaginal discharge ❖ Lower abdominal pain (tender uterus) ❖ Rebound tenderness ❖ Prolonged bleeding ❖ Purulent cervical/vaginal discharge ❖ Cervical motion tenderness <p><i>Management:</i></p> <ul style="list-style-type: none"> - Begin parenteral antibiotics as soon as possible before uterine evacuation. - Stabilize and refer to higher level of care of necessary. 	<ul style="list-style-type: none"> ❖ Nausea, vomiting, fever ❖ Abdominal or shoulder pain ❖ Prolonged bleeding ❖ Distended abdomen ❖ Absent bowel sounds ❖ Rebound tenderness <p><i>Management:</i></p> <ul style="list-style-type: none"> - Manage accordingly - Stabilize and refer to higher level of care if necessary.

Adapted from WHO, *Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors*, 2003

7 – INFORMED CONTRACEPTIVE CHOICE

Contraceptive Method*	When to Start
<ul style="list-style-type: none"> ❖ Oral Contraceptives (combined or progestin-only) ❖ Injectables ❖ Implants ❖ Condoms (male and female) 	<ul style="list-style-type: none"> ❖ Immediately, even if injury to genital tract or possible/confirmed infection
<ul style="list-style-type: none"> ❖ IUD 	<ul style="list-style-type: none"> ❖ If infection suspected, start once infection has resolved or injury is healed. ❖ Insert immediately upon completion of MVA.
<ul style="list-style-type: none"> ❖ IUD ❖ Combined vaginal ring ❖ Diaphragm 	<ul style="list-style-type: none"> ❖ Once injury to genital tract has healed
<ul style="list-style-type: none"> ❖ Combined vaginal ring ❖ Diaphragm 	<ul style="list-style-type: none"> ❖ In cases of uncomplicated uterine perforation
<ul style="list-style-type: none"> ❖ Natural Family Planning 	<ul style="list-style-type: none"> ❖ Await for menses to resume

Adapted from WHO, *Managing Complications in Pregnancy and Childbirth, A Guide for Midwives and Doctors*, 2003; WHO, *Family Planning, A Global Handbook for Providers*, 2007;

***Note: Per WHO guidelines, adolescents can safely use any type of contraceptive method.**

Flipchart 1: Procedural Considerations

- Treatment options are the same for adolescents and adult clients. However, adolescents often wait longer to seek services, which may result in more severe complications.
- Only ask the client to undress once you have completed the history, answered her questions, and are ready for the procedure. There is no need for the client to undress completely (only from the waist down). Provide client with a cover sheet.
- A smaller speculum should be used during the exam and procedure.
- Perform exam gently and slowly and explain what to expect before any action.
- Make sure that adolescents with disabilities have a full understanding of the exam and procedure, and that accommodation is provided according to needs throughout the procedure. Provide complete and direct information on treatment options:
 - MVA and misoprostol are highly effective, have fewer complications and are preferred to D&C. D&C is recommended when no other safe options are available.
 - Adolescents may prefer misoprostol because it is simple, avoids surgery, and has a shorter recovery time. Adolescents should be informed that misoprostol use may result in a longer period of bleeding and spotting, which may compromise their concerns over privacy and confidentiality. Further, the necessary follow-up visit after the administration of misoprostol may be difficult for some adolescents.

Flipchart 2: Strategies for Pain Management

- Understand all options to prevent and treat, including different medication options and dosing limits.
- Ensure the client receives adequate treatment for pain.
- Talk with the adolescent client throughout the procedure.
- Explain each step of the procedure before it is performed.
- Ensure that adolescents with disabilities have access to this information. Provide any accommodations as needed and ensure information is available in accessible formats.
- During the procedure, move slowly, without jerky or quick motions.
- Show the client how to minimize pain by taking slow deep breaths breathing in through the nose and out through the mouth. This type of breathing will help her relax.
- Tell the adolescent client she can and should ask for additional pain medication if the pain becomes too strong.
- Reassure her that she can ask you to pause briefly at any point in the procedure.
- Avoid giving wrong impressions (for example, saying “this won’t hurt” when it will hurt, or “I’m almost done” when you are not).
- Allow the client to have a supportive friend, partner, or relative at her side if she wishes.

Flipchart 3: Post-Procedure Considerations

- An adolescent may not be able to remain at the clinic as long as an adult woman can. She may not have permission from her family or husband to leave her home or community and she may be missed after a certain period of time.

- Provide counseling about contraceptive options and provide the method post procedure if possible.
- Make sure that the information provided is accessible and understandable for adolescents with disabilities, and always ensure that clients select their preferred contraceptive option out of free will.
- If she is unwilling to accept a method immediately post procedure, remind her that pregnancy can occur again within 10-14 days. Encourage her to return to the clinic any time to obtain a method. At a minimum provide condoms.
- Screen for potential sexual abuse, violence, or coercion and refer to appropriate psycho-social services.
- Consider that the safe abortion or post-abortion care visit may be the first visit to a health facility and provide an opportunity to assess, address, and/or refer for other sexual and reproductive health needs, such as:
 - HIV counseling and testing.
 - STI assessment and treatment.
 - Dual protection strategies.
 - HPV vaccination (where available).
 - Other issues, such as nutrition, anemia, etc.

UNIT 10 SUMMARY



TIME

30 minutes



METHODS

Small group work



MATERIALS NEEDED

Participant Handout 10d: Service Readiness Assessment Checklist



STEPS

1. Ask participants to reflect on everything they've discussed as part of this unit. Distribute **Participant Handout 10c: Service Readiness Assessment Checklist** to participants. Give them **5 minutes** to quickly review the checklist individually.
2. Ask participants to spend some time, either individually, or grouped according to their clinics, assessing their own clinics. Ask them to bring back their results for Unit 15: Providing Adolescent Services.

PARTICIPANT HANDOUT 10D: SERVICE READINESS ASSESSMENT CHECKLIST

Source: Adapted from Turner et al, Abortion care for young women: A training toolkit, 2011

This tool outlines sample questions to assess service facility readiness to provide abortion and post-abortion care services to adolescent and young women. Trainers should review this tool and select or adapt questions as appropriate for their local legal and policy context. If possible, trainers should engage adolescent and young women with and without disabilities in the review of this tool prior to use to ensure that their actual needs and desires for high-quality abortion and post-abortion care services are met.

This tool **should not** be adapted to avoid difficult conversations about cultural values on abortion and post-abortion services.

A. Does the facility offer rights-based care for adolescents and young people, including young persons with disabilities?

- Does the facility have written policies or protocols that affirm young people's rights to sexual and reproductive health information and services, privacy, and confidentiality?
- Has facility staff been trained on assessing adolescents' evolving capacity and supporting independent decision-making? Does the facility have guidelines that support independent decision-making by adolescent clients? Do facility staff adhere to these guidelines?
- Does the facility have a visible and clear statement on the rights of clients, including adolescents?
- Are the above-mentioned policies, protocols, guidelines and statements inclusive of persons with disabilities and consistently applied with them?

B. Does the facility offer opportunities for adolescents and young people to participate in ensuring youth friendly quality of care?

- Are young people, and specifically young women, involved in service delivery in any way other than as clients? How?
- Did young people, and specifically young women, participate or partner in the design of abortion and post-abortion care services? How?
- Do young women participate or partner in the evaluation of service delivery for abortion or post-abortion care services? How?
- Does a partnership with young people or youth groups exist?
- Are adolescents with disabilities an active stakeholder in shaping more inclusive and accessible services that meet their needs? If yes, how? Do they participate in the processes of improving service quality and/or accountability?

C. Is the facility making safe abortion and post-abortion care services available to young women?

Note: Not all questions may be applicable to your facility. Work with young women in your community to choose questions based on their needs.

- Is the facility open at hours outside of typical school and work hours?
- Is there a separate entrance for young women?
- Is the facility accessible for persons with different types of disabilities?
- Do key areas of the facility provide both visual and auditory privacy for young women?
 - Reception and waiting room? Are these accessible to persons with disabilities?
 - Counseling room? Is this accessible to persons with disabilities?
 - Examination and procedure room? Are these accessible to persons with disabilities?
 - Recovery room and bathrooms/toilet facilities? Are these accessible to persons with disabilities?
- Can young women be seen without an appointment?
- Does scheduling/provider workload allow for longer than usual counseling times when needed?
- Are medical records secure and never left easily visible to other clients or staff not directly involved in the client's care?

D. Clinic policies and guidelines

- Do clinical standards and protocols for safe abortion care for young women exist? If so, have they been distributed to, known by and adhered to by providers?
- Do clinical standards and protocols for post-abortion care for young women exist? If so, are they widely disseminated?
- Do facility policies or protocols require additional reporting on, or apply restrictions to, safe abortion or post-abortion care for young women not present in the law? How?
- Are facility policies or protocols disability inclusive?

E. Community outreach and education

- Does the facility conduct, support, or coordinate community outreach and education on young women's sexual and reproductive health and rights and the need to reduce unsafe abortion, including access to safe abortion services and post-abortion care? Are these accessible to young women with disabilities?
- Does the facility have any client handouts or materials about safe abortion and post-abortion care that are accessible to all young women including those with disabilities? Were young women involved in designing or producing these materials?

F. Payment and financial support

- Do payment options (sliding scale, free, other) exist for young women without means to pay full costs?
- Is the clinic connected to any support mechanisms (local women's groups, abortion funds, women with disabilities lead organizations, other) to help young women get financial support for abortion and post-abortion care services or other financial needs such as transportation or housing?

G. Staff preparedness

- Have all staff received training on or orientation to the legal and policy status of safe abortion and post-abortion care services in the country?
- Have all staff members attended a workshop that includes values clarification activities on

providing safe abortion and post-abortion care to all young women including young women with disabilities?

- Can young women be seen by a service provider of their preferred or requested sex? Can young women request a change in service provider for any reason?
- Are there peer educators/counselors present who can help young women or accompany them through the services if needed?

H. Referrals and other health services

- Are referrals made for any services not provided at the facility? Are those referrals made as part of institutional referral agreements? Are there any established mechanisms to ensure client follow-up?
- Are the referral mechanisms and options accessible for adolescent with disabilities?
- Are other health care services provided as part of the same visit if needed?
- How easy is it to navigate among the different health services during the same visit?
- Are safe abortion and post-abortion care services fully integrated with screening and response for sexual and gender-based violence?
- Are clients seen for safe abortion and post-abortion care services routinely offered access to contraceptive counseling and services?

I. Is the facility offering safe abortion and post-abortion care services that are clinically appropriate to young women?

- Are providers trained to counsel young women on sexuality, sexual and reproductive health, and safe abortion and post-abortion care?
- Are providers trained in the clinical specifics of youth friendly safe abortion and post-abortion care?
- Are providers trained to address stigma and self-stigma associated with seeking safe abortion and post-abortion care?
- Are providers prepared to alleviate young women's pain, and to identify higher levels of anxiety and lower tolerance for pain among young women?
- Are providers trained to offer the same quality standard of safe abortion and post-abortion services to adolescents with disabilities?

J. Is the facility recording age and disability-disaggregated safe abortion and post-abortion care statistics?

Note: In places with legal or customary restrictions on access to abortion, facilities may decide not to do this if not required by law.

- Does a logbook/register exist for safe abortion and post-abortion care services, which includes client age and disability?
- Is the facility recording, and disaggregating by age and disability, data for:
 - Number of clients asking for safe abortion in the past year.
 - Number of clients receiving safe abortion care in the past year.

- Number of clients seeking post-abortion care in the past year.
- Number of clients receiving post-abortion care in the past year.
- Number of clients seen for complications from unsafe abortion in the past year.
- Types of complications seen.
- Unsafe abortion-related morbidity and mortality.
- Percentage of clients asking for post-abortion contraception in the past year (by method if possible).
- Percentage of clients receiving post-abortion contraception in the past year (by method if possible).
- Percentage of clients receiving other services (by service).

UNIT 11: STI/HIV AND ADOLESCENTS

INTRODUCTION:

The WHO estimates that over 1 million sexually transmitted infections (STIs) are acquired every day, and that one-third of those infections occur in young people aged 15-24. Over 2 million adolescents (aged 10-19) worldwide are living with HIV, and 26 new infections occur among adolescents every hour. UNAIDS (2016) reports adolescent girls and young women aged 15–24 years as being at particularly high risk of HIV infection, accounting for 20% of new HIV infections among adults globally in 2015, despite accounting for just 11% of the adult population. In regions with higher HIV prevalence, the gender imbalance is even more pronounced: in sub-Saharan Africa, adolescent girls and young women account for 25% of all new HIV infections among adults, and women account for 56% of new HIV infections among adults. Similar HIV global data disaggregated by age and disability are not yet available. UNAIDS, however, highlights that persistent discrimination against and exclusion of persons with disabilities, in particular women and girls with disabilities, increases their vulnerability, including their risk of HIV infection. This is confirmed by the data available on sub-Saharan Africa that highlights an increased risk of HIV infection of 1.48 times in men with disabilities and 2.21 times in women with disabilities compared with men without disabilities. A recent study on Cameroon published by the Lancet, confirms that the higher prevalence of HIV infection in persons with disabilities reflects a higher exposure to HIV infection as well as the presence of disability-associated HIV infection. The susceptibility of people with disabilities to HIV infection seems to be shaped by social and environmental factors. Further research is needed to inform firm recommendations on how to protect this vulnerable population.

An article published in the 2016 Journal of Adolescent Health reported that young people may avoid seeking services for STI symptoms for multiple reasons, ranging from lack of information about STIs and confusion about what services for STIs entail to inability to afford the cost of services or transportation. In some instances, however, easily accessible and free STI testing and treatment services may encourage adolescents and youth, especially boys and young men, to seek SRH services.

In any event, providers working with adolescents and young people **must** promote dual protection approaches, ensuring adolescents and young people understand the importance of taking steps to prevent both unintended pregnancy and STI/HIV infection, and to manage existing infections. Linkages to antiretrovirals (ARVs), the clinical cascade and community-based support is essential, and sexual and reproductive health services must also be available for young people living with HIV to prevent STI co-infection, HIV reinfection and/or unintended pregnancy.

UNIT TRAINING OBJECTIVE:

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

 **SPECIFIC LEARNING OBJECTIVES:**

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

1. Understand the environment in which adolescents obtain information about sexuality, sexual and reproductive health.
2. Identify successful prevention strategies to prevent HIV and other STI transmission in adolescents.
3. Summarize appropriate clinical management of STIs.

TOTAL TIME: 2 HOURS 40 MINUTES

UNIT OVERVIEW:

Session	Methods	Materials	Time
11.1	Bingo game Trainer presentation	Participant Handout 11a Slides 11.1-11.3 <i>Optional: Local media articles</i>	1 hour
11.2	Group brainstorm	STI labels Colored candies or slips of paper Post-it notes Participant Handout 11b	30 minutes
11.3	Trainer presentation Group discussion	Slides 11.4-11.11	50 minutes
Unit Summary	Gallery walk	Post-it notes Flipchart	20 minutes



WORK FOR TRAINERS TO PREPARE IN ADVANCE

- Review Slides 11.1-11.11
- SO 11.1: Prepare bingo cards (double sided or two each) for participants. *Trainer's Note: If there is*

time, trainers should look for local media articles about adolescent sexuality, STIs, and HIV for the Media Bingo Game.

- SO 11.2: Prepare slips of paper, STI labels, and participant handouts for the group work.
- SO 11.2: Research national and local laws and policy on age of consent or parental consent/notification for adolescents to obtain sexual and reproductive health services, including HIV and other STI testing.
- Review the content of the UNAIDS publication *Disability and HIV* included in the references list and strengthen the understanding of the link between HIV and disability.



MAJOR REFERENCES AND TRAINING MATERIALS:

All in to #EndAdolescentAIDS Campaign: <http://allintoendadolescentaids.org/>

Colton, Tayla, Virginia Allread, Elaine Abrams, Anne Schoeneborn, Beatriz Thorne, and Ruby Fayorsey. 2012. *Adolescent HIV Care and Treatment: A Training Curriculum for Health Workers*. New York: Columbia University Mailman School of Public Health.

De Beaudrap P. et al. 2017. Prevalence of HIV infection among people with disabilities: A population-based observational study in Yaoundé, Cameroon (HandiVIH). *Lancet HIV*. April 4(4): e161-e168.

P. De Beaudrap. 2019. VIH & Handicap en Afrique de l'Ouest: Une analyse combinée de 4 études conduites au Burkina Faso, Niger, Guinée Bissau et Cap Vert. Lyon: Humanity & Inclusion.

Newton-Levinson, Anna, Jaime S. Leichter, and Venkatraman Chandra-Mouli. 2016. "Sexually Transmitted Infection Services for Adolescents and Youth in Low- and Middle-Income Countries: Perceived and Experienced Barriers to Accessing Care." *Journal of Adolescent Health* 59 (2016) 7-16.

United Nations Joint Programme on HIV/AIDS (UNAIDS). 2016. *Global AIDS Update: 2016*. Geneva: UNAIDS.

United Nations Joint Programme on HIV/AIDS (UNAIDS). 2017. *Disability and HIV*. Geneva: UNAIDS. https://www.unaids.org/sites/default/files/media_asset/JC2905_disability-and-HIV_en.pdf

World Health Organization. 2015a. *Guideline on When to Start Antiretroviral Therapy and on Pre-Exposure Prophylaxis for HIV*. Geneva: WHO.

World Health Organization. 2015b. *Sexually Transmitted Infection Fact Sheet*. <http://www.who.int/mediacentre/factsheets/fs110/en/>

World Health Organization. 2005. *Sexually Transmitted Infections among Adolescents: The need for adequate health services*. Geneva: WHO.

SPECIFIC OBJECTIVE 11.1: UNDERSTAND THE ENVIRONMENT IN WHICH ADOLESCENTS OBTAIN INFORMATION ABOUT SEXUALITY AND SEXUAL HEALTH



TIME

1 hour



METHODS

- Bingo game
- Trainer presentation



MATERIALS NEEDED

- Local Newspaper/Magazine Articles about STIs including HIV or Trainer's Tool: Sample Articles
- Participant Handout 11a: Myths, Misconceptions, and Media Bingo Card
- Slides 11.1-11.3



STEPS

Time: 30 minutes

1. Distribute **Participant Handout 11a: Myths, Misconceptions, and Media Bingo Card** (below) to participants. Tell participants to choose a side to start with and let them know that they will use both sides and it doesn't matter in what order.
2. Introduce the activity. Explain that the trainer will read aloud from sample media articles about adolescent sexuality and sexual health. Participants should cross out squares when they hear examples in the article and yell out "BINGO" when they have a full line crossed out, either vertically, diagonally, or horizontally.
3. Allow time for participants to look over the Bingo card and ask questions about how the terms are defined. Terms on the Bingo card include:
 - *Condom Dismissal*: Statements implying or directly stating that condoms are not protective or protective enough.
 - *Gender Stereotypes*: General statements about the difference between men and women, or about "all men" or "all women," or statements about traits based on gender.
 - *Male Urges*: Specific statements about men's sexual drive or urges.
 - *Marriage Bias*: Language promoting marriage as a precondition for sexual activity or about the importance of (heterosexual) marriage to society or about the social dangers of "gay marriage."
 - *Medical Inaccuracies*: Factually incorrect or misleading statements about science or medicine.
 - *Myths*: Commonly held but false information about gender, disability, sexuality, STIs, and HIV seen as factual.
 - *"Normal Sex"*: Language implying that there is a correct or "normal" way to have sex, or that certain types of sexual activity and/or orientations are abnormal or incorrect.
 - *Overly Scientific Language*: Use of complicated scientific words or phrases to describe sexual health issues.
 - *"Purity"*: Language or statements promoting chastity or purity, in particular for women and girls.
 - *Sex Shaming*: Judgmental or stigmatizing language about sexual activities, sexual orientations, or

- particular sexual acts, or implying negative associations with people who are sexually active.
- *Stigma (STIs/HIV)*: Judgmental language or statements associating STI or HIV infection with “bad” or “wrong” behavior or personality characteristics.

4. Read **Content: Article 1** below (or from a local media article). When a participant yells “BINGO,” have them come to the front of the room and explain to the rest of the group which boxes they’ve checked off to make a line and why. Ask if other participants disagree or have other examples from their sheets.

Content: Article 1

DISORDERS OF SEX: SEXUALLY TRANSMITTED DISEASES (STDs)

*This article was originally printed in Nigeria’s **The Nation** on February 26, 2016, and can be found here: <http://thenationonlineng.net/disorders-of-sex-sexually-transmitted-diseases-stds/>*

Properly conducted, sex is an enjoyable exercise.

Sex is like everything around us: It too is guided by some natural and man-made rules. When these rules are flouted or when an individual is abused or his/her sex organs are somewhat tampered with or the body is mishandled, then sex becomes a problem and an infection, an unwanted dangerous outside agent may be introduced into the person’s system. It’s not the intention of the author of this book to write on every sexually transmitted disease.

A general guidance will be enough. Any disease agent can become sexually transmitted so long as it affects the genitals or reproductive organs or the disease affects the entry point used for “sex”.

The following are the common sexual disorders or agents of sexual diseases:

Bacteria:

- Gonorrhoea
- Chlamydia trachomatis
- Syphilis
- Lymphogranuloma Inguinale
- Chancroid

Less well recognised but can be considered as sexually transmitted is a bacterium called Staph. Aureus.

Viruses

- Human Immune-Deficiency Virus (HIV)
- Herpes simplex virus (HSV): Type I and Type II
- Human Papilloma Virus (HPV)
- Hepatitis B and C

Parasites

- Trichomonas vaginalis (common in women but can be found in men too).

Fungus

- Candidiasis. Often called yeast, it is a common infection of the warm and moist areas of human body especially vagina. It may also affect other parts of the body such as mouth, gut, anus, and armpit. Untreated, it may be sexually transmitted to the sexual partner. (*Editor's note: Yeast is NOT defined as a sexually transmitted infection*).

Precautions

The probability of getting any of these infections is low provided:

- a. You stick to one sexual partner
- b. You are honest with your partner
- c. You put your sexual organs into the partner's correct and biologically appropriate body entry point for which it was designed.
- d. You use barrier a method such as a condom when engaging in sex with non-regular sexual partner. Although herpes type I may be contacted from kissing as are the above hepatitis viruses.

Recent Developments In recent years, there has been a spate of developments in what would otherwise not amount to sexually transmitted diseases.

In the last two years or so, Ebola ravaged West African countries of Liberia, Sierra Leone and Guinea. In recent times, there is a solid scientific proof that 9 months after an individual has

recovered from Ebola infection, he or she can transmit the infection to his or her spouse. We are still not sure if the duration of carrying the virus can be longer than 9 months. Thus, Ebola is effectively a sexually transmissible disease.

The lesson is many folds: When you are in Ebola-infected country, take caution in sexual engagement. Use protective methods such as condom or consider complete abstinence. Similarly, in the last one year, an old viral disease carried by mosquito has emerged. It's called Zika virus.

➤ **Trainer's Note:** *If one participant finishes quickly, feel free to continue with the first article after they've explained their result. You may continue as long or as short as you feel necessary to make your point*

5. Repeat with **Content: Article 2** below, having participants use the other side of their Bingo Card handout.

Content: Article 2

KENYA: POLICE WARN PARENTS OVER 'SEX' PARTY

This article was originally posted on AllAfrica.com on March 6, 2016, and can be found here: <http://allafrica.com/stories/201603060005.html>

If you are a parent, especially in Nairobi, you are warned to mark next Saturday on your calendar because it could be the ultimate nightmare for parents raising teenage children.

In what could be an indication of a new level of exploitation by adults luring underage children to house parties that offer alcohol, drugs and sex orgies, promoters of an event have been circulating an invitation on social media that promises to be the "most epic of all time".

The event that is planned to take place at an undisclosed location in Nairobi's upmarket Kileleshwa estate is apparently an imitation of the movie, "Project X", which is described globally as the standard measure of the ultimate home-wrecking hell raiser of a party by unsupervised suburban teenagers.

The 2012 American film is about a teen party filled with alcohol, drugs, topless girls and sex that totally went out of control.

Cases of teenagers emulating the film by staging their own parties have ended disastrously across the world, with some leading to death.

The messages by the supposed organisers of the Kileleshwa event who freely give their contacts, mainly circulated on WhatsApp, appear to advocate a Kenyan version and promise to encourage the teenagers to be involved in debauchery.

A series of games based on new ways to take drugs and alcohol that are popular in Western countries intended to show the revellers how to get high with very little doses are also lined up.

In a show of impunity, the event organisers have even opened social media accounts that have been attracting many followers.

Hundreds of teens have expressed interest to attend the party whose advance tickets cost Sh500.

Some shops on Moi Avenue have been identified for those who want to buy advance tickets. An M-Pesa number has also been provided. Only those who have paid will be given directions to the venue, according to the organisers.

But police told Sunday Nation that they are aware of the said party and said "it won't happen". Police spokesman Charles Owino warned parents to be careful about the behaviour of their children and their whereabouts.

"Rest assured that the organisers will be arrested and charged before it happens," he said.

WORRYING TREND

Nominated MP Isaac Mwaura said the event must be "stopped at all costs." "We cannot allow people to cash in on our vulnerable youth. I have already communicated to Mr (Joel) Kitili (the acting Deputy Inspector General of Police) for them to take action. We must safeguard the morals of our country," Mr Mwaura said.

One parent expressed his worry about the obsession with sex and drugs among the youth.

"Youth should engage in constructive projects like clearing garbage, helping in hospitals, sharpening their debating and fundraising skills. The obsession with sexual orgies is worrying," said Natado Nashon, a parent.

There have been concerns of children involved in underage drinking.

In October last year 550 students, most of them minors were arrested in a basement disco in Eldoret while on a hedonistic rampage of drugs and sex.

In the same month more than 200 boys and girls were arrested at a bar on Dubois Road in Nairobi where they were also drinking alcohol.

And in August, 45 high school students were arrested for smoking bhang, drinking and having sex in a moving bus in Murang'a.

The HIV infection rate among adolescents has also increased.

In its 2015 report on HIV/Aids among children released in December last year the United Nations Children's Fund says almost half of the adolescents with HIV worldwide are in six countries that include Kenya, Tanzania, South Africa, Nigeria, Mozambique and India.

But despite this risk, teenage parties where sex, drugs and alcohol are the main items in the menu have been increasingly becoming common.

6. If there is time and participants are interested, pass out additional Bingo cards and continue with **Supplemental Content: Article 3** below.
- **Trainer's Note:** *You can also substitute Article 3 for either Article 1 or 2 above, or use local media articles instead of the articles provided.*

Supplemental Content: Article 3

MORE YOUNG FILIPINOS HIV-POSITIVE

This article was originally posted in the Manila Times on March 25 2014 and can be found here: <http://www.manilatimes.net/more-young-filipinos-hiv-positive/85420/>

The Philippines is one of nine countries where the number of human immunodeficiency virus-acquired immunodeficiency syndrome (HIV- AIDS) cases is growing. But what is more alarming is that many of the new victims are teenagers, with some as young as 15.

Based on a study conducted by the Department of Health (DOH), more young Filipinos have acquired HIV. Data from the Philippine HIV/AIDS Registry showed that in January of this year alone, 118 of the new HIV patients belong to the 15 to 24 age bracket.

They are among the 448 fresh HIV cases reported for the first month of the year.

Half of the 448 victims, or 224 patients, are from Metro Manila, while 16 percent come from the Calabarzon region, seven percent from Davao region, and four percent from Western Visayas. The rest of the regions recorded less than one to two percent of HIV cases this year.

From 1984 to January 2014, 36 people below 15 years old were infected with HIV. For the same period, 429 people aged 15 to 19 acquired the virus, as well as 3,467 in the 20 to 24 age bracket. The United Nations Children's Fund (Unicef) has also noticed this disturbing trend, saying new HIV infections "now occur at a younger age."

“In some areas, one in three persons most at risk are in the 15-17 age group,” Unicef said. Experts attribute the spike in HIV cases to unprotected sex. The sharp increase in HIV cases started in 2008.

Teresita Bagasao, Country Coordinator for the UN Program in HIV/AIDS (UNAIDS), said there is a decline in infection and death figures worldwide. However, the Philippines is on an upward trend.

“Sad to say, we are included among nine countries with over 25 percent new reported infections. It’s worrisome because the new infections that have been reported have come only in the last three years,” she said.

The other countries where HIV/AIDS is on the rise are Bangladesh, Indonesia, Sri Lanka, Kaszakhstan, Kyrgystan, Republic of Moldova, Georgia, and Guinea-Bissau.

From 2008-2012, there was a 538 percent increase in new cases of HIV in the Philippines, according to the National Epidemiology Center of the Department of Health (DoH).

Bagasao said when the first infection was reported in 1984, HIV/AIDS was considered a slow and hidden disease. But since 2007 when one HIV case was reported every three days, the disease has been on a “fast and furious” rampage. Now, one HIV infection is reported every two hours or 30 cases a day.

According to a 2013 study of the University of the Philippines Population Institute (UPPI), premarital sex among the youth rose to 32 percent from 18 percent in 1994. The study showed that in 2013, 6.2 million Filipino youth had premarital sex, and more than half of this number—4.8 million young people—indulged in unprotected sex.

Of the 6.2 million, 7.3 percent engaged in casual sex (one with no relationship or payment involved, and happened only once or twice), and 5.3 percent of males had sex with other males.

However, only 40 percent of these youth aged 15 to 24 are aware of sexually transmitted diseases. However, 80 percent are aware of HIV/AIDS.

“This means that the youth are not able to connect AIDS with sexually transmitted diseases,” UPPI Dean Joy Natividad said. She described the findings as “shocking” because these are youth who have graduated from high school and college, but they do not understand STDs.

The study noted that unprotected sex could heighten the risk of pregnancy or acquiring sexually-transmitted diseases.

Infections among the youth, which comprise one-fourth of the total number of cases, increased tenfold in 2013, with 995 reported infections from 44 in 2006. The estimates exclude unreported cases.

Natividad said unprotected sex remains to be the main cause of HIV infection.

“There is a heightened, bolder and wider range of sexual behaviors including those that use the new high-speed technology,” she pointed out.

She said the study also looked into how many people found sex partners from texting and the Internet and found that ways of interaction can lead to risky behavior among the youth, such as casual, regular, non-romantic same-gender and extramarital sexual experience.

Meanwhile, Jeffrey Acaba, co-convenor of the Network to Stop AIDS-Philippines (NSAP), said migrants, transgenders, homosexuals and other vulnerable sectors are also at high risk.

“The question is, how do we give them access to HIV testing?” he said.

He added that even if condoms are now sold openly, there is still a “social stigma” on the person purchasing them.

7. Discuss with participants the information and media environment in which adolescents live. Sample discussion questions include:
 - a. How does the language in the media affect young people’s understanding of their sexual health?
 - b. How well does mass media/communications that promote healthy sexual and reproductive health behaviors reach adolescents and young people? Why or why not? Are the messages disability inclusive?
 - c. What are some of the common misconceptions young people come into services with?
 - d. Does disability add any additional layers of misconception? Are there any misconceptions directly or indirectly related to disability?
 - e. Where do these misconceptions come from?
 - f. How can a service provider counter some of the misinformation young people are exposed to?

8. Close the activity by explaining to participants that adolescents and young people face misinformation about gender, disability, sexuality, sexual health, and HIV/STIs every day. The service provider needs to be equipped not only to provide testing, but to have a compassionate counseling style that helps adolescents identify false information, find accurate information, develop skills to make safe choices and respond to stigma in their environment.

Time: 30 minutes

9. Introduce the trainer presentation **Content: Adolescent-Friendly Language** (Slides 11.1-11.3) below by reminding participants that service providers who work with youth and adolescents frequently find themselves wearing many professional hats, including medical clinician, educator, counselor, social worker, and ally, as well as personal and community hats—father, mother, sister, brother, aunty, uncle, faith leader, community leader.

Begin the presentation.

Content: Adolescent-Friendly Language (Slides 11.X-11.3)

Slide 11.1: Information Environment

Adolescents and young people navigate a complicated world of stereotypes, half-truths, and taboos when it comes to information about gender, sexuality, sexual health, STIs, and HIV. Even well-meaning sources of information for adolescents, such as parents, teachers, religious leaders, and the media, may not have all the latest medical or scientific information, and in any event are often uncomfortable explaining complicated and sensitive issues to young people in a straightforward and non-judgmental way. This is particularly true when it comes to adolescents with disabilities, due to the widespread taboos and myths linked to sexual behavior of persons with disabilities and the limited experience and knowledge of parents, teachers, religious leaders, and the media about sexuality and disability.

Service providers working with adolescents must balance between providing young people with medically accurate, honest assessments of their risk and avoiding language that stigmatizes young people based on their sexual activity or uses fear or shame as a motivator to avoid risk. Service providers should also find ways to praise and reinforce positive behaviors. Remember from Unit 1: adolescents are incredibly sensitive to dishonesty, unfairness, or judgment from adults, and respond more positively to honesty and direct language.

10. Tell participants that you're going to practice using non-judgmental language. Bring up **Slide 11.2: Common Statements about Adolescents** below. Ask participants to try rephrasing the statements in adolescent-friendly, non-judgmental language. Use **Supplemental Content: Rephrased Statements** below for examples as needed.

Slide 11.2: Common Statements about Adolescents

- “Youth lack self-control around sexual decision-making and have irresponsible sex.”
- “Adolescents with disabilities can't decide by themselves about their sexual life and need their parents/guardians to take decisions for them”.
- “Adolescents know nothing about the symptoms, transmission and treatment of STIs.”
- “Adolescents often experiment with drugs and alcohol which leads to irresponsible decisions, and unprotected sex.”
- “Young people often confuse sex with love and engage in sex before they are mature.”

Supplemental Content: Rephrased Statements

- “Young people have a harder time obtaining contraception and often face social disapproval if they are seen as planning for sexual activity by having condoms.”
- Adolescents with disabilities are often denied their sexual and reproductive autonomy as well as full access to SRH information and services. As a result they are more exposed to the risk of HIV, unintended pregnancies, HIV, or violence.
- “Adolescents lack *access* to basic information on the symptoms, transmission, and treatment of STIs.”
- “Experimentation with drugs and alcohol may happen as part of adolescence and may have an effect on some young people’s decisions about when they have sex and with whom.”
- “Young people are experiencing first love and relationships and frequently have questions about sex and how to know if they’re ‘ready.’”

11. Return to presenting **Content: Social Dynamics and Factors (Slide 11.3)** below.

Content: Social Dynamics and Factors (Slide 11.3)

There are some social dynamics and factors that affect adolescents’ risk for STI and HIV infection of which providers should be aware.

- **Trainer’s Note:** Ask participants to brainstorm a few factors before citing the following.

- Unequal gender norms drive power imbalances which can make adolescents more susceptible to sexual violence and sexual coercion.
- Adolescents’ need to belong to a social group increases the likelihood of sexual coercion and/or social pressures to have sex.
- Many cultures expect adolescent sexuality to be hidden or non-existent. This is especially true of young people living with HIV, adolescents with disabilities, and LGBTQ youth.
- The intersection of gender, age, and disability often results in additional vulnerabilities, marginalization and exclusion of persons with disabilities from social participation. This limits their access to information and services and makes adolescents with disabilities more susceptible to violence and coercion.
- Taboos often prevent young people from seeking accurate information on sexuality and sexual health. Adolescents with disabilities also face additional physical, communication and attitudinal barriers. These taboos and barriers leave them with unanswered questions and assumptions about the sexual activity and risk behaviors of their friend and peers.
- Young people are frequently disenfranchised and disempowered which can increase their vulnerability to harmful practices, such as early and/or forced marriage, female genital mutilation/cutting, or transactional, coercive, or even violent sexual relationships.
- Adolescents may fear seeking testing or treatment for STIs or HIV because of the social stigma attached to a positive test result. Fear may be even stronger among adolescents with disabilities who are already discriminated against because of their disability.
- Contraception can also be stigmatized, and young people may fear community judgment of their use of contraception.

12. Close the presentation by reminding participants that service providers must always support the adolescent's ability to obtain clear, factual and direct information, while correcting myths and dispelling stigma.

PARTICIPANT HANDOUT 11A: MYTHS, MISCONCEPTIONS, AND MEDIA BINGO

Side 1:

Sex Shaming	Condom Dismissal	Medical Inaccuracies	“Normal” Sex	Stigma (STIs/HIV)
Marriage Bias	“Purity”	Male Urges	Gender Stereotypes	Medical Inaccuracies
Myths	Stigma (STIs/HIV)	FREE SPACE	Overly Scientific Language	“Normal” Sex
Male Urges	Medical Inaccuracies	Sex Shaming	Stigma (STIs/HIV)	Marriage Bias
“Purity”	Gender Stereotypes	Overly Scientific Language	Myths	Sex Shaming

PARTICIPANT HANDOUT 11A: MYTHS, MISCONCEPTIONS, AND MEDIA BINGO

Side 2:

Overly Scientific Language	“Purity”	Sex Shaming	Marriage Bias	Condom Dismissal
Marriage Bias	Stigma (STIs/HIV)	Gender Stereotypes	“Normal” Sex	Medical Inaccuracies
Condom Dismissal	Male Urges	FREE SPACE	“Purity”	Stigma (STIs/HIV)
Myths	Marriage Bias	Medical Inaccuracies	Sex Shaming	Overly Scientific Language
Stigma (STIs/HIV)	Gender Stereotypes	Condom Dismissal	Myths	Male Urges

SPECIFIC OBJECTIVE 11.2: IDENTIFY PREVENTION STRATEGIES USED SUCCESSFULLY IN PREVENTING STI/HIV TRANSMISSION IN ADOLESCENTS



TIME

30 minutes



METHODS

- Group brainstorm



MATERIALS NEEDED

- Colored sweets or small pieces of colored paper in 4-5 different colors and a container to hold them.
- Large and small post-it notes in 3 different colors *or* blank paper/post-it notes and different colored markers.
- Labels for STIs.
- Participant Handout 11b: Common STIs,



STEPS

1. Introduce the activity to the participants. Pass around the container with the colored sweets or colored paper and have participants select a piece of paper or a sweet. Based on the color that they chose, participants can break into smaller groups.
2. Distribute **Participant Handout 11b: Common STIs**. Tell participants to use the handout as a reference for this exercise.

Time: 30 minutes

3. Assign each of the small groups an STI, being sure to include: HIV, herpes (HSV 1 and 2), HPV, syphilis, and gonorrhea or chlamydia.

➤ **Trainers Note:** *other STIs can be added, either for larger training groups or to adjust to local prevalence rates for specific infections. Create labels for each STI used and place them on the walls around the room.*

*In some countries, yeast infections are treated as STIs. A yeast infection can be transmitted during sexual intercourse, although this is rare. **Yeast infections are not considered an STI.** Vaginal yeast infections are caused by an overgrowth of the fungus, *Candida*, and most women will have at least one yeast infection in their life, which is not related to sexual activity.*

4. Provide each small group with the different color post-its/paper.
5. In the smaller groups, ask participants to discuss and put their responses on post-its to the following questions:
 - Why are adolescents at risk for this STI?
 - What prevention strategies can adolescents use to protect themselves from this STI?
 - How can you as a service provider help an adolescent client implement this prevention

strategy?

6. Ask one of the smaller groups to focus specifically on adolescents with disabilities, to discuss and put on post-its responses to the following questions:
 - Are adolescents with disabilities exposed to different risk factors for this STI? Why?
 - What prevention strategies can adolescents with disabilities use to protect themselves from this STI?
 - How can you as a service provider help adolescent clients with disabilities implement this prevention strategy?

➤ **Trainers Note:** *Have participants use their three different colors to separate their answers to the three questions. For example: Yellow = risks, Green = prevention strategies, and Blue = service support.*

7. Have participants place their post-its on the wall under a label for their STI, and then give all participants time to tour the room and look at other small groups' work.

➤ **Trainers Note:** *Use this time to also wander the room and keep an eye out for judgmental or stigmatizing language, in particular around adolescent risk. Also keep an eye out for prevention strategies which limit the expression of adolescent sexuality, such as total abstinence, or which are gender or disability biased, such as those that cite adolescent women as being responsible for sexual decision-making or adolescents with disabilities as being unable to take autonomous decisions on their sexual and reproductive health. If this language appears, make sure to address it in the group discussion.*

8. Ask the whole group to reconvene in the center of the room to discuss the activity, using the following prompts:

- a. What risks or prevention strategies stood out to you? Were there any listed under different STIs that you thought should also apply to your own?
- b. Did any of the language on risk stand out to you as being judgmental or "sex-negative" around adolescent sexuality? Did any of the language stand out as being particularly youth-friendly or sex-positive?
- c. What were some of the common risks across different STIs?
- d. What were some of the common prevention strategies?

➤ **Trainers Note:** *Ensure that all the prevention strategies listed below under **Supplemental Content: Prevention Strategies for Young People** have been mentioned.*

- e. Did any of the advice stand out as to how we as service providers can help adolescents implement prevention strategies? Were there any ideas you think you could use in your own work?

Supplemental Content: Prevention Strategies for Young People

Young people should have information about and be encouraged to:

Discuss STI and pregnancy risk and prevention with their partners. Young people should be supported

to develop strategies and skills to discuss risk and prevention with new partners before commencing a sexual relationship.

Find accurate information on risk. Young people should have accurate sources of information to understand how STIs are transmitted and to be able to assess their own level of risk. Mobile apps and online tools are increasingly available for young people to find information and assess their risk. Apps and online tools MUST be vetted to ensure they are evidence-informed.

FHI360 has developed the Mobile for Reproductive Health (m4RH) service, which is an automated, interactive and on-demand SMS system that provides simple, accurate and relevant information on SRH. See: <https://m4rh.fhi360.org/>

Get vaccinated for HPV. The vaccine for HPV is increasingly available to young people in low- and middle-income countries. The HPV vaccine is recommended by the WHO for adolescent girls as young as age 9. The HPV vaccine is also recommended for adolescent boys, both to protect them and their partners.

Know their condom and protection options. Adolescents should be able to easily obtain both female and male condoms, and know the various benefits, risks, and uses for each.

Learn how to use condoms and use them consistently and correctly. All adolescents should become comfortable with 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. This information should also include advice on lubricants which are safe to use with latex or other condoms.

Get tested between partners or with new partners. The importance of regular testing for those at risk of HIV should be emphasized. HIV testing and services can be integrated with other medical services, in particular sexual health and STI assessments. Providers should inform adolescents of relevant national laws affecting age of consent or parental consent/notification for HIV testing and other sexual and reproductive health services.

Recognize symptoms of STIs. If there is burning with urination and/or unusual discharge from the penis or vagina, or there are genital sores, young people should come to the clinic for assessment and treatment. Untreated STIs can cause more complex health problems, like pelvic inflammatory disease or infertility. Failure to properly assess and treat STIs can also increase risk of HIV infection.

Discuss sexual issues. Adolescents must feel comfortable communicating with their partners and with service providers about sex, sexual behaviors, and their sexual histories.

Frequently national laws only specifically cover age of consent for HIV testing and services, or for general medical services. These laws may not specify an age of consent for other sexual and reproductive health services or STI testing. Providers should clarify the policy or guidelines within their own clinic or organization as well as national and local laws and look for opportunities to improve adolescent access to services. For more information on services for adolescents living with HIV, see Unit 12. For more information on services for adolescents with disabilities see the chapter "Adolescents with Disabilities"

Understand their right to autonomy, or to control their bodies. Young people should be supported to know their right to determine if, when, how, how often, and with whom they are sexually active. This includes young persons with disabilities.

Access health and support services in the case of sexual violence. Adolescents should know and understand the role of health services in responding to sexual violence, including their access to Post-

Exposure Prophylaxis (PEP) for HIV, emergency contraception to reduce unintended pregnancy, and other psycho-social support.

Consider Pre-Exposure Prophylaxis (PrEP) for adolescents at high risk of HIV. The latest WHO guidance recommends the use of pre-exposure prophylaxis for people at “substantial risk” of acquiring HIV, including members of key populations such as young gay men, bisexual men, and men who have sex with men; young people who use injectable drugs; young transgender people; young people who sell or trade sex; or young people in sero-discordant couples. PrEP is also recommended for young people engaged in transactional or cross-generational or non-monogamous sexual relationships. The WHO has found no evidence that PrEP increases risk-taking behaviors among those who take the drug. PrEP does not affect the effectiveness of hormonal contraception.

PrEP should not displace or threaten the implementation of effective and well-established HIV prevention interventions, such as condom promotion and harm reduction. Stigma drives HIV infection, and stigma could either decrease or increase depending on the how PrEP is administered. PrEP should be promoted as a positive choice among people for whom it is most suitable and their communities, in conjunction with other appropriate prevention interventions. – WHO Guidance

PARTICIPANT HANDOUT 11B: COMMON STIs

Source: Center for Disease Control and Prevention Fact Sheets
(http://www.cdc.gov/std/healthcomm/fact_sheets.htm)

STI	Basics	Symptoms		Transmission
HIV	<ul style="list-style-type: none"> *Viral *manageable with treatment and care regimen 	<ul style="list-style-type: none"> *flu-like symptoms: fever, body aches, swollen glands *other STIs *tuberculosis 		<ul style="list-style-type: none"> *unprotected vaginal, oral or anal sex *contact with infected blood (shared needles) *mother to child during pregnancy, delivery or breast-feeding
Herpes (HSV1 and HSV2)	<ul style="list-style-type: none"> *Viral *manageable with treatment and care regimen 	<ul style="list-style-type: none"> *asymptomatic or mild initial symptoms *small, blister-like sores on the genitals, anus or mouth *flu-like symptoms: fever, body aches, swollen glands 		<ul style="list-style-type: none"> *unprotected vaginal, oral or anal sex *contact with an open sore
HPV	<ul style="list-style-type: none"> *Viral *Vaccine Available *linked to cervical and other cancers *frequently disappears on its own 	<ul style="list-style-type: none"> *frequently asymptomatic *causes genital warts *cervical cell abnormalities 		<ul style="list-style-type: none"> *unprotected vaginal, oral or anal sex
Syphilis	<ul style="list-style-type: none"> *Bacterial *treatable with antibiotics 	<p>Phase 1</p> <ul style="list-style-type: none"> *mild symptoms *small, painless sore *non-itchy body rash 	<p>Phase 2</p> <ul style="list-style-type: none"> *flu-like symptoms: fever, body aches, swollen glands *sore throat 	<ul style="list-style-type: none"> *unprotected vaginal, oral or anal sex *contact with an open sore *mother to child during delivery

			<ul style="list-style-type: none"> *hair loss *headache *weight loss *fatigue 	
Gonorrhoea	<ul style="list-style-type: none"> *Bacterial *treatable with antibiotics 	<ul style="list-style-type: none"> *frequently asymptomatic *burning during urination *vaginal, anal or penile discharge *testicular swelling *bleeding between periods (spotting) *anal itching, bleeding or soreness *painful bowel movements 	<ul style="list-style-type: none"> *unprotected vaginal, oral or anal sex *mother to child during delivery 	
Chlamydia	<ul style="list-style-type: none"> *Bacterial *treatable with antibiotics 	<ul style="list-style-type: none"> *frequently asymptomatic *vaginal or penile discharge *burning during urination *rectal pain, discharge, or bleeding *testicular swelling 	<ul style="list-style-type: none"> *unprotected vaginal, oral or anal sex 	
Trichomoniasis	<ul style="list-style-type: none"> *Parasitic *treatable with antibiotics 	<ul style="list-style-type: none"> *frequently asymptomatic *irritation or inflammation of urethra, vulva, or vagina *itching or irritated penis or vagina *burning during urination *vaginal or penile discharge 	<ul style="list-style-type: none"> *unprotected vaginal sex 	
Hepatitis	<ul style="list-style-type: none"> *Viral *vaccine available 	<ul style="list-style-type: none"> *fever *fatigue *loss of appetite *nausea/vomiting 	<ul style="list-style-type: none"> *unprotected vaginal, oral or anal sex *contact with infected blood (sharing needles) 	

	*manageable with support and care	*abdominal pain *grey bowel movements *joint pain *jaundice	*mother to child during delivery
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NOTE: ALTHOUGH YEAST OR CANDIDIASIS CAN BE TRANSMITTED VIA SEX, THIS IS RARE. YEAST/CANDIDIASIS IS NOT A SEXUALLY TRANSMITTED INFECTION

SPECIFIC OBJECTIVE 11.3: SUMMARIZE APPROPRIATE CLINICAL MANAGEMENT OF STIS



TIME

50 minutes



METHODS

- Trainer presentation
- Group discussion



MATERIALS NEEDED

- Slides 11.4-11.11



STEPS

Time: 20 minutes

1. Introduce the presentation. Remind participants that young people are at particular risk for STI transmission, including HIV and that adolescents with disabilities are exposed to even a higher risk. Present **Content: STI Prevalence and Testing** (Slides 11.4-11.11) below.

Content: STI Prevalence and Testing

Slides 11.4-11.11: Prevalence and Testing for STIs

Sexually transmitted infections, or STIs, are increasingly common among all people, including adolescents, worldwide. The WHO and the US-based Center for Disease Control and Prevention estimate that:

- Most sexually active adults will contract some strain of HPV at least once in their lifetime.
- More than 500 million people have a genital infection with HSV.
- There are an estimated 357 million new infections each year with one of four STIs: chlamydia, gonorrhea, syphilis (which are caused by bacteria), and trichomoniasis (which is caused by a parasite).

Many STIs have vague, mild or infrequent symptoms and symptoms may go away on their own. Young women often do not know they have been infected. Due to the limited availability of information and education on STIs, combined with cultural stigmas and taboos, many adolescents, young people, and adults fail to obtain sexual health services, even when they do experience symptoms. Persons with disabilities face even more barriers to accessing services.

Young women may present at clinics with candidiasis or a yeast infection. Although yeast can be transmitted sexually, this is rare. Yeast infections are common in hot, humid climates, and can occur in the absence of sexual activity. Yeast infection is more likely among women who:

- Are using antibiotics
- Are using combined oral contraceptives (due to estrogen content)

- Have a suppressed immune system due to diabetes or HIV
- Are pregnant
- Consume excess sugar
- Have nutritional deficiencies (zinc, B12)
- Wear tight clothing or nylon underwear

STIs are common worldwide, but low- and middle-income countries bear a huge burden of poor health outcomes related to undiagnosed or untreated STIs. While diagnostic tests are widely used to locate and treat asymptomatic STIs in high-income countries, these tests are frequently unavailable in low- and middle-income countries. Most countries use syndromic diagnosis, which is dependent on the presence of recognizable symptoms.

Where testing is available, it is often expensive or limited to select facilities, making it even more inaccessible. Low-cost, rapid tests are increasingly available for HIV and syphilis. The test for syphilis is new and may not be widely available.

2. Pause and ask participants to reflect on what tests if any are available in their clinic and in their nearest district health facility. Return to presentation with **Slide 11.8: Effective STI Treatment** below.

Slide 11.8-11.9: Effective STI Treatment

Source: World Health Organization

Effective treatment is currently available for several STIs.

- Three bacterial STIs (chlamydia, gonorrhoea and syphilis) and one parasitic STI (trichomoniasis) are generally curable with existing, effective regimens of antibiotics.
- For HSV and HIV, the most effective medications are antivirals that can moderate the course of the disease. There is no cure for HSV or HIV.
- For hepatitis B, immune system modulators (interferon) and antiviral medications can help to fight the virus and slow damage to the liver.

Safe and highly effective vaccines are available for hepatitis B and HPV. These vaccines represent major advances in STI prevention. The vaccine against hepatitis B is now included in infant immunization programmes in 93% of countries and has already prevented an estimated 1.3 million deaths from chronic liver disease and cancer.

Drug resistance of STIs to antibiotics—in particular gonorrhoea—has increased rapidly in recent years, thus limiting treatment options. New strains of gonorrhoea have emerged that demonstrate decreased sensitivity to the “last line” treatment option (oral and injectable cephalosporins). Gonorrhoea already shows resistance to multiple drugs, including penicillin, sulphonamides, tetracyclines, quinolones and macrolides. Antimicrobial resistance for other STIs, though less common, also exists, making prevention and prompt treatment critical.

Slide 11.10-11.11: STI case management

Low- and middle-income countries rely on identifying consistent, easily recognizable signs and symptoms to guide treatment, without the use of laboratory tests and in accordance with WHO

recommendations. This is called syndromic management. This approach, which relies on clinical algorithms, allows health workers to diagnose a specific infection on the basis of observed symptoms and syndromes (e.g., vaginal discharge, urethral discharge, genital ulcers, abdominal pain).

Syndromic management is simple, assures rapid, same-day treatment, and avoids expensive or unavailable diagnostic tests. However, this approach misses infections that do not demonstrate any symptoms or syndromes, which is true for the majority of STIs globally. Overuse of treatment regimens related to syndromic management contributes to STI drug resistance.

As already mentioned, many STIs present with few or mild symptoms making them difficult to diagnose and treat. Furthermore, many STIs present with symptoms that are identical to or mimic other health issues. For example, vaginal discharge is normal. It can also be related to an infection. In many settings, 40-50% of women will say "yes" when asked if they have discharge, and it is unclear if their discharge is normal or related to an infection. Treating all women who respond yes to the presence of discharge would lead to massive overtreatment of STIs. In fact, studies of the validity of syndromic management have shown that vaginal discharge should not be used as a routine screening question. There is some evidence that syndromic management of vaginal discharge can be strengthened by cervical examination to determine whether there is a cervical discharge or inflammation, but this requires training, tools, time, and supplies.

Time: 30 minutes

3. Ask participants to consider the following case studies in small groups at their tables. Ask them to come up with a diagnosis and treatment plan for each case study based on the resources they have available to them in their clinics.
4. Read **Content: Case Study 1** below and give groups **10 minutes** to discuss and write down a diagnosis and treatment plan.

Content: Case Study 1

A 17-year-old single man with a hearing disability complains of burning on urination and discharge from his penis. He says he has had a new sexual partner in the past month. On examination of the urethra, a thick yellowish discharge is visible.

5. Ask the group to reflect on the following questions:
 - a. What additional information do you need from this client? What follow-up questions would you ask?
 - b. How would you build a treatment plan for this client?
 - c. What additional resources does this client need? How can you talk to this client about future prevention strategies?

Remind participants that accommodations or accessible-format communications may be needed to ensure information is shared in a format that can be understood by the client and that the client is comfortable with. Refer to the communication tips available in the "Adolescents with Disabilities" chapter for all the relevant details on communicating with adolescents with hearing disabilities.

6. Read **Content: Case Study 2** below and repeat the questions from step 5.

Content: Case Study 2

A 19-year-old married woman comes in for routine examination. She reports no vaginal discharge or discomfort, but on visual inspection she appears to have some abnormal lesions on her cervix.

7. Close the activity by asking for examples of similar or challenging cases from the participants' practice. Identify any common challenges and brainstorm solutions among the group. Identify additional resources for participants seeking more information about particular STIs or management strategies.

UNIT 11 SUMMARY



TIME

20 minutes



METHODS

- Gallery walk



MATERIALS NEEDED

- Post-it notes
- Flipchart



STEPS

1. Ask participants to reflect on what they learned today. Give each participant a post-it note and ask them to write down one thing they learned today that they did not know before. Invite participants to walk around the room and look at the information on the walls in order to consider this.
2. Have participants post their notes on a blank flipchart at the front of the room. Gather around the flipchart and identify any trends.

UNIT 12: ADOLESCENTS LIVING WITH HIV

INTRODUCTION:

According to the United Nations Joint Program on HIV (UNAIDS), 20% of new HIV infections globally occur among young women aged 15-24, and an additional 12% occur among young men of that age group. Over 2 million adolescents (aged 10-19) worldwide are living with HIV, and 26 new infections occur among adolescents every hour. In addition, with advances in HIV testing, treatment and care, more and more perinatally infected children are living into and through adolescence, leaving a generation of young people who have grown up with HIV reaching maturity. These young people need access to sexual and reproductive health services to prevent STI co-infection, HIV re-infection and unintended pregnancy, along with access to psychosocial support services and other care as they manage the transition from childhood to adulthood while also living with HIV.

UNIT TRAINING OBJECTIVE:

To orient service providers on the rights, responsibilities, and unique needs of adolescents living with HIV.




SPECIFIC LEARNING OBJECTIVES:

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

4. Understand the rights and responsibilities of adolescents living with HIV and their service providers, in particular related to disclosure.
5. Identify the care, transition, psychosocial support, and SRH service needs for adolescents living with HIV.
6. Understand the different modes of transmission of HIV for adolescents and their implications for clinical care.

TOTAL TIME: 3 HOURS 15 MINUTES

UNIT OVERVIEW:

Session	Methods 	Materials 	Time 
12.1	Values clarification activity Trainer presentation	Agree/Disagree signs Character cards Slides 12.1-12.11 <i>Optional: Participant Handout 12a</i>	1 hour
12.2	Lava pit game Group discussion	Support service cards Tape Case study cards or prepared flipcharts Flipcharts and markers Candies or small prizes	30 minutes
12.3	Group discussion Trainer presentation Group work	Flipcharts and markers Slides 12.12-12.15 Participant Handout 12b	1 hour 25 minutes
Unit Summary	Pair interview		20 minutes



WORK FOR TRAINERS TO PREPARE IN ADVANCE:

- Review Slides 12.1-12.11
- SO 12.1: Prepare Agree/Disagree signs.
- SO 12.1: Research age of consent for HIV testing laws and policies, requirements for parental notification.
- SO 12.1: *OPTIONAL: Prepare Participant Handout 12a: Tips for Disclosure for Adolescents Living with*

HIV.

- SO 12.2: Prepare 3 sets of Support Service Cards, prepare case study cards, or prepare flip chart pages with case studies written on them.
- SO 12.3: Prepare flip charts with discussion questions in advance and set them up around the room.
- SO 12.3: Prepare Participant Handout 12b: Differences by Mode of Transmission.
- Review the content of the UNAIDS publication *Disability and HIV* included in the list of references to strengthen the understanding of the link between HIV and disability.



MAJOR REFERENCES AND TRAINING MATERIALS:

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age. Geneva: WHO.

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SPECIFIC OBJECTIVE 12.1: UNDERSTAND THE RIGHTS AND RESPONSIBILITIES OF SERVICES PROVIDERS AND ADOLESCENTS LIVING WITH HIV, IN PARTICULAR RELATED TO DISCLOSURE



TIME

1 hour



METHODS

- Values clarification activity
- Trainer Presentation



MATERIALS NEEDED

- Agree/Disagree signs
- Character cards
- Slides 12.1-12.11



STEPS

1. Introduce the activity to the participants. Have participants stand together in the center of the room. Place a sign that says “Agree” and one that says “Disagree” on opposite sides of the room.

Time: 20 minutes

2. Tell participants that they should move closer to one sign or another based on how they feel about each of the following statements. The closer they are to the sign, the stronger they agree or disagree with the statement. Clarify that there are no “right” or “wrong” answers.
3. Read the first statement:
 - a. Young people living with HIV can have happy and satisfying sexual lives.
4. Ask participants to quietly look around the room at where they’re all standing.
5. Read the next statement and give participants time to shift their positions, then repeat the instruction to note where everyone is standing. Repeat for the full list of statements below:
 - a. Sexuality and sexual pleasure are important for all young people, regardless of their HIV status.
 - b. Sexuality and sexual pleasure are important for all young people, regardless of their HIV and disability status.
 - c. Adolescents living with HIV have the capacity to make decisions about their sexual health and reproductive intentions.
 - d. Adolescents with disabilities living with HIV have the capacity to make decisions about their sexual health and reproductive intentions
 - e. Adolescents living with HIV should be required to disclose their HIV status to their sexual partners.
 - f. Learning about sexual pleasure is an important part of growing up for all adolescents, including adolescents with disabilities, regardless of their HIV status.

- g. The provider has a responsibility to inform the parent or guardian of an adolescent in their care when that adolescent is diagnosed with HIV.
 - h. Young people living with HIV have the right to decide if, when, how many, and with whom to have children.
 - i. Young persons with disabilities living with HIV have the right to decide if, when, how many, and with whom to have children.
 - j. Adolescents with disabilities are less at risk to be infected by HIV virus compared to the general population.
6. Ask participants to return to the center of the room. Ask if anyone wants to volunteer how they felt looking around the room after each statement. Ask volunteers:
- a. *How did you feel about the activity?*
 - b. *Did any of your responses surprise you?*
 - c. *What did you learn about your own and the opinions of others on the rights of adolescents living with HIV?*
 - d. *Were there times where you felt tempted to move with the majority of the group? Did you end up moving? How did that feel?*
 - e. *What did you learn about stigma around the sexuality of adolescents living with HIV?*
 - f. *What did you learn about stigma around the sexuality of adolescents with disabilities living with HIV (also called double stigma)?*
 - g. *How might that stigma (or double stigma) impact our practice as health providers working with adolescents living with HIV?*
7. Debrief in particular the last 2 questions. If there were statements where the majority of participants stood on one side or the other, discuss this commonality. Discuss how differences in opinion affect our work with these clients.
8. Thank the group for their participation and invite them to sit back down.

Time: 40 minutes

9. Present **Content: Rights and Responsibilities of Adolescents Living with HIV and their Service Providers** (Slides 12.1-12.11), below.

Content: Rights and Responsibilities of Adolescents Living with HIV and their Service Providers (Slides 12.1-12.11)

Slide 12.1: Rights

Adolescents living with HIV have all the same sexual, reproductive, and human rights as any other adolescent. Adolescents with disabilities living with HIV are not an exception. They have the right to know their HIV status and make their own decisions about how, when, and to whom to disclose. Service providers working with adolescents living with HIV must understand both how to inform

the adolescent about their health status and how best to support them to know their rights and responsibilities when it comes to their own and their partners' sexual and reproductive health risks.

- **Trainers Note:** *Ask for a show of hands: How many participants have had to disclose to an adolescent client their HIV status? How many have had to do so multiple times? Can you recall any of these cases involving adolescents with disabilities?*

Slide 12.2-12.3: Disclosure to Adolescents

There are multiple scenarios where a service provider would find themselves in the position of informing an adolescent client of their HIV status.

Most commonly, service providers might disclose the HIV status to an adolescent who has come in for voluntary counseling and testing services, who has most likely been infected through sexual activity or injectable drug use. In other cases, service providers may encounter adolescents who have been perinatally infected who have either made it to adolescence without being diagnosed or have not been informed of their status by their caregivers or guardians. In either case, service providers should consider:

- Is the adolescent over the legal age of consent for HIV testing?
- Does the provider have a legal requirement to inform the parent or guardian?
- Has the screening of the adolescent raised concerns about the home environment and the adolescents' safety?

When service providers need to disclose the HIV status to adolescent clients with disabilities, it is important to remember that:

- In the future, they will face additional barriers in accessing information and services due to double stigma and discrimination and may need additional support. Just as their peers without disabilities, adolescent clients with disabilities have the right to decide about their sexual and reproductive life.
- They may be exposed to higher risks of violence and abuse at home and in the community.

Slide 12.4-12.6: Tips for Disclosing to an Adolescent Client

Once you have the results of an adolescent client's HIV test, consider the following:

- Adolescents have the same right to know their status as adult clients. Any and all clinical guidelines for disclosing a positive HIV test result to an adult client must be applied to an adolescent client.
- When clients are adolescents with disabilities, the provider needs to ensure that the

disclosure is accessible and understandable, taking into account the specific barriers that persons with different types of disabilities may face and managing them appropriately (for example, how to disclose HIV test results to an adolescent with visual impairment without breaking confidentiality rules). On communication with adolescents with different types of disabilities, please refer also to unit 7 and the “Adolescents with Disabilities” chapter.

While an adolescent client may choose to have a parent, caretaker, partner, or friend in the room to receive their results, ensure that this is their choice. If the adolescent seems uncomfortable or the parent, caretaker, or other support person seems to be making decisions for the adolescent, err on the side of asking to speak to the adolescent alone. Additional care must be taken for adolescents with intellectual and developmental disabilities, as quite often their rights to be informed and to confidentiality are not respected (i.e., their parents/guardians have the tendency to make decisions for them, etc.). Moreover, the concepts of legal protection and legal guardianship are typically not well defined nor respected.

- Clients of all ages may have strong emotional reactions to disclosure of a positive status. Remain calm and allow some time for their initial reaction to subside.
- Remind the client that HIV is a manageable disease. Reassure the client that with proper treatment and care, they can live a full life with no restrictions on their activities. Include the information that with advances in treatment and prevention, people living with HIV can have fulfilling sexual and romantic relationships with partners while protecting them against transmission, and that people living with HIV can still have biological children without passing on the virus.

10. Pause and ask participants if any of them know the legal age of consent for HIV testing. Ask if anyone knows the legal parental notification requirements. Clarify any inaccuracies before returning to the presentation with **Slide 12.7: Legal Disclosure Requirements**.

Slide 12.7-12.9: Legal Disclosure Requirements

If there is no legal requirement for disclosure to the parent or guardian and the adolescent is over the legal age of consent, the adolescent has the right to determine if, when or how to disclose to their parents or guardians. If the adolescent is under the legal age of consent, or if the parent or guardian is aware of their status and has not disclosed to the adolescent, the provider should work to engage the parent or guardian in the disclosure process.

WHO (2014) states: “Wherever possible, adolescents should be provided with an opportunity to ask questions, discuss the issues and the challenges they face, and be supported to tell others their HIV status in a safe way. Health care providers should provide adolescents essential post-diagnosis and/or post-disclosure support. This should include initiating and facilitating discussions to explore the benefits and challenges adolescents may experience knowing their status; and to discuss existing and potential support mechanisms, including peer support opportunities. Adolescents recently diagnosed should be asked who they may want to inform and be encouraged to seek out someone they trust to support them.”

Young people living with HIV have the right to decide if, when, and how to disclose their HIV status to others. There are many reasons why an adolescent may choose not to disclose their status, including fear of stigma and discrimination, concerns about disclosing their sexual activity or use of injectable drugs, worry about judgment or isolation from the community, or fear of violence. This may be particularly true for adolescents with disabilities who worry about experiencing double stigma and discrimination based on HIV and disability. The adolescent knows best if and when it is safe to disclose. Disclosure to others can also offer positive results: increased caretaking and community support, better treatment, retention, and adherence, and more ability to negotiate sexual protection with a partner.

As a provider, you can help the adolescent weigh the risks and benefits of disclosure and offer support to adolescents as they plan to disclose.

11. Pause and ask participants to brainstorm some ways that service providers can support adolescents considering disclosure. Return to the presentation with **Slide 12.10: Support for Adolescent Disclosure** below.

Slides 12.10-12.11: Support for Adolescent Disclosure

Some ways service providers can support adolescents considering telling people their HIV status include:

- Know the relevant laws and policies. Some countries require disclosure to any current or new sexual partners, while some have protections for people living with HIV who fear violence or discrimination.
- Equip them with the information they need. What are their risks of transmitting to a new partner? How can they protect themselves and their partners? What health consequences should they watch for? Help the adolescent think through the conversation and what information they might be asked for or need to manage their loved one's reaction.
- Talk with them about any concerns they may have related to intimate partner violence (IPV). If they reveal they are experiencing IPV, the provider should be able to provide first line support as well as referral to the IPV counselor (if this person is available) or other local GBV response services.

Service delivery sites must meet the following requirements before assessing young people's concerns of or experiences around IPV:

- A protocol or standard operating procedure for asking about violence.
- An established process for referrals or linkages to local GBV response services, including counseling, child protection services, police and legal support.
- Providers who have received specialized training in gender sensitive, adolescent-centered, and first line support in assessing and supporting adolescent experience of IPV. For example, providers must be able to:

- Listen respectfully and empathetically.
 - Inquire about adolescent worries, concerns and needs, and provide answers to questions.
 - Offer non-judgmental and validating responses that reassure the adolescent that they are not to blame for IPV, and that they have acted appropriately in disclosing it
 - Act to ensure the adolescent's safety and minimize harm.
 - Provide the adolescent with emotional and practical support, such as a referral to GBV response services.
- A set of standardized questions that are used by providers to assess experience and/or fear of violence and to document responses.
 - Auditory and visual privacy that protects adolescent privacy, ensures their safety and minimizes harm.
- Help make a plan. Where should they have the conversation? How can they get out of the conversation if it goes badly? What's the best time to have the conversation? Sometimes it helps for the service provider to be present or to have the conversation at the clinic.
 - Follow up with the adolescent. How did it go? How would they do it differently next time? Was there information they needed that they didn't have?

It is important to remember, though, that over-emphasis on disclosure can discourage adolescents living with HIV from continuing treatment or care. At all times, emphasize all adolescent's right to choose if, how, and when to disclose their status, and that disclosure is their choice.

12. Close the presentation by leaving time for any questions or concerns. If participants need more resources on these topics, direct them to the additional resources listed at the beginning of this unit.

➤ **Trainers Note:** You may also choose to distribute **Optional Participant Handout 12a: Tips for Disclosure for Adolescents Living with HIV** if participants are interested in more tools to support adolescents with disclosing to partners and family.



OPTIONAL PARTICIPANT HANDOUT 12A: TIPS ON HIV DISCLOSURE

1. FOR PROVIDERS WHO NEED TO ADVISE ADOLESCENTS OF THEIR HIV STATUS

SOURCE: WORLD HEALTH ORGANIZATION

Disclosure to an adolescent about their own HIV status should ideally occur between the ages of 6–12 years, before puberty and the onset of sexual exploration. Early disclosure helps young people to better adhere to treatment, to be more engaged in their own self-care, to have a better understanding of HIV and related conditions and to know where and how to obtain services that maintain their own health and enable them to avoid infecting others.

Disclosure of HIV status to adolescents, however, often occurs late, and is unplanned, creating confusion for adolescents who learn of their HIV status without appropriate information and support. This can lead to an increased sense of stigma, shame, and fear.

Ideally, a parent or caregiver should be involved when disclosing HIV status to an adolescent. Parents and caregivers also fear stigma for themselves and their child/ward, which may block their ability to disclose HIV status to the adolescent. Providers can support parents and caregivers to explore their concerns and fears and provide them with information. Providers must also consider how to address circumstances in which adolescents have frequently changing, disengaged, or absent caregivers.

Disclosure support for adolescents should go beyond just advising them of their HIV status. The common challenges surrounding HIV continue throughout adolescence, sometimes with different concerns for those infected as children – through mother-to-child transmission – and for those infected during adolescence. In addition, adolescents from key populations, including persons with disabilities, experience legal and social concerns.

Adolescents should be provided with an opportunity to ask questions, discuss the issues and the challenges they face, and be supported to tell others their HIV status in a safe way.

Health care providers should provide adolescents essential post-diagnosis and/or post-disclosure support. This should include discussions that explore the benefits and challenges to knowing their status; and to discuss existing and potential support mechanisms, including peer support opportunities. Adolescents recently diagnosed should be asked who they may want to inform and be encouraged to seek out someone they trust to support them.

Providers can practice disclosure skills by conducting role plays with colleagues. Role plays assist in preparing providers to deal with unfamiliar or difficult situations, exploring likely reactions and different approaches to responding to them. Role plays help to build provider skills and confidence to handle real life situations.

2. FOR HELPING ADOLESCENTS LIVING WITH HIV TO DISCLOSE THEIR STATUS TO OTHERS

SOURCE: IPPF 2010

- Practice disclosing to people you trust, this could include family members or friends. Remember though that people will not all react in the same way.
- Speak to other young people living with HIV, or members of your support group, to learn from their experiences on different ways to disclose.
- Consider things like the best time to tell the person. When dating, some people tell their partner when they first meet while others wait till later. Do whatever makes you the most comfortable. If you are in a long-term relationship, try to find a time when your partner is calm and has time for a long conversation.
- Test how your partner(s) may react to your HIV status by asking them questions like 'what do you think about HIV?' and 'have you met anyone with HIV?', or talking about a news story. This will help you get a sense of what they think about HIV and how they might react.
- Think of disclosing in a location that you feel comfortable and safe in — a private place like in your house, a friend's house, or in a public place where other people are around.
- If you think your partner(s) may get violent or angry, try to tell your partner in a safe environment and have a plan in place for your safety.
- Be ready for a conversation about HIV after you disclose. Your partner(s) may have questions about living with HIV, such as the risk of transmission, and safer sex. They may also have questions about your relationship. A counselor can also help with this.
- More often than not, disclosing is a process rather than a one-time event. Expect several conversations. Your partner(s) may need time to deal with their emotions. They may have new questions about HIV.
- Plan to go out with people you trust after you disclose. You can celebrate a positive outcome, discuss strategies for supporting a hesitant but willing partner, or get support for dealing with a negative reaction.

SPECIFIC OBJECTIVE 12.2: IDENTIFY THE CARE, PSYCHOSOCIAL SUPPORT, AND SRH SERVICE NEEDS FOR ADOLESCENTS LIVING WITH HIV



TIME

30 minutes



METHODS

- Lava pit game
- Group discussion



MATERIALS NEEDED

- 3 sets of colored cards or sheets of paper with various types of services written on them (see below), 3 of each
- Flipcharts (3) one per group
- Tape 3 rolls
- Case study cards – one per group (or case studies can be written on the flipcharts for each group)
- Candies or small prizes



STEPS

1. Set up three flip charts around the perimeter of the room. In the center of the room, scatter the colored cards with the various support services written on them.

Time: 30 minutes

2. Divide participants into three groups, ask each to stand by their flip chart.
3. Introduce activity to participants: explain that they will be retrieving the support services they think their adolescent needs from the center of the room and placing them on their flip chart with tape. The catch is that participants are not allowed to touch the ground in the center of the room: they can only step on the service cards. Additionally, only one person from each group can be in the center at a time. The first group to collect all the services they need will win a prize.
4. Give the groups **one minute** to discuss and make a plan for how to get the services they need.
5. Give the groups **5 minutes** to get as many services as they think they need out of the center of the room and onto their flip chart. Have the groups call out when they're finished.
6. Review each group's flip chart, in the order they finished. Have each group present their flip charts and answer the following questions:
 - Why did you select these services? Which ones did you think were most important, and why?
 - Which services did you think this adolescent didn't need? Why not?
 - Which supports can you provide, and which ones do you need to refer the adolescent to or bring in other support for yourself?

- What other resources might be available to this adolescent in their community?
 - Which additional support or resources might be important to provide in the case of adolescents with disabilities knowing that resources at the community level may not be accessible to them?
7. Check to see if any of the support services were left out by all three groups. If so, ask the group why they think none of them needed that support. Ask the group to reflect on which of the supports are available in their communities and how they can use them effectively.
 8. Restate that providers need to know how to respond to the needs of adolescent clients living with HIV and what services are available for them to refer to. Close the activity by rewarding all the participants with a candy or small prize.



TRAINERS TOOL: SUPPORT SERVICES CARDS

Color 1: Psychosocial Support (3 of each)

Mental Health Counseling

**Substance Abuse Counseling
or Support Groups**

**Death and Bereavement
Counseling**

**Positive Living Networks and
Groups**

Family Counseling

Legal Defense

Employment Support

**Tutoring or Educational
Support**

Faith-based Support Groups

Peer Support Networks

**Intimate Partner Violence
Screening and Counseling**

**Economic Strengthening
Support**

Color 2: Sexual and Reproductive Health Services (3 of each)

**Family Planning and
Contraceptive Services**

**STI Testing, Care and
Treatment**

**HPV Vaccination and Cervical
Cancer Screening**

**Prevention Information and
Education**

**Sexuality Education and
Information**

**Sexual and Gender Based
Violence and Post-Rape Care**

**Safe Abortion and Post-
Abortion Care**

PMTCT

**Disclosure Counseling (self
and others)**

Color 3: Care Needs (3 of each)

ARTs

Food Security

Nutritional Counseling

Housing

Compassion

**Health Information and
Services**

**Treatment for Opportunistic
Infections**

**Counseling on Treatment
Adherence**

**Transition from Pediatric to
Adult Care**

**Routine Tuberculosis (TB)
Screening and Preventive
Therapy (TBT)**

Viral Load Testing

Rehabilitation Services

Case Studies (1 of each)

Adolescent male, 15, with a hearing disability, sexually active, living at home with parents who are unaware of his HIV status, struggling with frequent illnesses.

Adolescent female, 17, perinatally infected, orphaned, living with an auntie, working in a market, not in school, goes on and off treatment based on earnings.

Adolescent female, 14, in school, engaged in transactional sex to pay school fees, newly infected.

SPECIFIC OBJECTIVE 12.3: UNDERSTAND THE DIFFERENT MODES OF TRANSMISSION OF HIV FOR ADOLESCENTS AND THEIR IMPLICATIONS FOR CARE



TIME

1 hour 25 minutes



METHODS

- Group discussion
- Trainer presentation
- Group work



MATERIALS NEEDED

- Flipcharts and markers
- Slides 12.12-12.15
- Participant Handout 12b: Difference by Mode of Transmission



STEPS

1. In advance of the session, set up the room by placing prepared flipcharts around the room with the following questions.
 - a. *Question 1: How do adolescents living with HIV make their first contact with health services?*
 - b. *Question 2: What makes it easier for an adolescent living with HIV to return to health services?*
 - c. *Question 3: What makes it harder for an adolescent living with HIV to return to health services?*

Time: 20 minutes

2. Explain to participants that you're going to start with a quick group discussion to set the scene for what we're learning today. Ask participants to raise their hands if they have had an adolescent living with HIV come to them for services in the past week, month or year.
3. Ask a volunteer to estimate how many young people living with HIV attend their clinic every month. Ask them to estimate how many of them were infected perinatally and how many acquired HIV as adolescents. Ask them to estimate how many of them had a disability. Ask one or two more volunteers for the same information.
4. Explain that we can expect to see more and more adolescents living with HIV coming into clinics. Ask participants why we expect this. Reasons can/should include:
 - As ART use increases and improves among perinatally infected children, young people born with HIV are reaching sexual maturity.
 - As HIV stigma decreases, more adolescents are getting tested and learning their status.
 - Adolescents still face higher rates of new infection than other age groups because they lack information, experience inequitable gender norms, and adolescent girls and young women are biologically susceptible to contracting HIV when having sex with an HIV +

partner. Stigma around expressing their sexuality creates barriers to information and condoms.

5. Turn participants' attention to Question 1: How do adolescents living with HIV make their first contact with health services? Have participants shout out ideas and record them on the flip chart. Are there differences based on mode of exposure to HIV and age at transmission?
6. Repeat with Questions 2 and 3 on separate flip charts.
7. Have participants call out which of their responses to Questions 2 and 3 are internal to the adolescent, which are related to the individual health worker, which are a part of the health service system, and which are related to other factors (peers, families, community, etc.). If none of the participants has mentioned disability in their responses, take the initiative to ask them if disability is in their opinion a factor that makes it easier or harder for an adolescent living with HIV to return to health services and why.
8. Conclude the activity by summarizing the main points of discussion, then introduce the presentation.

Time: 20 minutes

9. Introduce the presentation by saying: Sexual and reproductive health service providers are increasingly seeing a population of adolescents and young people living with HIV.
10. Ask participants to call out a few ideas why they are seeing more adolescents living with HIV. Present **Content: Adolescents Living with HIV** (Slides 12.12-12.15) below.

Content: Adolescents Living with HIV (Slides 12.12-12.15)

Slide 12.12: More Adolescents Living with HIV

For service providers, learning to care for adolescents living with HIV will be increasingly necessary in the coming years. Optimal HIV care and treatment for these adolescents will vary, depending on mode of transmission, age, sex, gender, disability, social factors and disease progression. This unit covers some basic considerations for providers working with adolescents living with HIV, but there are many more detailed guidance and training documents available, for those who wish to go more in depth.

- **Trainers note:** Three key tools are listed in the additional resources section at the start of this unit:
1. *Adolescent HIV Care and Treatment: A Training Curriculum for Health Workers.*
 2. *Transitioning of Care and Other Services for Adolescents Living with HIV in Sub-Saharan Africa.*
 3. *Adolescent HIV Testing, Counselling and Care: Implementation guidance for health providers and planners.*

If participants are interested in more information and support on these topics, consider adding more time and activities from the first tool to this training, or scheduling a more in-depth follow-up training.

11. Distribute **Participant Handout 12b: Differences by Mode of Transmission**. Return to the presentation with **Slide 12.13: Modes of Transmission** below.

Slide 12.13-12.15: Modes of Transmission

Source: Adapted from WHO 2013a

The specific needs and challenges of three groups should be considered:

1. *Adolescents infected perinatally, diagnosed early, and on treatment:* These adolescents may be on complex ART regimens and even last line treatment options, and need support to continue their treatment and care. For many health providers, this means helping the adolescent assume greater responsibility for their own care, addressing developmental delays, supporting safe and beneficial disclosure by the adolescent to family and peers, treating opportunistic infections, providing linkages to psycho-social support, family planning and reproductive health services, and ensuring access to PMTCT for pregnant adolescent girls living with HIV.
2. *Adolescents infected perinatally, not diagnosed early, and not on treatment:* A large number of perinatally infected adolescents may reach puberty undiagnosed or untreated, particularly in low-resource settings or generalized epidemics. Some adolescents may have been diagnosed but lost to follow-up or may be encountering HIV testing for the first time in their adolescence. These slow progressors may have chronic medical problems, opportunistic infections, or developmental delay issues that will need attention.
3. *Infected during adolescence:* For adolescents in generalized epidemic areas, the primary mode of transmission is through sexual intercourse. Adolescents may also acquire HIV through injecting drug use, unsafe medical practices or procedures, or harmful traditional practices. Approaches to care and treatment for these adolescents may differ from those infected perinatally and should consider the rights of adolescents to care and treatment which is free from stigma or discrimination on the basis of their sexuality, sexual orientation, or sexual activity.

12. Close the presentation by leaving time for questions and clarifications from the group.

Time: 45 minutes

13. Ask participants to take some time to review **Participant Handout 12b: Differences by Mode of Transmission**. Ask if there are any questions or additions to the two columns that have been filled out for them. Have the group reflect back on the warm-up activity, and the presentation, and ask them to fill out the third column with clinical or care strategies, working in pairs.

➤ **Trainer's Note:** *If participants are struggling with filling out the handout, provide a few clarifying examples from the Response Guide (below).*

14. Emphasize that in many cases, the care strategies for adolescents infected perinatally or during adolescence may be the same or similar.
15. Allow **15 minutes** for the pairs to complete the handout. Have participants combine their pair with another to form a group of four and spend an additional **10 minutes** comparing their responses.
16. In plenary, facilitate a discussion focusing on the following questions:
 - Are there places where care strategies differ for adolescents who are perinatally infected and those who are infected during adolescence? In what way?
 - Where are care strategies similar or the same?
 - How would care strategies differ for adolescents who are unaware of their HIV status?
 - Are there existing clinical guidelines or standards for these issues? How accessible are they for service providers?
17. Close the discussion by pointing out that those infected during adolescence may experience greater stigma related to their HIV status than those infected perinatally. Those infected during adolescence may be “blamed” for their own infection. Ask participants to reflect on how stigma and bias might affect their access to care and on the additional barriers adolescents with disabilities living with HIV may face as a result of disability and HIV-based discrimination.

PARTICIPANT HANDOUT 12B: DIFFERENCES BY MODE OF TRANSMISSION

Source: AIDSTAR One

Mode of Transmission		
Perinatally (P)	During adolescence (A)	1-2 Care/Clinical Strategies relating to:
More likely to have opportunistic infections	Fewer opportunistic infections	P:
		A:
More likely to not be on first line drugs and in need of complex ART regimens	ART resistance less likely	P:
		A:
More obstacles to achieving self-management and autonomy, bereavement, and developmental delays	Less likely to experience obstacles to achieving self-management and autonomy, but may experience other obstacles such as stigma, grief, etc.	P:
		A:
More physical and developmental delays	Less likely to have physical and developmental delays	P:
		A:
Higher risks of complications during pregnancy	Lower number of complications during pregnancy	P:
		A:
Higher mortality rates	Long-term chronic disease outlook	P:
		A:
		P:

Mode of Transmission		
May not know HIV status although may have been in treatment and may experience Challenges to adherence if they do not know their status	May experience adherence challenges	A:
More likely to have experienced multiple losses related to HIV (parents, siblings, etc.)	More likely to have denial and fear of HIV	P:
		A:
More secrecy regarding disclosure	More likely to be misinformed about HIV	P:
		A:
May struggle with issues related to intimacy, sexuality, and sexual identity	May distrust clinical facilities	P:
		A:
May have heightened concerns about pregnancy and starting families	Lack of belief in clinical treatment to prevent vertical HIV transmission	P:
		A:
More likely to have support from family/caregiver and health provider	More likely to lack familial, clinical and social supports	P:
		A:

TRAINER TOOL 12A: RESPONSE GUIDE TO PARTICIPANT HANDOUT

Trainers Note: these responses are not comprehensive: participants may have additional responses to share with the group.

Mode of Transmission		
Perinatal (P)	During Adolescence (A)	Care Strategies relating to:
More like to have opportunistic infections	Fewer opportunistic infections	P: Clinical treatment for opportunistic infections
		A: Education about symptoms and potential infections to be aware of
More like to not be on first line drugs and in need of complex ART regimens	ART resistance less likely	P: Treatment support and more complex regimens
		A: Initial treatment
More obstacles to achieving self-management and autonomy	Less likely to experience obstacles to achieving self-management and autonomy, but may experience other obstacles such as stigma, grief, etc.	P: Psychosocial and educational support referrals, counseling on treatment and self-care
		A: Counseling on treatment and self-care
More physical and developmental delays	Less likely to have physical and developmental delays	P: Clinical and medical treatment where appropriate, counseling on pubertal delays and effects of HIV
		A: General SRH counseling and support services
		P: Contraceptive services, antenatal care, PMTCT treatment

Mode of Transmission		
Higher risks of complications during pregnancy	Lower number of complications during pregnancy	A: Contraceptive services, antenatal care, PMTCT treatment
Higher mortality rates	Long-term chronic disease outlook	P: Psychosocial support, service referrals
		A: Counseling on treatment and self-care, psychosocial support service referrals
may not know HIV status although may have been in treatment and may experience challenges to adherence if they do not know their status	may experience more adherence challenges	P: Disclosure (self & others)
		A: Treatment support
Perinatal (P)	During Adolescence (A)	Care Strategies relating to:
More likely to have experienced multiple losses related to HIV (parents, siblings, etc.)	More likely to have denial and fear of HIV	P: PSychosocial support service referrals, stigma and self-care counseling
		A: Education and counseling on stigma and self-care
More secrecy regarding disclosure	More likely to be misinformed about HIV	P: Disclosure (self & others), education on rights and stigma
		A: Education and counseling
May struggle with issues related to intimacy, sexuality, and sexual identity	May distrust clinical facilities	P: education and counseling on sexual rights of adolescents living with HIV
		A: Education and counseling on sexual rights of adolescents living with HIV, stigma

Mode of Transmission		
May have heightened concerns about pregnancy and starting families	Lack of belief in clinical treatment to prevent vertical HIV transmission	P: General sexual and reproductive health services, education and counseling
		A: Counseling on PMTCT
More likely to have support from family/caregiver and health provider	More likely to lack familial, clinical and social supports	P: Psychosocial support referrals
		A: Psychosocial support referrals

UNIT 12 SUMMARY



TIME

20 minutes



METHODS

- Pair interview



MATERIALS NEEDED

- None



STEPS

1. Divide participants into pairs. Have them interview each other about the unit using the following questions:
 - Was there something new you learned today?
 - What experience do you have with adolescents living with HIV?
 - Do you feel confident about your ability to treat and work with adolescents living with HIV?
 - How do you feel about supporting adolescents with disabilities living with HIV?

UNIT 13:

SEXUAL AND GENDER-BASED VIOLENCE (SGBV)

INTRODUCTION:

Sexual and gender-based violence (SGBV) is sometimes considered a separate issue from sexual and reproductive health. The experience of violence, though, and in particular sexual violence, has direct effects on sexual and reproductive health, mental health, and the health of families, children, and adolescents. In many cultures, violence is taboo, and violence that occurs within the home or is based on gender or sexuality is considered shameful or a private affair. As providers and counselors, it is important to recognize the effects of SGBV on clients and their sexual and reproductive health, and to be prepared to screen for and counsel clients affected by SGBV. Available evidence suggests that many young people's first sexual experience is coerced or forced, and the perpetrator is often known; however, young people may not articulate their experiences as SGBV. The limited data available also suggest that young persons with disabilities are more likely to experience sexual violence than their peers without disabilities. Estimates suggest that 40 to 68 percent of young women with disabilities and 16 to 30 percent of young men with disabilities will experience sexual violence before the age of 18. According to UNICEF, young persons with intellectual and developmental disabilities are among the most vulnerable and are almost five times more likely to be subjected to sexual violence than their peers without disabilities. Reasons for these higher rates of violence include but are not limited to: stigma, discrimination, dependence, negative traditional beliefs, and impunity. Young persons with disabilities can also face the most barriers to accessing services and receiving support.

In any event, if SGBV or an experience of coerced/forced sex is not acknowledged or addressed in a professional, nonjudgmental manner, it can lead to further sexual and reproductive health problems. Providers and counselors should possess good counseling skills and accurate knowledge of both the prevalence and effects of SGBV to help all adolescent clients.

UNIT TRAINING OBJECTIVE:

To help providers recognize and respond to SGBV as a sexual and reproductive health and rights issue.




SPECIFIC LEARNING OBJECTIVES:

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

7. Explain the importance of SGBV as a sexual and reproductive health and rights issue.
8. Identify physical and behavioral indicators of SGBV.
9. Demonstrate how to screen for and counsel clients with a history of SGBV.
10. Identify clinical care needs and appropriate services for survivors of SGBV.

TOTAL TIME: 4 HOURS 55 MINUTES

UNIT OVERVIEW:

Session	Methods 	Materials 	Time 
13.1	Group brainstorm Quiz	Flipcharts and markers Participant Handout 13A	1 hour 15 minutes
13.2	Group brainstorm Trainer presentation	Flipcharts and markers Slides 13.1-13.6	1 hour
13.3	Small group work Trainer presentation Role play	Participant Handout 13b Slides 13.7-13.16	1 hour 25 minutes
13.4	Trainer presentation Group brainstorm	Slides 13.17-13.22 Flipcharts and markers Participant Handout 13c	55 minutes
Unit Summary	Individual reflection	Empty box or bag index cards	10 minutes



WORK FOR TRAINERS TO DO IN ADVANCE:

- Review Slides 13.1-13.22.
- Review the materials on SGBV and disability included in the reference list.
- Research common SGBV issues in your area and resources and services available for survivors. Find out if these are accessible and currently used by persons with disabilities and, if not, why.
- Prepare Participant Handouts 13a-c.
- Locate an empty box or bag.



MAJOR REFERENCES AND TRAINING MATERIALS:

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SPECIFIC OBJECTIVE 13.1: EXPLAIN THE IMPORTANCE OF SGBV AS A SEXUAL AND REPRODUCTIVE HEALTH ISSUE



TIME

1 hour 15 minutes



METHODS

- Group brainstorm
- Quiz



MATERIALS NEEDED

- Flipcharts and markers
- Participant Handout 13A: SGBV Fact or Fiction



STEPS

1. Introduce the unit by telling participants that adolescents experience many types of violence, physical, emotional, and sexual, and that all of these forms of violence may have an effect on their sexual and reproductive health.

Time: 35 minutes

Write “Types of Violence” on the top of a flipchart. Ask participants to brainstorm some of the kinds of violence they think the adolescents in their community can or do face. Ask them if, in their opinion, adolescents with disabilities experience some forms of violence more than others. If yes, why.

- **Trainer’s Note:** *Some of the types of violence that participants should include are: sexual violence, incest, domestic abuse, bullying, gang violence, early and forced marriage, female circumcision/female genital mutilation, emotional abuse, sexual abuse, sexual assault, harassment, corporal punishment, coercion, rape, relationship violence, intimate partner violence, forced abortion, and forced sterilization.*

Some people may cite “prostitution” or sex work as a type of violence. If a participant calls out prostitution or sex work, clarify that any forced labor of any kind, including sex work, is violence, but that not all sex work is forced or involuntary.

2. Ask participants if they need clarification on any of the terms on the sheet. Make sure there is a clear understanding of what people mean by these terms before moving forward. Some definitions are included for you below in **Supplemental Content: SGBV Terms**.

Supplemental Content: SGBV Terms

Sources: WHO 2016b, UNICEF 2015, Amnesty International 2015

1. **Bullying:** Bullying is an aggressive and repeated pattern of hostile behavior and is based on a real or perceived power imbalance. Bullying can involve physical or sexual

harassment, threats, isolation, shaming and stigmatization, or physical assault. Bullying can happen in schools, in workplaces, in the community, online, or in any space where people regularly gather.

2. **Domestic Abuse/Domestic Violence:** Any violence or abuse that takes place inside the home or family. Violence may or may not be directed against the adolescent but may have physical or psychological effects on the adolescent. The WHO reports that children who grow up in families where there is violence may suffer a range of behavioral and emotional disturbance, which increases their risks for perpetrating or experiencing violence later in life.
3. **Homophobic and Transphobic Violence:** According to the Office of the High Commissioner on Human Rights: "Homophobic and transphobic violence has been reported in all regions of the world. It ranges from aggressive, sustained psychological bullying to physical assault, torture, kidnapping and targeted killings. Sexual violence has also been widely reported, including so-called 'corrective' or 'punitive' rape, in which men rape women assumed to be lesbians on the pretext of trying to 'cure' their victims of homosexuality."
4. **Intimate Partner Violence:** Refers to behavior by an intimate partner or ex-partner that causes physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors.
5. **Female Circumcision/Female Genital Mutilation (FGM):** The removal of part or all of the external female genitalia. This practice has been linked in some countries with girls' or young women's rites of passage. It is seen as a way of controlling women's or girls' sexuality and is still practiced in many parts of the world. FGM can have serious consequences for girls' and women's physical and mental health. It sometimes results in excessive bleeding, infection, transmission of diseases, trauma and pain and even death, and often leads to difficulties in intercourse and childbirth.
6. **Rape:** Defined as the use of physical and/or emotional coercion, or threats to use coercion, to penetrate a child, adolescent, or adult vaginally, orally, or anally against her/his wishes. Rape is not a form of sexual passion; it is a form of violence and control. Rape can be perpetrated by a stranger, but is more commonly perpetrated by an acquaintance, spouse, or romantic partner. Rape is also common in conflict areas or against sexual or racial minority communities (see **Homophobic and Transphobic Violence**, above). Rape is always a human rights violation and is also considered a war crime or hate crime.
7. **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. Sexual abuse can occur anywhere, and to anyone.
8. **Sexual Violence:** Sexual violence includes both physical and psychological attacks directed towards a person's sexual characteristics. It is not limited to a physical invasion of the person's body and may include acts that do not involve penetration or physical contact.
9. **Forced Abortion and Forced Sterilization:** Forced abortion and forced sterilization may occur when the perpetrator causes abortion by force, threat or coercion, or by taking advantage of woman's incapability to give her consent, or where she gives her consent under duress. Women and girls with disabilities are exposed to forced abortion and sterilization more than their peers without disabilities, as they are often denied their sexual and reproductive autonomy, with family members/guardians making decisions

about their reproductive life without asking their opinion or consent. In some cases, due to limited or inaccessible information, they may also have a diminished understanding of what it means to have an abortion or be sterilized, which could lead to agreeing to the procedure without giving truly informed consent.

3. Ask for a volunteer to circle the types of violence that can be sexual or because of an adolescent's sexuality.
4. Ask for another volunteer to circle the types of violence that can be based on an adolescent's gender identity or expression, using a different colored marker. At this point, all of the terms should be circled at least once.
5. On another flipchart page, write "Sexual and Gender-Based Violence." Tell participants that any kind of violence can be sexual or gender-based, if it involves sexual abuse, coercion, harassment, or assault, or if it is violence committed against a person based on their sex, gender, sexuality, sexual orientation, gender identity, or gender expression.
6. Ask participants how they would tell if violence is gender-based. Ask for examples of violence that is gender-based, versus violence that isn't.
7. Underneath "Sexual and Gender-Based Violence" write the term "Violence Against Women and Girls." Tell participants that most gender-based violence is violence against women and girls because of their gender, but that gender-based violence includes violence against people of all genders when it occurs because of how people live and express their gender identity. For example, bullying and violence against boys for being "too feminine" would also be considered a type of gender-based violence.
8. Ask if participants are clear on the various types of sexual and gender-based violence their clients may be experiencing or have experienced. Clarify any definitions or misconceptions.

Time: 40 minutes

9. Introduce the next activity. Tell participants that because of the connection to sex, because much SGBV occurs within the family or within intimate relationships, and because of social taboos around talking about SGBV with others, there are all sorts of misunderstandings and social assumptions about SGBV.
 10. Pass out **Participant Handout 13A: SGBV Fact or Fiction**. Tell participants that they will do a short exercise to uncover some of the common misconceptions about SGBV. Give participants **10 minutes** to complete the handout.
 11. Once participants have finished filling out their handout, go through the answers with the group. Clarify misconceptions and answer questions using **Content: SGBV Fact or Fiction Discussion Guide** below.
- **Trainer's Note:** *You do not need to read out every point on the discussion guide below during your group discussion. These points are here for you to use in case some common but difficult questions arise.*

Content: SGBV Fact or Fiction Discussion Guide

- i. Fact Fiction **Rape happens only to women**

Rape can be committed against and be committed by people of all sexes/genders. Because of the public perception of rape as a crime by men against women, people who experience other forms of rape may not know that it is rape. Men who come forward to report being raped by other men or by women are frequently subjected to social scorn, disapproval, or dismissal leading to additional stigma against men who have been sexually assaulted.

- ii. Fact Fiction **Sexual abuse only means rape.**

Sexual abuse includes all forms of sexual coercion, harassment and assault. It can include emotional abuse, physical abuse or assault, or economic coercion and abuse as weapons. It may or may not include rape, but should not be taken any less seriously. Any type of unwanted sexual contact is considered sexual abuse and is a violation of basic human rights.

- iii. Fact Fiction **Anyone can commit sexual or gender-based violence.**

People can be loving and caring and commit violence against another person. Sometimes, people who commit sexual and gender-based violence think they are doing what the victim wants or is in their best interest. Some examples include:

1. *Parents who want their daughters circumcised to help them fit into their community or to be more marriageable.*
2. *Parents who think that forcing their gay or lesbian children to have heterosexual sex will “cure” them of homosexuality.*
3. *Partners who think beating their wives or husbands is “teaching” them.*
4. *Parents or guardians who think that forcing sterilization upon adolescent girls with disabilities is in their best interest to prevent unwanted pregnancies.*
5. *Parents or guardians who think that forcing abortion upon adolescent girls with disabilities is in their best interest because their impairment would prevent them from being good mothers.*

Providers may sometimes be called upon to educate parents or caretakers about abuse while supporting adolescent clients with services and mental health care.

- iv. Fact Fiction **Rape is an act of uncontrollable sexual desire.**

Rape is about control, power, and violent dominance, not sexual desire. All people can control their sexual desire and should be taught that anger and violence are not an acceptable response to disappointment, rejection, or frustration. Rape is also a tool for social dominance and control, for example:

1. *Rape of “enemy” women in war or conflict zones.*
2. *Rape of “enemy” combatants in war or conflict zones.*
3. *Rape in prison as a form of establishing hierarchy.*

- v. Fact Fiction **SGBV is more common in lower socio-economic groups.**

SGBV can happen anywhere and to anyone. SGBV is not more common in certain groups or communities: it is every society and every community's problem. Certain groups are more at risk for SGBV: these are groups that are already stigmatized or discriminated against because of their sexuality and gender, and include:

1. *Adolescent girls*
2. *Women*
3. *LGBTI Communities*
4. *Commercial Sex Workers*

Because SGBV relies on power imbalances between perpetrators and victims, groups that are marginalized in society may also be at risk for SGBV, combined with other forms of hate-motivated violence. These groups include:

1. *Racial and ethnic minorities*
2. *Communities living in poverty*
3. *Persons with disabilities*
4. *Non-majority religious groups*

vi. Fact Fiction **People in abusive relationships should just leave.**

It is not always easy or safe for someone in an abusive relationship to leave their partner or abuser. Providers can help clients think of a safety plan if they are thinking of leaving an abusive relationship. Abuse can start small and grow slowly, making it hard for someone to realize or admit to themselves that their partner is abusing them. Society and communities don't always make it easy for people to leave abusive partners, and sometimes blame the victim for the abuse or for ending the relationship. Persons with disabilities in abusive relationships may face even more difficulties in leaving their abusive partners when they are economically dependent on them or if the partner is also their caregiver. Moreover, some shelters and other services available to people who experience violence/abuse are not accessible to persons with disabilities.

vii. Fact Fiction **Most rapes are committed by strangers.**

Most rapes are committed by perpetrators who know the victim. Perpetrators can include a parent, spouse, partner, ex-partner, friend, family member, another person in the home, teacher, neighbor, employer, colleague, caregiver. More rarely it is a stranger.

viii. Fact Fiction **You can change another person's violent behavior by changing your own.**

No one can control how someone else will act. You can do specific things to avoid being in risky situations or to protect yourself, including:

- *Asking a friend to walk you home when you are out late.*
- *Not leaving drinks or food unattended at a bar or restaurant.*
- *Meeting people for the first time in groups or in public places.*

Blaming the victim for what they were wearing or how they behave contributes to social stigma against people who have been assaulted.

- ix. Fact Fiction **It is rape if someone puts his or her fingers inside a woman's vagina without her permission.**

Though rape laws vary from country to country, rape is commonly defined as the use of physical and/or emotional coercion, or threats to use coercion, to penetrate a child, adolescent, or adult vaginally, orally, or anally against her/his wishes. Rape does not have to involve penetration with a penis to be rape. The use of fingers or external objects is also considered rape. When coercion or threats are involved, the person being raped may not be able to fight or say no. Adolescents should be taught about consent as a vital part of sexual contact.

- x. Fact Fiction **It is easy to tell if someone has been subject to SGBV.**

People respond to trauma differently: there isn't one "right" way of being a victim. Not all SGBV leaves physical marks or scars that are visible to health providers.

- xi. Fact Fiction **People who experience sexual or intimate partner violence as children are more likely to perpetrate or experience sexual or intimate partner violence as adults.**

Sexual violence during childhood is associated with perpetration of violence and being a victim of violence later in life. Children who grow up in families where there is violence also have a higher risk of perpetrating or being the victim of violence later in life. Sexual violence during childhood is also associated with other physical and mental health risks, including depression, suicide, sleep difficulties, eating disorders, alcoholism, and post-traumatic stress disorder. (Source: WHO 2016b)

- xii. Fact Fiction **SGBV is uncommon among adolescents in my community.**

1 in 3 women worldwide have experienced sexual violence or intimate partner violence in their lifetime. 1 in 4 women aged 15 to 19 worldwide report having been subject to sexual violence since the age of 15. Most women first experience sexual violence during their adolescence. Many women (as many as 70% in some communities) report that their first sexual experience was forced. 1 in 3 girls aged 13 to 15 worldwide experience regular bullying (Source: WHO 2016b, UNICEF 2015, WHO 2013). 40 to 68 percent of young women with disabilities and 16 to 30 percent of young men with disabilities will experience sexual violence before the age of 18 (Source: Management Sciences for Health & UNFPA 2016).

- xii. Fact Fiction **Women ask to be raped when they wear revealing clothing or act flirtatious.**

No one asks to be raped. A woman has the right to wear whatever she pleases without it being taken as an invitation for assault. Dressing attractively and flirting are not an invitation for rape.

- xiv. Fact Fiction **If a victim doesn't want to involve the police, it is because they are lying about having been assaulted.**

Some people who have been assaulted choose to report the assault to the police, and some do not. It is

the victim's choice whether they want to go to the police to report. Many victims have legitimate fear of retribution from the police or from the perpetrator for reporting them. Police stations and services are often inaccessible to persons with disabilities due to physical barriers, communication and attitudinal barriers, as well as lack of accommodation. Attitudinal barriers often exist because of police officers' lack of understanding about disability, as well as misconceptions and wrong assumptions related to sexuality and disabilities.

Some countries have mandatory reporting laws when a provider suspects that a child is being sexually or physically abused. Providers should always communicate to their clients what they are legally required to report.

xv. Fact Fiction **Some people pretend they don't want sex or say "no" when they really mean yes.**

It should always be taken seriously when someone says "No." Many perpetrators of sexual violence use this argument to justify their behavior. Adolescent education about sexual health and sexuality should include a discussion of consent.

xvi. Fact Fiction **Adolescents with disabilities do not experience sexual violence**

Adolescents with disabilities are nearly three times more likely to experience sexual violence than their peers without disabilities. While children with disabilities are also at risk of sexual violence, the available data highlights that this risk increases as soon as they reach puberty. While boys with disabilities are also at risk of sexual violence, girls are more likely to experience it.

12. Remind participants that the clients who come to them for services live in the same societies and are raised hearing the same things that they do. Explain that one reason women and other people who experience SGBV so rarely seek treatment, much less justice, is because they are taught to blame themselves for the violence that they have experienced.
13. Ask participants to quickly brainstorm how they could use this information in their practice. What are some ways they can correct myths and misinformation with their clients?
14. Close the session by thanking participants for their time.



PARTICIPANT HANDOUT 13A: SGBV FACT OR FICTION

- i. Fact Fiction **Rape happens only to women.**
- ii. Fact Fiction **Sexual abuse only means rape.**
- iii. Fact Fiction **Anyone can commit sexual or gender-based violence.**
- iv. Fact Fiction **Rape is an act of uncontrollable sexual desire.**
- v. Fact Fiction **SGBV is more common in lower socio-economic groups.**
- vi. Fact Fiction **People in abusive relationships should just leave.**
- vii. Fact Fiction **Most rapes are committed by strangers.**
- viii. Fact Fiction **You can change another person's violent behavior by changing your own.**
- ix. Fact Fiction **It is rape if someone puts his or her fingers inside a woman's vagina without her permission.**
- x. Fact Fiction **It is easy to tell if someone has been subject to SGBV.**
- xi. Fact Fiction **People who experience sexual or intimate partner violence as children are more likely to perpetrate or experience sexual or intimate partner violence as adults.**

- xii. Fact Fiction **SGBV is uncommon among adolescents in my community.**
- xii. Fact Fiction **Women ask to be raped when they wear revealing clothing or act flirtatious.**
- xiv. Fact Fiction **If a victim doesn't want to involve the police, it is because they are lying about having been assaulted.**
- xiv. Fact Fiction **Some people pretend they don't want sex or say "no" when they really mean yes.**
- xvi. Fact Fiction **Adolescents with disabilities do not experience sexual violence.**

SPECIFIC OBJECTIVE 13.2: IDENTIFY PHYSICAL AND BEHAVIORAL INDICATORS OF SGBV



TIME

1 hour



METHODS

- Group brainstorm
- Trainer presentation



MATERIALS NEEDED

- Flipcharts and markers
- Slides 13.1-13.6



STEPS

Time: 30 Minutes

1. Divide the group into 2 teams. Give each team 2 pieces of flipchart paper and markers.
2. Tell the teams that they will race to see which team can come up with the most correct answers in the time available.
3. Ask the teams to think of as many physical signs of sexual and gender-based violence as they can and write them down on a flipchart page. Give teams **5 minutes** to brainstorm.
4. When time is up, have one participant from each team present their flipchart to the larger group. Supplement their responses with information from the list in **Supplemental Content: Physical Indicators** below.

Supplemental Content: Physical Indicators

1. Difficulty walking or sitting
2. Torn, stained, or bloody underclothing
3. Pain, swelling, itching, bleeding, lacerations, or bruising in the genital area
4. Abdominal pain
5. Abrasions or lacerations of the hymen, labia, perineum, posterior forchette, and breasts
6. Unexplained vaginal or penile discharge
7. Labial fusion
8. Repeated or poorly explained injuries
9. Multiple unwanted pregnancies
10. Repeated STIs
11. Unexplained chronic pain or conditions (pelvic pain or sexual problems, gastrointestinal problems, kidney or bladder infections, headaches)
12. Sudden unexplained weight gain or loss
13. Self-inflicted injuries or self-harm
14. Recurrent urinary tract infections

5. Have teams return to their charts and give them **5 minutes** to list emotional or behavioral signs of SGBV.
6. When time is up, have the teams report back on the signs they've listed. Supplement their responses with information from **Supplemental Content: Emotional and Behavioral Indicators** below.

Supplemental Content: Emotional and Behavioral Indicators

1. Ongoing emotional health issues (stress, anxiety, or depression)
 2. Suicidal thoughts or suicide attempts
 3. Repeated complaints of non-existent symptoms
 4. Overtly sexualized behavior (excessive masturbation, inability to distinguish affection from sexual behavior)
 5. Post-traumatic stress disorder
 6. Fear, guilt, or shame
 7. Hostility or aggressive behavior
 8. Development of speech impediments
 9. Insomnia or sleeping disorders
 10. Eating disorders
 11. Trouble in school or acting out, sudden changes in behavior
 12. Sexually aggressive or violent behavior
 13. Overreliance on a caretaker or partner for decision-making
7. Invite groups to clap for each other and sit back down. Explain to participants that many of these signs can be controversial or culturally specific, and they should not be seen as diagnostic. Remind participants that people react to trauma in different ways, and there are no “tests” that definitely diagnose adolescents who have experienced sexual and gender based violence.

Time: 30 minutes

8. Introduce the presentation **Content: Screening for SGBV** (Slides 13.1-13.6) below. Tell participants that the best screening tool they have in their toolbox is an open, accepting counseling manner and good history-taking.

Content: Screening for SGBV (Slides 13.1-13.6)

Slides 13.1.13.2: Cultural Environment

Providers should be aware of the different types of sexual and gender-based violence that are most commonly seen in the communities where they work.

1. Globally, about 1 in 3 of all women have experienced either physical and/or intimate partner violence in their lifetime.
2. 1 in 4 women aged 15 to 19 worldwide report sexual violence since the age of 15.
3. As many as 70% of adolescent women report their first sexual experience as forced.
4. 1 in 3 girls aged 13 to 15 experience regular bullying.
5. Globally, 40-68% of young women with disabilities and 16-30% of young men with

- disabilities experience sexual violence before the age of 18.
6. More than 200 million girls and women alive today have undergone female genital mutilation.
 7. 1 in 3 girls in the developing world are married before the age of 18.
 8. People who identify or are presumed to be lesbian, gay, bisexual, transgender, or intersex experience violence and discrimination, including bullying, physical and sexual assault, and murder at increased levels in all areas of the world. (Sources: WHO 2016b, UNICEF 2015, WHO 2014, WHO, *Girls not Brides*, Office of the High Commission on Human Rights, and Management Sciences for Health & UNFPA. 2016)

Slide 13.3-13.4: Screening Environment

What do you do if you suspect that an adolescent client has experienced sexual or gender-based violence?

1. Do not raise the issue in front of partners, parents, or caretakers. Only ask about violence when the client is alone.
2. Establish a safe, private, and confidential environment for the client.
3. Use empathetic, non-judgmental body language and words.
4. Use words that are appropriate and relevant, and that the client is most comfortable using.
5. When clients are adolescents with disabilities, use language that is accessible and understandable, taking into account the specific barriers that persons with different types of disabilities may face and providing accommodation as needed. On communication with adolescents with disabilities, please refer also to unit 7 and to the “Adolescents with Disabilities” chapter.
6. Start with normalizing statements, like:
 - *Many adolescents sometimes have problems with their parents and/or romantic partners and/or or someone with whom they live.*
 - *Sometimes I see health problems like this with other adolescents who have been having trouble at home and/or in school, and/or in their relationship.*
7. Maintain respectful attitude, calm voice, and eye contact as culturally appropriate.
8. Avoid distraction and interruption.
9. Take time to collect all needed information

Slide 13.5: Screening Questions

Source: WHO 2014

Here are some simple and direct questions you can pose if you suspect a client is experiencing SGBV:

1. Are you afraid of your parents/husband/wife/partner/caregiver?
2. Has anyone ever threatened to hurt you or physically harm you in some way? When did it happen?
3. Does someone at home or in your life bully or insult you?
4. Does your partner try to control you, for example, by keeping you in the house against your wish or not letting you out of the house when you desire to do so?

5. Has anyone forced you or pushed you to have sexual contact that you didn't want at the time?
 6. Has anyone threatened to kill you?
9. Ask participants if they have had an experience with a client that they suspected was experiencing violence but who didn't want to disclose to them. Ask a volunteer to share a story about the experience and what they did. Ask participants if they had a similar experience that involved clients with disabilities. If yes, ask a volunteer to share a story. Return to the presentation with **Slide 13.6: Disclosure.**

Slide 13.6: Disclosure

If you suspect sexual or gender-based violence, but the client does not appear willing to disclose, there are still things you can do to support them.

1. Give the client time and make sure they know they can come back for any reason.
 2. Tell them about services that are available if they need or decide to use them.
10. Close by reminding participants that this is an area that many clients aren't comfortable discussing with their health provider, regardless of their age or disability. Tell participants that in the next session they will be brainstorming and practicing some techniques for helping adolescent clients experiencing SGBV.

SPECIFIC OBJECTIVE 13.3: DEMONSTRATE HOW TO SCREEN FOR AND COUNSEL CLIENTS WITH A HISTORY OF SGBV



TIME

1 hour 25 minutes



METHODS

- Small group activity
- Trainer presentation
- Role play



MATERIALS NEEDED

- Participant Handout 13B: List of Barriers to Screening
- Slides 13.7-13.16



STEPS

1. Divide participants into pairs or small groups of three. Pass out **Participant Handout 13B: List of Barriers to Screening**.

Time: 20 Minutes

2. Explain that addressing SGBV and supporting adolescents who have experienced violence can be overwhelming for providers. Assign each barrier to one of the pairs or small groups (you can assign multiple barriers to a group if needed).
3. Ask the pairs or small groups to spend **5 minutes** brainstorming how to address each barrier they are assigned (if groups have more than one barrier, give them **5 minutes** each).
4. When time is up, have groups take turns reporting back on their barriers and responses and discussing with the whole group. Supplement their discussion using **Content: SGBV Barriers Discussion Guide** below.

Content: SGBV Barriers Discussion Guide

a. Time Constraints.

- *Clinics are already seeing clients who have experienced SGBV. SGBV is linked to a higher rate of repeat visits and increased use of services, and can be the cause of chronic or repeat SRH problems.*
- *Early Identification of and attention to SGBV can reduce repeat visits and protect clients' health.*
- *Developing a screening tool and referral program can make dealing with SGBV more time-efficient and less stressful for providers and clients.*

b. Lack of training about the issue.

- *Compassion, empathy, and commitment are important skills for providers to have to provide SGBV care.*
- *Knowledgeable providers could conduct a training for all clinic staff on how to identify, screen and refer women who have experienced SGBV.*

c. Provider feels there is nothing they can do to help.

- *While you may not be able to solve the problem, you can help by:*
 - *Identifying the problem;*
 - *Providing an opportunity for the client to talk;*
 - *Helping the client build a safety plan;*
 - *Helping the client identify a safe space to stay temporarily; and*
 - *Setting up a referral process to existing services.*

d. The clinic is not the place to address SGBV.

- *SGBV is closely tied to sexual and reproductive health problems, mental health issues, and other health concerns.*
- *If adolescents are already coming for SRH care, SRH services may be the only point of contact between adolescents and the health system.*
- *If there are no referral services in the community, the clinic may be the only place where SGBV is addressed.*
- *Screening for SGBV is the next logical action in comprehensive SRH care for adolescents.*

e. There are more important health issues to be addressed.

- *SGBV and its associated health consequences are just as – or even more – common than many other conditions for which providers routinely screen.*
- *SGBV can have significant effects on the clients' future SRH and other health outcomes and can span generations.*
- *Violence against children and SGBV are a global epidemic. All societies can agree on the need to reduce the level of violence faced by adolescents and children.*

f. Adolescents don't want to talk to their health providers about their experiences.

- *Research and clinical experience suggest that adolescents may be more likely to talk to health providers about their experiences, as health providers are seen as a "neutral" safe party.*
- *Many adolescents hope that someone will ask about their experiences or concerns. They may respond well to direct questions.*
- *Providers can ensure adolescents feel safe, by paying attention to privacy and confidentiality, using non-judgmental and empathetic language and engaging in active listening. These actions may encourage adolescents to open up more.*

g. Belief that SGBV is a private or shameful issue.

- *Staff already discuss sensitive or personal topics with clients of all ages.*
- *There is a great deal of cultural and community shame around SGBV and it is rarely discussed.*

- h. **Belief that SGBV doesn't happen in my community or with the clients that I see.**
 - *SGBV happens in all societies and within all different socio-economic classes.*
 - i. **Belief that SGBV is a "normal" part of growing up.**
 - *SGBV may be common but should never be "normal."*
 - *SGBV is a serious problem with concrete health consequences.*
 - j. **There are no services available for survivors, so why bother screening?**
 - *Health programs to identify the resources in their communities and build referral links with those services.*
 - *Screening for SGBV helps establish the link between SGBV and SRH outcomes.*
 - *Screening at health services can help create community awareness about and attention to SGBV.*
 - *Some health programs have started their own programs to deal with SGBV in communities where services are lacking.*
 - k. **Screening for SGBV is not the health provider's responsibility.**
 - *SGBV is an SRH issue, and screening for SGBV is the provider's responsibility.*
 - *If left untreated, SGBV can lead to more complicated SRH problems.*
 - *The provider is often the only person with the opportunity to screen for SGBV.*
5. Ask participants if they can think of any other barriers to SGBV screening or integration of SGBV services with SRH services. Emphasize that all of these barriers can be overcome.

Time: 30 minutes

6. Introduce **Content: SGBV Screening** (Slides 13.7-13.16) below. Tell participants that after the presentation, they will practice some basic screening techniques with each other in small groups.

Content: SGBV Screening (Slides 13.7-13.16)

Slide 13.7: LIVES Technique

When screening for SGBV with adolescent clients or clients of any age, providers can use the "LIVES" technique to identify emotional and practical needs at the same time.

Listen: Listen to the client closely, with empathy, and without judging.

Inquire: Assess and respond to the client's needs and concerns – emotional, physical, social, and practical.

Validate: Demonstrate that you understand and believe your client. Assure your client that they are not to blame.

Enhance safety: Discuss and help your client create a plan to protect themselves from further harm.

Support: Connect your client to information, services, and social support.

Source: Adapted from WHO 2014

Slides 13.8-13.9: Emotional Needs

The goal of first-line support and the LIVES technique is to provide emotional and practical care. It can include:

- Identifying the client's needs and concerns. Building trust and rapport by asking about neutral topics before delving into direct questions about the abuse.
- Listening and validating the client's experiences.
- Helping the client feel connected to others.
- Helping the client remain calm and hopeful.
- Empowering the client to feel able to help themselves and to ask for help.
- Exploring the client's options.
- Respecting the client's wishes.
- Helping the client find social, physical, and emotional support.

You do *not* need to:

- Solve the client's problems.
- Convince the client to leave a violent relationship.
- Convince the client to go for any other services.
- Convince the client to report to the police or any other authority.
- Ask detailed questions that make the client relive painful events.
- Ask the client to analyze what happened or why.
- Provide a justification or explanation for what happened.
- Pressure the client to tell you their feelings or reactions.

Sometimes, our actions can cause more harm than good despite our best intentions. Always pay close attention to the client's physical and emotional language and provide time and space for them to share on their own terms.

Slide 13.10: History Taking

- For reasons of confidentiality and safety interview clients on their own (e.g. away from parent/guardian/ or caregiver), while offering another adult as support.
- General medical information
- Gynecological history
- Questions about the assault
 - Only ask about what is needed for medical care (e.g. penetration, oral, vaginal, anal)

- Minimize need for client to repeatedly describe assault or history of abuse, as it can be re-traumatizing
- Explain Purpose:
 - Guide exam so injuries can be found and treated
 - Assess risk of pregnancy, STIs, HIV
 - Guide specimen collection and documentation
- Assessment of mental state
 - If signs of severe emotional distress, ask specific questions

Slides 13.11 – 13.16: Physical Exam

1. Obtain Informed consent for physical exam and each step.
 - a. What is informed consent?
 - The voluntary agreement of an individual who has legal capacity to give consent.
 - To provide “informed consent,” the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent.
 - Determining who is “legally” able to give consent for certain types of services will depend on the context in which you work.
 - Usually children under age 15 are not legally able to provide consent on their own,
 - The process of obtaining informed consent may require longer time when there are communication barriers linked to a client’s disability. This does not absolve a service provider of their obligation to obtain informed consent. On the contrary, providers must ensure whatever accommodation necessary in order to allow smooth communication with the client. Refer to the “Adolescents with Disabilities” chapter for additional inputs on the subject.
 - b. There are three key components to the informed consent process:
 - Provide all possible information and options to a survivor in a way they can understand.
 - Determine if they can understand this information and/or their decisions. This is also referred to as “capacity to consent”)
 - Ensure that the decisions of all survivors, including survivors with disabilities, are voluntary and not coerced by others such as family members, guardians, caregivers or even service providers.
2. Describe the four aspects of the exam to the client:
 - Medical
 - Pelvic

- Forensic evidence collection
 - Release of medical information/ evidence to police (if she wants legal redress).
3. Tell the patient that s/he is in control of this exam.
 - They should tell you to stop any time they feel uncomfortable.
 - For reasons of confidentiality and safety the patient's parent(s) or caregivers should be asked to leave so that the young person has total privacy.
 - Some survivors of sexual violence may find a physical exam traumatizing. Always allow the client to reschedule. Never act impatient or annoyed if they ask to stop or pause for any reason.
 4. When conducting the exam, have an observer present, preferably a trained support person or same sex health worker.
 - Introduce and explain role of observer
 - Besides the observer, keep the number of people to a minimum
 5. Ask if there is any additional or specific support that the client desires such as a friend or family member.
 6. Ask if the client is comfortable with a male provider examining her. If not, find a female provider.
 7. Communicate to patient during the exam what will happen next. "I will be examining your _____".
 - During a physical exam the provider should report what they observe in a non-emotional, non-judgmental way. "I see you have a small cut here, does it hurt?"
 - Do not explain any diagnosis or ask further questions about the possibility of sexual abuse until after the client is fully clothed and the exam is over.
 8. If necessary, translate all information into the clients' language to make sure they understand. Ensure accommodation is provided as needed to allow full and smooth communication with clients with different types of disabilities.
 9. Close the presentation by asking if there are any questions about screening or the counseling environment for adolescents who have experienced SGBV.

Time: 45 minutes

10. Divide participants into three groups. Each group should identify one person to play the provider and one to play the client.
11. Assign each "client" one of the roles from **Content: SGBV Case Studies** below.

Content: SGBV Case Studies

Client #1: A is a 14-year-old girl with a hearing disability. She does not know sign language but she can read and write. You start communicating with her in writing using a pencil and a piece of paper. She tells you that she has been sent to the clinic by her mother. She seems very depressed and has stopped eating. She shares with you that she is afraid to use the community latrine. When encouraged, she tells you that a few nights ago a neighbor followed her to the toilet and forced himself on her. She is afraid to tell her parents because she knows that they will blame her for “enticing” the neighbor.

Client #2: T is a 13-year-old boy. He comes to you because he is planning to have sex for the first time but seems reluctant or scared. He tells you that his father has hired a sex worker to “teach” him about sex and help him “become a man.” He has bruises on his arms and neck, which he says are from the boys at school. He says that he has always been made fun of for being too feminine, but that recently the boys have started beating him physically. His father thinks the sex worker will “fix” him and solve this problem.

Client #3: S is a 15-year-old girl. She comes into the clinic frequently, complaining of genital pain, discharge, or itching. She never seems to have any real symptoms and has been a challenge to treat. On this most recent visit, her boyfriend accompanies her to the clinic. He seems impatient and irritated with being there, and when he is in the room she appears extremely anxious and defers all questions to him.

Client #4: B is a 16-years old girl with Down syndrome. She comes to you because she is having sex with her boyfriend and she is afraid to get pregnant. He is her neighbor and he is 21. She asks you not to say anything to her parents because, as he told her, they would not approve if they knew she has a boyfriend who is different from her, who does not have Down syndrome. You suspect he is taking advantage of her.

12. In the groups, ask participants to spend **10 minutes** playing out the role they’ve been assigned, while the rest of the group observes. Remind the participants that the volunteer playing the provider should consider the pieces of the LIVES technique. The group members observing should watch for empathy, language, and successful identification of the client’s emotional and practical needs.
13. Allow **10 minutes** for the role play. Then ask groups to stop, and have the observers report back to the volunteers what they think the “provider” did well, what needed improvement, and any suggestions for how to treat this client. Allow an additional **15 minutes** for this feedback.
14. Reconvene the larger group. Ask for general feedback using the following discussion questions:
 - a. *Is it difficult or uncomfortable to ask questions about SGBV?*
 - b. *Is it more difficult or uncomfortable when the client has a disability?*

- c. *How comfortable was it for the client to answer those questions?*
- d. *How can we as providers help make these conversations easier for all our clients, including clients with disabilities?*

15. Thank participants for their time and close the discussion.



PARTICIPANT HANDOUT 13B: BARRIERS TO SGBV SCREENING

What are some responses to these barriers?

1. Time Constraints.

2. Lack of training about the issue.

3. Provider feels there is nothing they can do to help.

4. The clinic is not the place to address SGBV.

5. There are more important health issues to be addressed.

6. Adolescents don't want to talk to their health providers about their experiences.

7. Belief that SGBV is a private or shameful issue.

8. Belief that SGV doesn't happen in my community or with the clients that I see.

9. Belief that SGBV is a “normal” part of growing up.

10. There are no services available for survivors, so why bother screening?

11. Screening for SGBV is not the health provider’s responsibility.

SPECIFIC OBJECTIVE 13.4: IDENTIFY CLINICAL CARE NEEDS AND APPROPRIATE SERVICES FOR SURVIVORS OF SGBV



TIME

55 minutes



METHODS

- Trainer presentation
- Group brainstorm



MATERIALS NEEDED

- Slides 13.17-13.22
- Flipcharts and markers



STEPS

Time: 25 minutes

1. Introduce the topic by explaining to participants that while they have discussed and practiced counseling and screening techniques, they will also need to be aware of the clinical services needed by and available to survivors of SGBV.
2. Present **Content: Services for Survivors** (Slides 13.17-13.22) below.

Content: Services for Survivors (Slides 13.17-13.22)

Source: Adapted from WHO 2014

Slide 13.17: Physical Exam

In cases of SGBV, the physical exam can be both a vital health service and a record of evidence for the police or other authorities. If you suspect that a client has been subjected to SGBV, consider the need for evidence collection as you provide services.

After taking a history, explain the physical exam to the client and obtain informed consent. Explain that you will be writing down what you see during the exam, the same as you would for any health service. Reassure the client that they are in control, and can ask you to stop, pause, or not record anything at any point during the exam.

3. Pause and distribute **Participant Handout 13C: Physical Exam Checklist**. Review the content with participants and leave time for clarifying questions or discussion.
4. Return to the presentation with **Slide 13.18: Recording Findings** below.

Source: Adapted from WHO 2014

Slide 13.18: Recording Findings

Health care providers are sometimes asked to answer questions from the police, lawyers, or other authorities about injuries to women and adolescents they have treated. While confidentiality of the patient must be prioritized, sometimes careful documentation of findings and treatment on the history and exam form can make the difference in protecting and helping a client find justice.

Authorities will look for:

- Type of injury (cut, bruise, abrasion, fracture, other)
- Description of the injury (length, depth, other characteristics)
- Where on the body the injury can be found
- Possible cause of injury (e.g. gunshot, bite marks, knife, other)
- The immediate and potential long-term consequences of the injury
- Treatment provided

Slides 13.19-13.20: Treatment

In addition to the medical treatment of injuries, some particular SRH services may be necessary for adolescents who have experienced SGBV. Some treatments to consider include:

Emergency Contraception: Should be taken as soon as possible. EC can be administered up to five (5) days after an assault. Any woman can take EC, and there is no need to screen for health conditions or test for pregnancy. EC pills will not cause abortion to an established pregnancy.

Emergency Copper IUD: Can provide emergency contraception if inserted within 5 days after an assault. Should only be used for women interested in the IUD and long-term contraception.

STI prevention: Adolescents who have been sexually assaulted can be given antibiotics to prevent or treat potential bacterial infection with chlamydia, gonorrhea, trichomonas, and syphilis. There is no need for testing before treatment.

Hepatitis B Vaccine: Clients who haven't been vaccinated for hepatitis B can receive the first dose at the visit and come back for the rest of the course. If the client is uncertain, test first for antibodies before providing the vaccine.

HIV Post-Exposure Prophylaxis (PEP): PEP can be given to clients within 72 hours of an assault. PEP should be given if the perpetrator is of unknown HIV status, the client's HIV status is unknown, and the client does not want to wait for a test.

5. Ask participants if there are other services or treatments with which clients should be provided following an assault. Ask when they think clients should come back for follow-up and discuss what kinds of follow-up would be needed. Record their responses.
6. Tell participants that some forms of SGBV need specific attention. Return to the presentation with **Slide 13.21: Services for Adolescent Survivors of Childhood SGBV**

Slide 13.21-13.22: Services for Adolescent Survivors of Childhood SGBV

Many clients will have experienced violence at an earlier point in their lives, and it is important to be aware of their SRH needs.

- **Female genital mutilation (FGM)/female genital cutting (FGC):** Adolescent clients who have experienced FGM/FGC may have particular concerns about their genital health, ability to experience sexual intercourse, and need for contraception. Depending on the type of FGM/FGC, girls and young women may also experience infection, inflammation, or severe pain. For adolescents with type III FGM (the most severe form, also known as infibulation), deinfibulation by a trained health professional is recommended. Counseling for preventing or treating female sexual dysfunction is recommended for all women living with FGM.
 - **Young Married Women:** While some adolescents marry before the age of 18 by choice, many women who marry young are forced or coerced by their families, communities, and future spouses. These young women, particularly those married to older men, may be at increased risk for intimate partner violence, STIs and HIV, and pregnancy. They should be screened for violence and counseled on contraception and STI /HIV prevention.
7. Ask if there are any other special concerns that providers have about adolescents in their communities. Take some time to brainstorm specific services, counseling, and social protection services for these adolescents. Discuss if these services are accessible and/or used by adolescents with disabilities and related experiences.

Time: 30 Minutes

8. Break participants into four groups. Assign the groups to the two case studies. Read the scenarios from **Content: Case Studies** below.

Content: Case Studies

a) K comes into your clinic because she thinks she might have an STI. She is 16. After talking with her, you discover that her older cousin, aged 19, who lives with her family, has been forcing her to have sex.

b) K comes into your clinic because she thinks she might have an STI. She is 16 and has a visual disability. After talking with her, you discover that her older cousin, aged 19, who lives with her family, has been forcing her to have sex.

9. Ask each group to brainstorm what steps they would take to make sure K was safe and received assistance. Ask the groups to focus on what services the client would need. Give groups **15 minutes** to discuss.
10. Ask groups to share back with the larger group. Compare their responses, clarify any differences,

and highlight which differences are linked to K's disability.

- 11.** Close by reminding participants that sexual and gender-based violence is a very complex problem. The provider can only do so much. It is important to do what one can but not feel discouraged because one provider cannot solve the whole problem.



PARTICIPANT HANDOUT 13C: PHYSICAL EXAM CHECKLIST

Source: WHO 2014

Job Aid

Physical exam checklist	
Look at all the following	Look for and record
<ul style="list-style-type: none">• General appearance• Hands and wrists, forearms, inner surfaces of upper arms, armpits• Face, including inside of mouth• Ears, including inside and behind ears• Head• Neck• Chest, including breasts• Abdomen• Buttocks, thighs, including inner thighs, legs and feet	<ul style="list-style-type: none">• Active bleeding• Bruising• Redness or swelling• Cuts or abrasions• Evidence that hair has been pulled out, and recent evidence of missing teeth• Injuries such as bite marks or gunshot wounds• Evidence of internal traumatic injuries in the abdomen• Ruptured ear drum
Genito-anal examination	
<ul style="list-style-type: none">• Genitals (external)• Genitals (internal examination, using a speculum)• Anal region (external)	<ul style="list-style-type: none">• Active bleeding• Bruising• Redness or swelling• Cuts or abrasions• Foreign body presence

UNIT 13 SUMMARY



TIME

10 minutes



METHODS

- Individual reflection



MATERIALS NEEDED

- Empty box or bag
- Index cards



STEPS

1. Place an empty box or bag at the back of the room. Distribute one index card to each participant.
2. Ask participants to place their heads down on the table or lie down and close their eyes. Instruct the participants to keep their eyes closed while taking 8 slow, deep breaths.
3. While participants are breathing, remind them that some challenges we deal with as providers can take an emotional toll. Ask them to reflect on how they are feeling after today's discussion. Remind them of the importance of self-care for professionals who provide SGBV services.
4. Tell participants that when they are ready, they can open their eyes. Ask participants to please write one thing they learned today on their index card and leave it in the empty box at the back of the room on their way out.

UNIT 14:

ADOLESCENT BIRTH, POSTPARTUM CARE, AND PARENTING

INTRODUCTION:

Every year, 16 million women aged 15 to 19 and 1 million girls under the age of 15 give birth. The birth of a child is both an exhilarating and an exhausting experience, and sometimes a dangerous one. Complications during pregnancy and childbirth are the second most common cause of death for women aged 15 to 19 years old globally, and children born to adolescent mothers face a substantially higher risk of dying before their fifth birthday than children born to women over the age of 19. Moreover, the risk of prolonged labor and therefore obstetric fistulas is higher among young women. Young mothers are also more likely to have long-term complications (such as urinary incontinence) and to experience postpartum depression. Adolescent mothers may face discrimination and often struggle to finish their education, find meaningful work, or to get the support they need to ensure their own and their children's health. To successfully help the adolescent through pregnancy, childbirth and motherhood, providers need to distinguish how an adolescent's emotional and physical needs are different from those of an adult woman and develop appropriate responses.

UNIT TRAINING OBJECTIVE:

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




SPECIFIC LEARNING OBJECTIVES:

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

1. identify the essential components of routine antenatal care for adolescents.
2. Identify the psychosocial and SRH needs of adolescents during birth and the immediate postpartum period.
3. Discuss challenges facing adolescent parents, parenting skills, and infant feeding.

TOTAL TIME: 2 HOURS 40 MINUTES

UNIT OVERVIEW:

Session	Methods 	Materials 	Time 
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14.1	Group brainstorm Quiz	Flipcharts and markers Trainer's Tool 14a Slides 14.1-14.8	1 hour
14.2	Trainer presentation	Slides 14.9-14.13	20 minutes
14.3	Small group activity Trainer presentation Group discussion	Flipcharts Extra markers, art supplies, magazines, tape Slides 14.14-14.24	1 hour
Unit Summary	Reflection		20 minutes



WORK FOR TRAINERS TO PREPARE IN ADVANCE:

- Review Slides 14.1-14.24 and localize content as needed.
- Prepare Trainer's Tool.
- SO 14.3: Collect extra markers, art supplies, magazines, and tape or glue.



MAJOR REFERENCES AND TRAINING MATERIALS:

EngenderHealth. 2008. *Youth-friendly Services for Married Youth: A Curriculum for Trainers*. New York, NY: EngenderHealth.

London School of Hygiene and Tropical Medicine (LSHTM). 2019: Access to health services for 1 billion people with disabilities: <https://www.lshtm.ac.uk/research/centres/international-centre-evidence-disability/missing-billion>

Office of the High Commissioner on Human Rights (OHCHR), et al. 2014. *Eliminating forced, coercive and otherwise involuntary sterilization: An interagency statement – OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF and WHO*. https://apps.who.int/iris/bitstream/handle/10665/112848/9789241507325_eng.pdf?sequence=1

Pathfinder International. 2016. *Providing Reproductive Health Services to Young Married Women and First-time Parents: A Supplemental Training Module for Facility-based Health Care Providers*. Watertown, MA: Pathfinder International.

World Health Organization (WHO). 2016. *Guideline updates on HIV and infant feeding: the duration of breastfeeding, and support from health services to improve feeding practices among mothers living with HIV*. Geneva: WHO.

World Health Organization (WHO). 2014. *Adolescent Pregnancy: Factsheet*. Geneva: WHO.

<http://www.who.int/mediacentre/factsheets/fs364/en/>

World Health Organization (WHO). 2010. *Adolescent job aid: A handy desk reference tool for primary level health workers*. Geneva: WHO.

SPECIFIC OBJECTIVE 14.1: IDENTIFY THE ESSENTIAL COMPONENTS OF ROUTINE ANTENATAL CARE FOR ADOLESCENTS



TIME

1 hour



METHODS

- Group brainstorm
- Trainer presentation
- Quiz



MATERIALS NEEDED

- Flipcharts and markers
- Slides 14.1-14.8
- Trainer's Tool 14a: Quiz Game Questions
- Tape



STEPS

Time: 10 minutes

1. Set up a flipchart at the front of the room. Introduce the topic to participants with **Content: Introduction** below.

Content: Introduction

The World Health Organization reports that every year, 16 million women aged 15 to 19 and 1 million girls under the age of 15 give birth. The birth of a child is both an exhilarating and an exhausting experience, and sometimes a dangerous one. Complications during pregnancy and childbirth are the second most common cause of death for women aged 15 to 19 years old globally, and children born to adolescent mothers face a substantially higher risk of dying than those born to women over the age of 19.

2. Write the word "Risk" at the top of the flipchart page. Ask participants to brainstorm reasons why pregnancy and childbirth in adolescence is more dangerous. Record their responses, supplementing as needed from **Supplemental Content: Adolescent Pregnancy Risks** below.

Supplemental Content: Adolescent Pregnancy Risks

Pregnant adolescents have a higher clinical risk of:

- Premature labor
- Hemorrhage
- Obstructed or prolonged labor
- Iron-deficiency anemia
- Spontaneous abortion/miscarriage

- Fistula

Pregnant adolescents also have higher risks for:

- Stigmatization of pregnancy
- Unsafe abortion
- Malnutrition
- Violence from families or partners

3. Ask participants to review the flipchart with the risks.

Time: 20 minutes

4. Introduce the presentation **Content: Antenatal Care for Adolescents** (Slides 14.1-14.8) below by telling participants that while the bulk of antenatal care for adolescents is the same as antenatal care for women over the age of 20, there are specific risks require some additional attention.

Content: Antenatal Care for Adolescents

Slide 14.1: Steps of Antenatal Care

1. Assess the pregnant adolescent
2. Respond to observed signs or volunteered problems
3. Give preventive measures
4. Advise and counsel on nutrition and self-care
5. Develop (or review) the birth and emergency plan
6. Advise and counsel on contraception after delivery
7. Advise on routine and follow-up visits

(Source: WHO Job Aid 2010)

5. Pause and ask participants for a few examples of things they should include in a history to assess risk for a pregnant adolescent. Return to the presentation with **Slide 14.2: Adolescent Risk Assessment** below.

Slides 14.2-14.3: Adolescent Risk Assessment

Assess whether you think your client is at high risk. In addition to her age, some factors to look for include:

- Parity: Is this her first pregnancy? Is this a closely spaced pregnancy (less than 2 years after a previous birth? Less than 6 months after a miscarriage or abortion?)
- Delivery site: Has she planned and/or prepared where she will deliver?
- Family support: Does she have enough food, money, help with work/chores and adequate opportunities to rest and attend ANC clinics?
- Interpersonal violence: Are there signs of domestic or intimate partner violence?
- Does she have any type of disability that might require additional attention or accommodation?

- Is there a history of:
 - Anemia
 - Abdominal surgery
 - Genital tract surgery
 - Female genital mutilation/female genital cutting
 - Blood transfusion
 - STIs, including HIV
 - Sickle cell, heart disease, diabetes, epilepsy, asthma, or tuberculosis
 - Drug or alcohol use
 - Malnutrition
6. Pause and ask participants to think about what else to include in a standard adolescent antenatal visit. Return to the presentation with **Slide 14.4: The Antenatal Visit** below.

Slide 14.4-14.5: The Antenatal Visit

In addition to standard screening and counseling, screen the adolescent for anemia and offer specific counseling on nutrition. Help the client to establish a birth plan.

Nutrition: adolescents may not have much knowledge about nutrition, either for the fetus or herself. Take a diet history: ask your patient what she usually eats and how much. Adolescents who are not yet physically mature and are still growing will need a higher nutrient intake.

Advise the client to eat the following foods. Counsel her not to overcook the food, because cooking food too long destroys folic acid, an important nutrient.

- Protein: meats, fish, beans, eggs and nuts.
- Calcium, particularly during breastfeeding: milk, yogurt, cheese, green leafy vegetables, bone meal, beans, soy, and shellfish.
- Zinc: spinach, beef, shrimp, kidney beans, flax and pumpkin seeds.
- Iron: egg yolk; groundnuts; dried navy and lima beans, dried apricots, peaches, prunes, figs, dates, and raisins; molasses; fish and meat; sunflower seeds; nuts; spinach, amaranth leaves.
- Folic acid: dark green leafy vegetables, liver, fish, nuts, legumes, eggs, whole grains and mushrooms.

Slide 14.6: Developing a Birth Plan

The place most suitable for birth may depend on many factors, including but not limited to the client's age poverty, illiteracy, as well as any disability.

In situations that require support from a caregiver to be present throughout the pregnancy and birth, the caregiver should be included in the birth plan.

Indications for delivery at referral hospital level:

- Age less than 14 years

- Transverse lie or other obvious malpresentation within one month of expected delivery
- Obvious multiple pregnancy
- Prior delivery by caesarean
- Documented third degree tear
- History of or current vaginal bleeding or other complication during this pregnancy
- Tubal ligation or IUD desired immediately after delivery

(Source: WHO 2010)

Indications for delivery at primary health care (or higher) level

- Age less than 16 years
- First birth
- Prior delivery with heavy bleeding
- Prior delivery with convulsions
- Prior delivery by forceps or vacuum
- Last baby born dead or died within first day
- More than six previous births

(Source: WHO 2010)

Slide 14.8: Other Considerations

Advise the client about the following considerations when making a birth plan.

- Decrease her workload and increase rest in the third trimester
- Know the signs of labor/danger signs
- Make arrangements for transport before birth, and be aware of costs
- Plan for delivery costs
- Pack clean clothes and cloths for herself and the baby, any home-based maternal records
- Make sure there is care for other children while she is at the facility
- Identify a person who can support her during delivery
- Start thinking about whether or not she will use contraception after delivery. Which method might be best for her contraceptive needs? When should she plan to start?

7. Stop and ask participants to volunteer any other considerations they think should be discussed with pregnant adolescent clients. Discuss any questions or clarifications.

Time: 30 minutes

8. Divide participants into three teams. Have teams come up with a group name while you tape up quiz questions from **Trainer's Tool 14A: Quiz Game Questions** to a flipchart at the front of the room, with questions covered so they cannot be read.
9. Explain that the point of the game will be to see which team can answer the most questions correctly. Point out the questions: explain that the teams will take turns

choosing a question. Once the question is read, the first team to get the answer “wins” the points.

- 10.** Play the game – have the teams alternate choosing questions from the flipchart. Accept short answers during the game.
- 11.** Once all questions have been answered, review the questions again, this time going into more detail about the answers using the long answer on the card. Clarify any questions from participants during the discussion.
- 12.** Close by asking how providing care for an adolescent is different from providing care for an older pregnant woman. Ask how the addition of other vulnerability factors (disability, HIV positive, street life, poverty, etc.) may influence the care to be provided to the adolescent client. Discuss participants’ responses.

TRAINER'S TOOL 14A: QUIZ GAME QUESTIONS

Preparation Instructions: Print or write each question onto a separate card or colored sheet of paper.

Question 1: Which contraceptive methods should not be used by young women under the age of 25 who have had children?

Short Answer 1: None.

Long Answer 1: All women and young persons, including women and young persons with disabilities, have a right to equal access to voluntary family planning and modern contraceptive methods, as well as counselling on how to safely and effectively use them. Nearly all contraceptive methods are safe for women of all ages. This includes pills, injectables, implants, IUDs, condoms, and more. While age or parity is not a clinical contraindication for any method, sterilization is the only method that is considered contraindicated for most young women due to their stage of life and the permanent nature of this method. Young women who request sterilization should not be denied the method based on their age, but counseled on the permanence of the method and other options available to them to ensure informed choice. Like any other contraceptive method, sterilization should only be provided with the full, free and informed consent of the individual. However, in some countries, people belonging to certain population groups, including people living with HIV, persons with disabilities, indigenous peoples and ethnic minorities, transgender and intersex persons, continue to be sterilized without their full, free and informed consent. In particular for persons with disabilities, coercive and involuntary sterilization as well as long-term contraception are often used as a method of fertility regulation on a precautionary basis. Women with intellectual and developmental disabilities, who are often treated as if they have no control—or should have no control—over their sexual and reproductive choices, are particularly vulnerable to these practices. The United Nations Committees on the Rights of the Child and on the Rights of Persons with Disabilities have specifically addressed forced and coercive sterilization of persons with disabilities including children under the age of 18 years. They have recognized that forced and coercive sterilization is a form of violence and have called for states to revise laws and administrative measures to prohibit this practice.

All clients should also be told that only male or female condoms alone or condoms used with another contraceptive method protect from both unintended pregnancy and STIs, including HIV.

Question 2: When should a pregnant adolescent begin to consider postpartum contraceptive use?

Short Answer 2: During antenatal counseling, as early as possible.

Long Answer 2: Initial counseling on postpartum contraceptive use and healthy timing and spacing of pregnancy should happen during the antenatal visits. Adolescent clients should be told that they can become pregnant again within four weeks after delivery if they are not exclusively breastfeeding and they resume sexual activity. They should at least begin to consider what contraceptive method they might wish to use and when. IUDs can be inserted within a 48-hour window post-delivery. (After 48 hours, IUD insertion must be delayed until four weeks postpartum). Implants can be inserted after childbirth and before discharge.

(Source: WHO 2010)

Question 3: Which contraceptive methods can be used while a woman is breastfeeding?

Short Answer 3: LAM, mini-pills, implants, IUDs, and condoms.

Long Answer 3: Lactational Amenorrhea Method, or LAM, only prevents pregnancy IF the baby is less than 6 months old, the baby is exclusively breastfed (e.g. the baby is fully breastfed on average every 4 hours, and no other food is given), and the woman's monthly bleeding has not returned. Other methods can be combined with LAM to prevent unintended pregnancy: the woman/couple can use the mini-pill (progestin-only), implants, IUDs, and male and female condoms during the postpartum period and while breastfeeding.

Question 4: What are symptoms of pregnancy in an adolescent client?

Short Answer 4: Missing monthly bleeding, breast tenderness, nausea or vomiting.

Long Answer 4: Standard symptoms of pregnancy include: late or missing monthly bleeding, nausea or vomiting in the morning, and swelling or soreness of breasts. All of these symptoms are also common for adolescents going through puberty, so providers counseling clients concerned about pregnancy should also check if the client is sexually active, is using any contraceptive method, whether contraceptive use is regular or sporadic, and if the client has had sex since her last monthly bleeding.

(Source: WHO 2010)

Question 5: Give 3 examples of times when a provider can discuss contraception with an adolescent client.

Short Answer 5: *(Any three of the following)* standard health visits, HIV voluntary counseling and testing, prenatal consultations, postnatal consultations, visits to monitor infant health, and vaccination visits.

Long Answer 5: Every interaction with an adolescent client is an opportunity for contraceptive counseling. For pregnant adolescents and young parents, counseling on the importance of spacing births should begin during prenatal consultations. If a woman wants to space her next pregnancy, she can begin to think about which contraceptive method she might want to use

during the postpartum period. Postpartum checks and child health visits are also a good opportunity to provide counseling on healthy timing and spacing of pregnancy and contraception.

Question 6: Give 4 examples of ways in which confidentiality can be maintained during a consultation with a pregnant adolescent client, a young married woman, or young mother, an adolescent client with a disability.

Short Answer 6: *(Any of the following)* Carry out the consultation in a separate or partitioned room, make sure no one other than members of staff required for the consultation are present, keep any notes in a locked place, do not call out the client's full name or reason for her visit in the waiting area, do not discuss the consultation with anyone (including her husband, partner, family, or family-in-law, or caregiver). In the case of pregnant adolescent clients with disabilities who are accompanied by an assistant or a sign language interpreter whose presence in the consultation room is explicitly authorized by the client, remind the assistant/interpreter that the information shared during the consultation needs to be kept confidential at all times.

Long Answer 6: Young married women will often experience significant pressure to conceive, particularly if they have not yet had a child. Young mothers may also be expected to have several children in rapid succession and may be discouraged from obtaining contraception. On the other hand, young adolescents with disabilities are often vulnerable to coercive and involuntary sterilization, abortion, as well as long-term contraception, which are often requested by parents or guardians based on the justification that it is "for their own good". It is important to maintain client confidentiality when counseling and treating young married women, young mothers, soon-to-be-mothers, or adolescent clients with disabilities so that they are able to make the best decisions for their needs.

SPECIFIC OBJECTIVE 14.2: IDENTIFY THE PSYCHOSOCIAL AND SRH NEEDS OF ADOLESCENTS DURING BIRTH AND THE IMMEDIATE POSTPARTUM PERIOD



TIME

20 minutes



METHODS

- Trainer presentation



MATERIALS NEEDED

- Slides 14.9-14.13



STEPS

1. Introduce the topic: remind participants that adolescence is a time of immense change, and that providing support for adolescents during birth and the postpartum period will likely require patience, compassion, and understanding.

Time: 20 minutes

2. Ask if participants can suggest ways for each other on how to supportively manage adolescent clients during birth. Transition into the presentation **Content: Support during Birth and Postpartum** (Slides 14.9-14.13) below.

Content: Support during Birth and Postpartum (Slides 14.9-14.13)

Slide 14.9: Birth

- Adapt your demeanor to the adolescent's individual needs to support her efforts. Provide caring, clear and understandable explanations throughout.
- Create an atmosphere of inclusion with family or support people.
- When preparing to perform examinations and procedures, clearly 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: shouting is not acceptable.
- Please take in account that some kinds of disability can make the typical lithotomy position during actual birth not the best choice for some women. Providers must be prepared to deliver in alternate positions with the possibility of assistive devices.

Slide 14.10: Immediate Postpartum Care

- As with most new mothers, the adolescent will be concerned if the baby is not close to her. Other mothers need rest or some time alone. Ask the mother what she wants without pressing her into immediately taking care of her baby.

- 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—pride, accomplishment, fatigue, and hormonal shifts.
 - Adolescent mothers have the compound challenge of needing to establish their own identity while they adjust to their new role and identity as a mother.
 - If the adolescent has elected for immediate contraception (e.g. IUD insertion), provide contraception or contraceptive advice.
 - Before the adolescent leaves the facility, explain which signs of postpartum complications she should watch for and remind her when to for follow-up.
3. Pause and ask participants what they can do within the first hour to facilitate mother-child bonding. Supplement their responses with **Supplemental Content: Mother-Child Bonding** below.

Supplemental Content: Mother-Child Bonding

- Keep mother and baby together as much as possible.
 - Conduct preliminary infant examination in the presence of the mother and include her.
 - Show her the unique aspects of her baby.
 - Have her touch the baby’s head, count fingers and toes.
 - Point out to her the baby’s normal reflexes.
 - Assist her to breastfeed with correct attachment
 - If the newborn has any visible impairment, be reassuring and tell the young mother that she will receive the information and support needed to find the appropriate care for her child.
 - The need and importance of Mother-Child bonding is NOT impacted by disability. Do not make decisions for the mother based on the fact that she has a disability but always ask her what she feels is best for her. She is in the best position to decide as she has been living with her disability for long time or for her entire life and she knows what she can or cannot do.
4. Return to the presentation with **Slide 14.11: Postpartum Period** below.

Slide 14.11-14.12: Postpartum Period

The first 6 weeks following a birth is a time of tremendous adjustment that will affect the young mother physically and emotionally. Circumstances could be even more challenging for young mothers with disabilities. For this reason, postpartum care should not be focused on the infant only but it should also take into account the specific situation of the mother and her needs. Care should be provided according to the mother’s needs in an enabling environment that fosters her self-confidence. Care must not be provided on the basis of assumptions about what the mother cannot do or which tasks she has difficulties with. The young mother will need support not only from the provider but from her family and social network. This support is not always

available in a community that stigmatizes adolescent pregnancy, especially if she is not married. This can leave adolescent mothers at risk for postpartum depression.

Many new mothers feel some sadness or “blues,” usually within a week following birth, ranging from mild (feeling “down,” teary, unexplained sadness, easily upset) to more profound. Providers should watch for signs of severe postpartum depression:

- Loss of interest in things the client used to enjoy
- Anxiety or panic attacks
- Extreme mood swings
- Development of disordered eating
- Crying uncontrollably for long periods of time
- Misery
- Trouble sleeping
- Disinterest in the baby, family, or friends

Source: American Psychological Association, 2007

Please consider that women with disabilities face a greater risk of developing postpartum depression (PPD) than women without disabilities. Screening for the main mood disorders and raising the awareness of family members on PPD are key factors for providing timely and adequate care.

5. Pause and ask participants what they think the provider’s role should be during the postpartum period. Return to the presentation with **Slide 14.13: Clinical Care in the Postpartum Period** below.

Slide 14.13: Clinical Care in the Postpartum Period

- Home visits: Starting within 48 hours of discharge.
 - Scheduled follow-up visits at 2, 4, and/or 6 weeks after birth which will address:
 - Problem-solving common physical discomforts: increased perspiration, perineal pain, breast engorgement, constipation, haemorrhoids
 - Nutrition and hydration, especially if breastfeeding
 - Correct breastfeeding and mother-child interaction
 - At 4 or 6 weeks, take a complete history and perform a complete physical examination.
 - Encourage experienced caretakers and family members to support the young mother without taking over direct care of the baby.
 - Connect the new mother with other young mothers or new mother support networks within the community.
 - Provide contraceptive counselling and supplies, support future planning for healthy timing and spacing of pregnancy.
6. Ask participants if they remember from the previous session which contraceptive methods are safe for breastfeeding mothers in the immediate postpartum period. Remind them of the need to include counselling on healthy timing and spacing of pregnancy during prenatal, postnatal, and follow-up visits.

SPECIFIC OBJECTIVE 14.3: DISCUSS CHALLENGES FACING ADOLESCENT PARENTS: PARENTING SKILLS, AND INFANT FEEDING



TIME

1 hour



METHODS

- Small group activity
- Trainer presentation
- Group discussion



MATERIALS NEEDED

- Flipcharts and markers
- Extra markers, art supplies, magazines, scissors, and tape
- Slides 14.14-14.24



STEPS

Time: 30 minutes

1. Ask participants to brainstorm some of the challenges that young people in their community face when they become parents keeping in mind some of the vulnerability factors mentioned earlier on in the unit such as disability, HIV, poverty, etc. Flipchart their responses at the front of the room.
2. Divide the participants into small groups of 3-4 people each. Give each group a flipchart page.
3. Explain to the groups that the purpose of this exercise is to visualize the challenges and pressures on young parents. Instruct groups to draw two figures on their flipchart. These two figures represent the new parents.
4. Place the art supplies, magazines, scissors, and tape at the front of room. Tell groups that they will have **20 minutes** to create a picture of young parents which shows the challenges they face in their relationship, as parents, and in society.
5. While participants are working in their small groups, go around the room and monitor their progress. If it seems like groups are getting stuck, give them some ideas from **Supplemental Content: Challenges for Adolescent Parents** below.

Supplemental Content: Challenges for Adolescent Parents

- Feelings of inadequacy
- Feeling unprepared

- Confusion
 - Anxiety about the baby's health
 - Social isolation or discrimination
 - Resentment or depression over loss of leisure
 - Family or community disapproval
 - Policies barring re-entry to school
 - Loss of work
 - Concerns about being "left behind" peers
 - Challenges in maintaining a relationship
 - Fatigue
6. Have one representative from each group present their flipchart to the whole group. Allow time for clarifying questions or reactions after each presentation.
7. Facilitate a plenary discussion about the activity using the following discussion questions:
- a. *Which of these challenges are internal and which are external/social?*
 - b. *Are there different challenges based on the gender of the parent?*
 - c. *Are there different challenges for young mothers with disabilities?*
 - d. *How do the challenges affect the adolescent parent's physical, mental and emotional health and ability to care for a child?*
 - e. *How can providers support new parents with and without disabilities and their families and communities?*
8. On a flipchart, record responses to question above, "How can providers support new parents with and without disabilities and their families and communities?"

Time: 30 minutes

9. Ask participants to review their responses and consider what specific support adolescent fathers might need. Begin presentation **Content: Adolescent Parenting** (Slides 14.14-14.24) below with **Slide 14.4: What Adolescent Fathers Need** below.

Content: Adolescent Parenting

Slides 14.14-14.15: What Adolescent Fathers Need

- Acceptance and integration into antenatal, delivery and postnatal services.
- Counselling about sexual and reproductive health, including the importance of contraception to space the next pregnancy.
- Exposure to positive models of and information about positive parenting skills.
- Encouragement to learn effective parenting skills, such as feeding, bathing, changing nappies, playing, positive social interactions, and participating in health care discussions.
- If one or both parents have a disability, it may be helpful to know where to acquire information and support for them on how to parent independently.

- Information about the importance of breastfeeding, immunization, nutrition, and growth monitoring.
- Continued access to economic and educational opportunity.
- Information about healthy timing and spacing of pregnancy and family health.
- Positive relationship models and information about how to best support their partner.
- Positive fatherhood role models.
- Information has to be accessible for all, including persons with disabilities.

10. Pause and ask participants what the specific needs for adolescent mothers might be. Return to presentation with **Slide 14.16: What Adolescent Mothers Need** below. Aquire

Slide 14.16-14.17: What Adolescent Mothers Need

- Information about the importance of antenatal care, trained providers during delivery and postpartum care.
- Social support during and after pregnancy.
- Postnatal support and health care for themselves and their infants.
- Information about the importance of breastfeeding, immunization, nutrition, and growth monitoring.
- If one or both parents have a disability, it may be helpful to know where to acquire information and support for them on how to parent independently.
- Encouragement to learn positive parenting skills, such as feeding, bathing, changing nappies, playing, positive social interactions, and participating in health care discussions.
- Counseling about sexual and reproductive health, including information about modern contraception to delay the next pregnancy.
- Appropriate contraceptive methods, based on her breastfeeding status.
- Information about healthy timing and spacing of pregnancy and family health.
- A confidential, private, affordable, and welcoming service environment.
- Continued access to economic and educational opportunity .
- All information has to be accessible for all, including persons with disabilities.

11. Pause and point out the overlap between what young fathers and young mothers need. Remind participants that positive and gender equal parenting skills are learned and developed during this time. Return to the presentation with **Slide 14.18 Parenting: Immunization** below.

Slide 14.18: Parenting: Immunization

Immunization: When to immunize

- BCG: Birth or any time 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.

Slide 14.19: Parenting: Infant Feeding

Breast milk is the perfect, complete food for a baby:

- It has all the nutrients the baby needs.
- It is easy for the baby to digest.
- It gives the baby important protection from infections.
- It always fresh, clean, and ready to drink.

Breastfeeding also has advantages for the mother and her family:

- It slows the return of the mother's menstruation after birth.
- It helps prevent the mother from getting pregnant again too soon.
- It does not cost anything.

Slide 14.20: Parenting: Breastfeeding

How to have enough milk:

Breast milk is the best and only food the baby needs for the first six months. To produce enough milk, the mother needs to be healthy, drink plenty of fluids, eat plenty of nutritious food, and get plenty of rest.

For HIV positive mothers, the combination of exclusive breastfeeding until age 1 and the use of antiretroviral treatment will ensure the baby benefits from breastfeeding with reduced risk of HIV.

(Source: WHO 2016)

When to stop breastfeeding:

Babies should have only breast milk for the first 6 months but can be breastfed for at least 2 years. Most older babies won't breastfeed as often as young babies.

Slide 14.21-14.22: Adolescents and Breastfeeding

Breastfeeding can be a challenge for adolescents: it can be demanding of their time, confine their movements, and restrict their ability to return to their education or work. It can be messy and uncomfortable. Providers can help adolescents maintain a realistic perspective of breastfeeding that helps the young mother with her planning and decision-making.

- Emphasize that breastfeeding forms an important bond between mother and baby.
- Offer emotional support if she feels judged or isolated for breastfeeding. Remind her that she is doing something special and miraculous that only she can do to maintain the health of her baby.

- Give practical suggestions to help her plan for breastfeeding, starting during antenatal care. Provide breastfeeding guidance from the moment of delivery. All information has to be accessible for all including persons with disabilities.
- Emphasize the convenience, efficiency and cost-savings of breastfeeding plus the health benefits to the child.
- Help set short-term goals. Breastfeeding until she returns to school is better than not breastfeeding at all, combining breastfeeding with formula or other feeding is better than not at all.
- Connect her with social supports if they exist. Mother to mother support relationships can help adolescent mothers sustain breastfeeding.
- Focus on positive body-image. Breastfeeding can help her return to her pre-pregnant shape.

Slide 14.23-14.24: Parenting: Bottlefeeding

Mothers should never be pressured into any method of infant feeding but should be supported with information and evidence to make an informed choice. Bottle feeding is an acceptable choice for many young mothers. All information has to be accessible for all, including persons with disabilities.

Adolescent mothers may have the option of using commercial formula or concentrate and should learn how to prepare formula correctly. Warn mothers to not overdilute formula, which could damage the healthy growth of the child.

If the mother cannot afford commercial formula, she may choose to make her own formula. She should NOT use cow's milk for an infant younger than 1 year because it is too high in protein and has inadequate amounts of vitamins and iron.

She should be advised of the following:

- How to prepare, use, and store the formula.
- How to maintain and clean nipples, bottles, and other supplies.
- The importance of holding and cuddling the child during bottle-feeding to support bonding.

12. Finish the presentation by asking for clarifying questions or reflections from participants.

13. Ask if any participants have a story they would like to share about a young mother or young parents they have worked with, what the challenges and success were. Allow time for sharing and comparison of participants' experiences.

UNIT 14 SUMMARY



TIME

20 minutes



METHODS

Reflection



MATERIALS NEEDED

None



STEPS

1. Ask participants to reflect on the unit using the following questions:
 - What challenges can I help adolescent parents and pregnant adolescents get past? What about adolescent parents and pregnant adolescents with disabilities?
 - What challenges need more support from the community?

UNIT 15: DESIGNING ADOLESCENT SERVICES

INTRODUCTION:

To successfully serve adolescent clients with sexual and reproductive health care, service programs must attract, adequately and comfortably meet the needs of, and retain these clients. By conducting a facility assessment, participants learn to identify and evaluate the characteristics of youth-friendly services. The knowledge gained from the assessment can then be applied to services that are provided in their own clinics. To ensure that services are friendly and accessible to all adolescents, when conducting the assessment participants need to keep in mind the different vulnerability factors identified and discussed in the previous units. When it comes to youth with disabilities, the assessment will need to consider the accessibility of the services. The assessment will be conducted with the full participation of adolescents with different types of disabilities in order to identify the barriers that limit persons with disabilities to access information and services, to evaluate the characteristics of youth-friendly and disability-inclusive services, and to discuss any necessary adaptations and accommodations. The assessment phase can be expanded to include a participatory accessibility survey as part of a monitoring and evaluation plan to be jointly implemented by the stakeholders that take part in the project.

- **Trainer's Note:** *This unit is designed to be delivered with youth trainers. The lesson and activities can be modified for an adult provider-only participant group, but trainers are strongly encouraged to include youth participants. The participation of youth trainers with different types of disabilities within the training is essential. Accommodations (sign language interpretation and/or Computer Aided Real-Time Transcription (CART)⁴ personal assistants, braille, large print, easy-to-read materials, etc.) should be provided as needed to ensure the full participation of young trainers with disabilities.*

UNIT TRAINING OBJECTIVE:

To help providers evaluate and develop youth friendly services in their clinic or organization and take into account the needs of all youth clients, including adolescents with disabilities.


SPECIFIC LEARNING OBJECTIVES:

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




11. Define what makes services youth friendly.

⁴ CART is a method of making spoken word accessible to individuals with hearing disabilities, cognitive, or learning disabilities. CART transforms spoken word into a written transcript in real time, so users can read what the speaker is saying. The transcript is typically displayed on a projector screen or the individual's own computer monitor.

12. Discuss different models of service delivery for adolescent clients.
13. Demonstrate how to evaluate and plan youth-friendly services that respond to the needs of all clients, including adolescents with disabilities.

 **TOTAL TIME: 8 HOURS 30 MINUTES**

UNIT OVERVIEW:

Session	Methods 	Materials 	Time 
15.1	Trainer presentation Small group activity	Slides 15.1-15.6 Flipcharts and markers Participant Handouts 7a-c	1 hour 15 minutes
15.2	Trainer presentation Individual worksheets	Slides 15.7-15.14 Participant Handout 15a Flipcharts and markers	1 hour 30 minutes
15.3	Group discussion Site visit	Flipcharts and markers Participant Handouts 15b-c	5 hours 15 minutes
Unit Summary	Pair interview	None	20 minutes



WORK FOR TRAINERS TO PREPARE IN ADVANCE:

- Make arrangements for a clinic visit well in advance and check the arrangements again during the course (several days before the visit is scheduled). Ensure the clinic visit is accessible to persons with disabilities to allow everybody's participation. If necessary, contact in advance a local Organization of Persons with Disabilities for assistance. If possible, divide participants up into several groups and schedule visits at 2 or 3 clinics in the area.
- Prepare copies of Participant Handouts 15a-e. Make sure you prepare extra copies of Participant Handout 15c so that participants can assess their own facility after the training.

- Review slides 15.1-15.14 and content from sessions.
- Discuss and plan with youth co-facilitators how to divide presentation and activities.



MAJOR REFERENCES AND TRAINING MATERIALS:

International Planned Parenthood Federation (IPPF). 2008. *Provide: Strengthening youth friendly services*. London: IPPF.

Simon, C., R. Benevides, G. Hainsworth, G. Morgan, and K. Chau. 2015. *Thinking outside the separate space: A decision-making tool for designing youth-friendly services*. Washington, DC: Evidence to Action Project/Pathfinder International.

UNFPA and Women Enabled International. 2018. *Women and Young Persons with Disabilities. Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights for Women and Young Persons with Disabilities*. New York: UNFPA

World Health Organization (WHO). 2009. *Quality Assessment Guidebook: A guide to assessing health services for adolescent clients*. Geneva: WHO.

SPECIFIC OBJECTIVE 15.1: DEFINE WHAT MAKES SERVICES YOUTH-FRIENDLY



TIME

1 hour 15 minutes



METHODS

- Trainer presentation
- Small group discussion



MATERIALS NEEDED

- Slides 15.1-15.6
- Flipcharts and markers
- Participant Handouts 8a-8c
- Participant Homework from Unit 8



STEPS

- **Trainer's note:** *This program should be delivered by both the lead trainer and a youth counterpart, if available. The participation of youth trainers with different types of disabilities in the training is essential. Accommodations should be provided as needed to ensure full participation of young trainers with disabilities. The trainers should work together beforehand to decide how best to divide the information, with a preference towards the youth trainer delivering more of the content.*

1. Introduce the session and the youth co-facilitator. Explain that one key pathway to success in designing youth-friendly SRH services is the active participation of young people in the design of services and monitoring of quality of care. Have the youth co-facilitator explain that young people with and without disabilities are best able to identify those barriers that prevent them from obtaining services, and strategies to overcome those barriers.

Time: 15 minutes

2. Introduce the presentation **Content: Characteristics of Youth-Friendly Services** (Slides 15.1-15.6) below.

Content: Characteristics of Youth-Friendly Services (Slides 15.1-15.6)

(Source: Simon et al)

Slide 15.1: 5 Characteristics of Youth-Friendly Services

WHO has established that youth-friendly services are:

- *Equitable:* All adolescents, not just certain groups, are able to obtain the services they need including adolescents with disabilities, refugees, migrants, adolescents from poor and remote areas.

- *Accessible:* All adolescents, including adolescents with 365isabilities, are able to obtain the services that are provided.
- *Acceptable:* Health services are provided in ways that meet the expectations of all adolescent clients.
- *Appropriate:* The health services that adolescents need are provided.
- *Effective:* The right health services are provided in the right way and make a positive contribution to the health of adolescents.

Slide 15.2: Health Provider and Staff Competencies

Health providers must be trained and equipped to reflect on how community social norms, local attitudes, beliefs and values influence the delivery of youth SRH and how their intersection with specific vulnerability factors (such as gender, disability, ethnicity, etc.) may result in additional barriers.

To be able to offer disability-inclusive services, all staff need to be trained on how to best communicate with persons with different types of 365isabilities and provide them accommodations as needed. More information available in the “Adolescents with 365isabilities” chapter.

All staff must be oriented on providing confidential, non-judgmental friendly health services to all adolescents.

All staff must treat all young people with respect and demonstrate non-judgmental attitudes toward all regardless their gender, disability, age, ethnicity, etc.

All health providers must be aware of and apply laws and policies related to youth SRH access and choice, including those that allow young clients to receive services without the consent of their parents or spouses.

Slide 15.3: Universal Design

Services should follow the principles of Universal Design in order to ensure meaningful access to services to the widest number of clients, including adolescents with disabilities and vulnerable individuals. Universal design means the process of creating products (services, devices, environments, systems, and processes) which are usable by people with the widest possible range of abilities.

The accessibility of facilities that where not developed following the principles of Universal Design can be improved through accommodations. Accommodations include different modifications and adjustments that ensure persons with disabilities can enter the facilities and use the services on an equal basis with others. These include but are not limited to: installing ramps, enlarging toilet stalls to accommodate wheelchairs and adding grab bars, providing sign language interpretation, braille, large print, and easy-to-read materials. Accommodations are not necessarily costly and can be done through the use of local materials and with the support of local Organizations of Persons with Disabilities. For additional

information on accommodations related to communication in low-resource settings please see the chapter “Adolescents with disabilities.”

Slide 15.5: Health Facility Characteristics

Hours are convenient for young people of all genders.

Services are conveniently located so that young people of all genders can access them

SRH services, including contraceptives, are offered for free or at an affordable price for young people.

There are short waiting times for services.

Counseling and treatment rooms guarantee both auditory and visual privacy.

Where needed, specific times, days, or spaces may be set aside for young people, so that they can avoid being seen by the community.

3. Pause and ask participants to reflect on these characteristics. Ask where and how these are different from the expectations for services for adult clients. Where are they the same?
4. Record participants’ responses. Ask them if they can think of other needs of adolescent clients. Remind participants to keep in mind the needs of the most vulnerable youth groups, including adolescents with disabilities.

Time: 1 hour

5. On another flipchart, divide the page in half. Label one side of the page “Clinic” and one side “Service.”
6. Ask participants to think what changes could be made at their clinic or facility to make it more youth-friendly and disability-inclusive. Ask them to list out some changes that could be made at the clinic level, or in the running and environment of the clinic itself. Record their responses on the “clinic” side of the page.
7. Now ask participants to brainstorm some ways they can make the service interaction (or the interaction between the provider and the adolescent client) more youth-friendly and disability-inclusive. Record their responses on the “service” side of the page.
8. Divide participants into small groups of 3-4 people each. Ask participants to take out Handouts 8a-8c and their revised SRH History form that they’ve developed.

➤ **Trainer's Note:** *Try to make sure that if there are multiple providers, clinics, or facilities, that they are divided into separate groups. For example, if there are four providers from the same clinic, they should be in four separate groups, and not one group of four. If you have multiple young people or youth co-facilitators, divide them among the groups as well to provide feedback.*

9. In their small groups, have participants review **Participant Handouts 8a-8c** and their revised SRH History forms. Have them compare the revisions they've made to the history form, using the following prompts:
 - a. If there was a pre-existing history form, how does yours change or update it?
 - b. What changes or updates did multiple people in your group make? Why?
 - c. Did anyone have a change or a suggestion for their history form that was unique? What was it?
 - d. Were there any changes that your group didn't agree on? Why?
 - e. What support would you need to make these changes at your clinic?
10. Allow **20 minutes** for discussion in the small groups. Ask groups to appoint a rapporteur to report back at the end of discussion.
11. Bring groups back and ask for the rapporteur from each group to report back to the plenary on what they discussed. Ask them to focus on what changes were most common and if there were any controversial changes.
12. Ask the whole group to discuss the final question: *What support would you need to make these changes at your clinic?* Ask participants to think about how they would go about making changes, and what changes they would want to make.
13. Use **Slide 15.5: Design Characteristics** below to close and summarize discussion. Compare the changes that participants said they would like to make with the characteristics of youth-friendly services contained in the slide presentation.

Slides 15.5-15.6: Design Characteristics

- Information, education, and communication materials are available for young people and accessible to all—including youth who face communication barriers, such as young persons with disabilities and young people with low literacy skills. According to the local resources available, adapted materials may include but are not limited to easy to read documents, images, videos with captions, Braille, and large print and audio materials.
- Community health workers/peer educators are available onsite and/or in the community and provide or link young people to health services.
- A diverse group of young people are involved in the design and monitoring of quality services, including adolescents with different types of disabilities.
- A discussion platform is organized in order to set up a list of shared indicators to monitor and evaluate the quality, youth friendliness, and accessibility of

services.

- Written guidelines exist and are well-known and applied by all staff providing services to young people.
- Drop-in clients are welcomed and/or appointments can be quickly arranged.
- Youth-friendly services are publicized and promoted in the community.

SPECIFIC OBJECTIVE 15.2: DISCUSS DIFFERENT MODELS OF SERVICE DELIVERY FOR ADOLESCENT CLIENTS



TIME

1 hour 30 minutes



METHODS

- Trainer presentation
- Individual worksheets



MATERIALS NEEDED

- Slides 15.7-15.14
- Participant Handout 15a: Choosing a YFS Delivery Model
- Flipcharts and markers



STEPS

- **Trainer's note:** *This program should be delivered by both the lead trainer and a youth counterpart, if available. The participation of youth trainers with different types of disabilities in the training is essential. Accommodations should be provided as needed to ensure full participation of young trainers with disabilities. The trainers should work together beforehand to decide how best to divide the information, with a preference towards the youth trainer delivering more of the content.*

Time: 30 minutes

1. Remind participants of the discussion from Unit 9 about the multiple sources of information that young people use to learn about sexual and reproductive health. Ask participants if there are also multiple sources for where adolescents can obtain sexual and reproductive health supplies and commodities.
2. Tell participants that research shows that young people obtain information and services through many channels outside the clinic. The changing landscape for young people, including the changes in technology means that we need to start thinking about how to make youth-friendly services available where young people already gather, and not just wait for them to come to our clinics.
3. Introduce the presentation **Content: Different YFS Models** (Slides 15.7-15.14 by saying that the presentation will explore some different models for delivering services, and how to know which model is best for the young people you are trying to reach.
4. Remind participants that while many of them may work out of clinics, there could be opportunities for them to suggest new clinical and outreach strategies to improve their service reach.

- **Trainer's Note:** *Pause frequently during slide presentation for questions, clarifications, or for participants to share their experiences with different models of service. If there is time, stop at each slide to ask which participants have experience with that model of service and what that experience is. If youth co-trainers are available, have them share their experience as well.*

Content : Different YFS Models

Source : Simon et al

Slide 15.7: Model 1: Standalone Clinic

- A completely separate health center/clinic dedicated to serving adolescent and youth with a range of clinical services.
- May also include peer educators or counselors for onsite counseling, as well as measures to promote services among young people in the immediate area.
- Most common in cities or urban areas with a high volume of young clients to offset/justify costs.
- High-volume clinics located in urban areas are the easiest setting where accessibility surveys can be implemented, Universal Design principles applied, and accommodations introduced, as the additional related costs can be better justified and/or rapidly recuperated due to high demand.

Slide 15.8: Model 2: Separate Space for YFS

- SRH services for young people provided in a separate room or separate building by specifically trained providers, and/or
- Specific services for young people offered on specific days or times in a public or private facility.
- Typically depends on a dedicated YFS provider who offers a wide range of integrated SRH services.
- May include a separate YFS waiting area or “youth corner” with information, education, and communications materials, peer educators or counselors, or separate triage and reception areas for young clients.
- May also include subsidized pricing for young clients.
- Most common in larger health centers or hospitals that have sufficient space.
- In these dedicated spaces, an accessibility survey to identify the barriers faced by youth with disabilities can be easily implemented, Universal Design principles applied, and accommodations introduced.

Slide 15.9: Model 3: Mainstreamed YFS

- Services mainstreamed within existing services through a range of service delivery points in a public or private health facility.
- Requires that all (or most) health providers and support staff in the health facility are trained to offer youth friendly services to young people as part of their routine

service delivery.

- Can be offered at any level of health facility, including primary care facilities.
- May also include promotion strategies to attract young clients, coordination with peer educators and counselors, and tailored information, education, and communications materials for young people.
- Mainstream YFS that are also disability-inclusive should be considered as the final goal to successfully reach all young people.

Slides 15.10-15.11: Model 4: Mobile Outreach Services

- Services offered in strategic locations close to the people that most need them.
- Can include:
 - Mobile clinics (a full range of services offered in a specially equipped van/bus),
 - Satellite clinics (a full range of services offered in an existing non-health space on a routine basis),
 - Services offered by a mobile team of health providers at lower level health facilities that don't routinely offer those services, such as implants or IUD insertions, and
 - Other non-routine outreach events.
- Can be offered in non-health settings to reach targeted groups of young people, possibly including schools, workplaces, prisons, military facilities, sports clubs or events, shelters for street youth, and others.
- Need to be promoted and tied to awareness-raising about types of services to be offered.
- Inclusive mobile outreach services are very effective at covering the last mile between health facilities and clients, as they manage to serve all those clients who live far away from clinics and cannot benefit from accessible or affordable transportation to reach them independently.

Slide 15.12: Model 5: Community-based Services

- Some youth-friendly services can be offered outside of static health facilities by peers or by community health outreach workers who have been trained and are supported to offer a range of SRH services.
- Services may include counseling, select contraceptive methods (condoms, combined oral contraceptives, emergency contraception, injectables), HIV counseling and treatment adherence support, and referrals and vouchers for other services.
- In this model, peers may be peer educators or "peer providers" and are adolescents or youth with similar characteristics as the target population. Community health outreach workers are lay health workers, usually adults, who are trained to provide a range of services at the community level.

Slide 15.13: Model 6: Drug Shops and Pharmacies

- Young people increasingly seek sexual and reproductive health supplies and counseling directly from pharmacies and drug shops both in the private and public sector.

- Can be easily accessible, fast, and relatively anonymous, but may also come with associated fees and costs.
- Can be considered a model of delivering youth-friendly services if staff members are trained to provide accurate, non-judgmental, disability-inclusive and comprehensive counseling to adolescents and youth.
- Frequently linked to social marketing campaigns that drive demand for particular commodities or brands.

Slide 15.14: Model 7: SRH Services in Non-Health Settings

- Model varies from place to place to accommodate the conditions of the setting and the needs of the target population.
 - Offered in a range of different non-health settings where there is a large adolescent and youth population.
 - The accessibility of the services needs to be ensured to allow the highest number of youth to benefit from the proposed services.
5. If you didn't have time to discuss during the slide presentation, pause now and ask which of the models' participants have the most experience with. Which models do they think show the most promise for reaching the adolescents in their community?

Time: 1 hour

6. Distribute **Participant Handout 15a: Choosing a YFS Delivery Model** to participants.
7. Divide participants into pairs and have them work together for **40 minutes** to complete the handout. Divide young people into pairs with adult participants.
8. Bring participants back to the group to discuss the handout. Ask if anyone had any challenges with the questions. Ask participants to share some resources they thought of for the landscape analysis and pre-existing resources. Flipchart the resources for participants.
9. Close by reminding participants about the site visit for the next session.



PARTICIPANT HANDOUT 15A: CHOOSING A YFS DELIVERY MODEL

Fill out alone or in pairs.

Step 1: Health outcomes and target populations.

The first steps in designing YFS is to ask: what are the desired health outcomes you aim to achieve? And which target populations of adolescents and youth are you trying to attract? Jot some notes below about the need in your area.

Step 2: Consider the landscape.

Consider what's already available for young people in your community or catchment area. What health services exist? Who provides them? Are young people using the resources available to them, and if not, why not? Are young people with disabilities using them? If not, why? Note some of the organizations, people, or sources you could go to find this information for your area. *Tip: Local young people and youth organizations are a good place to start to find out what's available and what barriers exist. Local Organizations of Persons with Disabilities are a good place to start to find out more about the services available to youth with disabilities in the area.*

Step 3: Determine the package.

The full range of SRH services can and should be provided for all adolescents and young people, but for efficiency, services should be prioritized based on need. The landscape analysis and consideration of the health outcomes and target populations will help determine which services should be provided and which model will work best.

For each of the models below, fill out the services and target populations boxes from the list provided or add your own. *Tip: there will be overlap and repetition among models, but not all services can be delivered by all models.*

Model	Service Package	Target Population	List of SRH Services	Possible Target Populations
Standalone Clinic			<ul style="list-style-type: none"> • Counseling on SRH, including puberty, relationships, and sexuality. • HPV screening and vaccines • Gynecological exams • Pregnancy testing • Contraception counseling and a full range of contraceptive methods • Counseling and treatment of irregular or painful menstruation • Reproductive and urinary tract infection testing and treatment. • STI counseling and treatment • HIV counseling and testing • HIV treatment, care, and support • Safe abortion and PAC • Antenatal care, delivery services, and postnatal care • PMTCT • SGBV 	<ul style="list-style-type: none"> • Age cohorts: 10-14, 15-19, 20-24 • Young men • Unmarried adolescents • Married adolescents • Young parents • LGBTI adolescents • Young key populations (young MSM, IDUs, sex workers) • Young people living with HIV • In-school adolescents • Out-of-school adolescents • Employed adolescents • Out-of-work adolescents • Adolescent heads of households • Orphans and vulnerable children • Young refugees and migrants • Urban adolescents • Rural adolescents • Young people living
Separate Space				
Mainstreamed YFS				
Mobile Outreach				
Community-based Services				
Drug Shops and Pharmacies				
Non-Health Settings				

			screening and care	<ul style="list-style-type: none"> in poverty • Young people with disabilities
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Step 4: Determine available resources.

What are the available financial, in-kind, and existing resources available for service delivery, training, demand generation, or youth participation? Fill out the table below with some ideas.

	service delivery	training	demand generation	youth participation
financial resources				
in-kind resources				
existing programs/resources				

Step 5: Decide on desired level of coverage.

Are your services national? Local? Focused on specific geographic areas or target populations of adolescents and young people? Jot some notes below.

Step 6: Select a model.

Consider all of the above steps and review your notes. Consider whether more than one model is needed, and what the limitations of the model(s) might be.

Which model/s could work for your area/population?

Model 1: Standalone Clinic

Model 2: Separate Space

Model 3: Mainstreamed YFS
Outreach

Model 4: Mobile

Model 5: Community-based Services

Model 6: Drug Shops and
Pharmacies

Model 7: Non-health Settings

Step 7: Make a plan.

How can you introduce these ideas at your clinic? What could make these changes sustainable? Jot some notes below.

SPECIFIC OBJECTIVE 15.3: DEMONSTRATE HOW TO EVALUATE AND PLAN YOUTH-FRIENDLY SERVICES



TIME

5 hours 15 minutes



METHODS

- Group discussion
- Site visit



MATERIALS NEEDED

- Flipcharts and markers
- Participant Handout 15b: Facility Assessment Tool
- Participant Handout 15c: Action Plan



STEPS

1. Gather participants together to discuss the purpose of the site visit. Remind participants that this is an exercise to see what improvements could be made, not a criticism of the existing services. Any health service facility will always have room to grow.

Time: 30 minutes

2. Review **Content: Assessing Services** below with participants.

Content: Assessing Services

- Conduct a needs assessment of adolescent services provided at the health facility.
 - Identify existing problems in providing an integral quality service for adolescent clients. *Tip:* To enrich the discussion, identify specific youth populations such as youth with disabilities, unmarried girls, very young adolescents or others with unique needs.
 - Identify human resources and materials available in the institution.
 - Develop proposals to solve the problems identified.
 - Present an action plan to implement the proposals.
3. Pass out **Participant Handout 15b: Facility Assessment Tool**. Explain to participants that they will visit a nearby facility and conduct an assessment. The purpose of the assessment is to prepare participants to conduct their own facility assessment. The assessment should take about a half day.
 4. Walk through the steps of the facility assessment with the participants to make sure they are clear on the handout.

5. Review **Content: How to Conduct an Assessment** below with participants. Make sure participants are clear on their role as observers only. They may ask questions but are not there to criticize or correct staff of the health facility. They should strive to respect clients' privacy and interfere as little as possible with facility routine.

Content: How to Conduct an Assessment

- Talk with the staff at the facility, especially the clinic manager providing sexual and reproductive health services to assess willingness to strengthen adolescent services. The clinic in-charge will be key to leading all staff to change attitudes and practices toward improved adolescents.
 - Collect information, using the assessment tool, on the range and quality of adolescent services at the selected facility.
6. Divide participants into working groups and assign a youth co-facilitator or trainer to lead each group.

Time: 3 hours

7. Split up and conduct facility assessment at nearby facility/facilities. Ask groups to return at a set time to finish their training.

Time: 45 minutes

8. After participants return from their visit, ask each group to present the conclusions of their facility assessment to the larger group. They should identify which areas they thought were good, which areas needed improvement, and recommendations for improving services. Allow **10 minutes** for each group to gather their thoughts before presenting.
9. Reconvene the larger group. Allow each group **10-15 minutes** for their presentation. The groups should compare their conclusions with those of the other groups.
10. Distribute extra copies of **Participant Handout 15b: Facility Assessment Tool** so that participants can evaluate their own facility after the training.

Time: 1 hour

11. Distribute **Participant Handout 15c: Action Plan**. Divide participants according to facility, clinic, or organization (*participants who work at/come from the same facility or organization should work together*).
12. Ask participants to use their completed **Handout 15a: Choosing a YFS Delivery Model** and the facility evaluation they just completed to consider some initial plans for what they would like to improve at their own facilities. Allow **45 minutes** for groups to develop their plans.
13. Have groups spend **5 minutes** reporting back to the plenary about their plans. Discuss commonalities and how they can support each other going forward.

PARTICIPANT HANDOUT 15B: FACILITY ASSESSMENT FORM

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.

Date of Visit: _____

Name of Facility: _____

Location: _____ Rural _____ Urban _____ Peri-urban _____

Type of Facility: MOH _____ NGO _____ Other _____

Level of Facility: _____

Number of Rooms: Total _____ Waiting Room _____ Examination Room _____ Lab _____

Other _____

Staff Interviewed:

Person Conducting Assessment:

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.

Service Provided	Total Clients Served		Total Young Clients Served						Comments/Recommendations
	F	M	(20-24)		(15-19)		(10-14)		
	F	M	F	M	F	M	F	M	
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.

Schedule of Available Services							
Services Offered	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Counseling							
Contraception/Dual Protection							

HIV/AIDS							
Nutrition							
Sexual Abuse							
Other RH Issues							
Testing							
STI							
VCT							
Pregnancy							
Treatment							
STI							
Postabortion Care							
Sexual Abuse or Violence							
Other Services							
Contraception							
Abortion (if legal)							
Prenatal Care							
Delivery							
Postnatal Care							

Other services							
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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.

Name	Sex	Title	Type of Training	Training Agency and Date	% of Time Serving Adolescents

1=Counseling

2=Peer Counseling

3=Family Planning

4=Management of STIs
Training

5=Postabortion Care
8=Other

6=Adolescent Reproductive Health/Youth Friendly Services 7=Life Skills and Livelihood

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.

Does the facility have a separate space to provide services for adolescent clients?	E, IC	
Does the facility have a separate waiting room for adolescent clients?	E, IC	
Is there a counseling area that provides both visual and auditory privacy?	E, IC	
Is there an examination room that provides visual and auditory privacy?	E, IC	

R = Review clinic records and environment
 E = Examine clinic layout
 IS = Interview clinic managers and staff
 IC = Interview clients
 O = Observe provider-client interaction
 P = Review clinic policies and procedures

1. Location	Method	Answer	Comments/Recommendations
How far is the facility from public transportation?	E, IS, IC		
How far is the facility from places where adolescents spend their free time?	E, IS, IC		
How far is the facility from schools in the area?	E, IS, IC		
2. Facility Hours			
What time is the clinic scheduled to open?	IS, IC		
What is the official closing time for the facility?	IS, IC		
Does the facility have separate hours for adolescents?	IS, IC		
Is there a sign with services and clinic working hours?	E		
What times are convenient for adolescents to seek services?	IS, IC		
3. Facility Environment			
Does the facility provide a comfortable setting for adolescent clients?	E, IC		
3. Facility Environment (continued)	Method	Answer	Comments/Recommendations
Are young men welcomed and served either for their own needs or as partners?	IS, IC, P		
Are young women welcomed and served either for their own needs or as partners?	IS, IC, P		
4. Staff Preparedness			
Are staff trained to serve adolescent clients in RH?	IS		
Are providers given specialized training?	IS		
Did all staff members receive at least an orientation about adolescent clients? What type of orientation was this and how long was it?	IS		
Do providers show respect for the client during counseling and consultations?	IS, IC		

5. Services Provided		In what languages are IEC materials available?	IS, IC, E	
Is counseling on sexuality, safer sex, pregnancy prevention, and STI and HIV prevention provided?	IS, IC, P	Are group (or rap) discussions held? Please describe.	IS, IC, O	
		Are there ways clients can access information or counseling off-site (telephone hotline, website, materials sent by mail)?	IS, IC, E	
What contraceptive methods are offered?	R, IS, IC, P	Please describe.		
Are condoms provided to males and females?	IS, IC, O, P			
Are supplies (condoms, other contraceptive methods, and drugs) sufficient to meet the need?	IS, IC	8. Youth Involvement		
Is pregnancy testing offered?	R, IS, IC, P	What ways can adolescents suggest/recommend changes to make services more comfortable and responsive?	IS, IC, E, P	
Is STI testing available? What type is available?	R, IS, IC, P	Are adolescents involved in decision-making about how programs are delivered? How?	IS, IC, P	
Are there other RH services in demand by young people that you offer? Which ones?	IS, IC	How can adolescents be involved in decision-making at the facility?	IS, IC	
Do you make referrals for important needs you cannot meet (e.g. sexual abuse)? Please give examples.	R, IS, IC, P	What other roles can adolescents play in clinic operations or guidance?	IS, IC	
Is there an effective formal referral system in place?	IS, IC, P	9. Supportive Policies		
6. Peer Education/Counseling Program	Method	Answer	Comments/Recommendations	
Is a peer education/counseling program available? If so, please describe.	IS, IC, O	Are adolescents mentioned in any of the facility guidelines? How?	IS, P	
How many peer counselors are working with the facility?	IS	Do written procedures exist for protecting client confidentiality? Please describe.	IS, P	
How many hours a week do they each spend at the facility?	IS			
Is there a system for supervising and monitoring counselors? If so, what kind of system?	IS, P	9. Supportive Policies (continued)		Method
7. Educational Activities		Is the registration process private so that other waiting clients cannot overhear the conversation?	IS, IC, E, P	A
Are educational materials available on-site (A/V, computers, printed material)? Which ones?	IS, IC, E	Are records stored so that confidentiality is assured?	IS, E, P	
Are there print materials available for clients to take? Describe materials and comment.	IS, IC, E	Are there any contraceptive methods that adolescents cannot receive? Which ones?	IS, IC, P	

Are spousal or parental consent forms required? Which type and under what circumstances?	IS, IC, P	What is the average time allowed for client/provider interaction?	IS, IC, O, P	
Is there a minimum age requirement to serve adolescents? If yes, why and for what service?	IS, IC, P	11. Publicity/Recruitment		
Are adolescent clients served without regard to their marital status?	IS, IC, P	Does publicity about the clinic identify services offered and stress confidentiality?	IS, IC, E	
Are pelvic exams routinely required? For what reasons?	IS, IC, P	Are there staff or volunteers who do outreach activities? If so, what type?	IS, IC, O	
Do policies or procedures exist that pose barriers to youth friendly services?	IS, IC, P	12. Fees		Method
10. Administrative Procedures		How much are adolescents charged for specific methods and services?	IS, IC, P	
Can adolescent clients be seen without an appointment?	IS, IC, P	Are these fees affordable by adolescents in the catchment area?	IS, IC	
If appointments are required, can they be expedited for adolescent clients?	IS, IC, P			
How long would an adolescent client wait, on average, to see a provider?	IS, IC			

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.

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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

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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

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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,

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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 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

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gives the facility a bad reputation that dissuades 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 dispel 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.

Participant Handout 15c: Action Plan

Action Required	Person Responsible	Date Planned/Completed	Obstacles

UNIT 15 SUMMARY



TIME

20 minutes



METHODS

- Pair interview



MATERIALS NEEDED

- None



STEPS

2. Divide participants into pairs. Have them interview each other about the unit using the following questions:
 - Was there something new you learned today?
 - Do you feel confident about your ability to implement your action plan?

UNIT 16: ADOLESCENTS WITH DISABILITIES

INTRODUCTION:

According to the global data currently available, there are over 1 billion persons with disabilities living in the world today, which account for about 15% to 20% of the world population. An estimated 80% live in a developing country and between 180 and 220 million are youth.


All young persons are entitled to the same basic human rights. However, children and adolescents with disabilities are far more likely than their peers without disabilities to be denied these rights. They experience poorer access to education, have limited access to employment and social protection, and more limited access to general health information and services, including those related to sexual and reproductive health.

Adolescents with disabilities are first of all adolescents, with the same SRH rights and needs of their peers without disabilities. Despite a real need for quality information, counseling and services, many adolescents with disabilities find it difficult to access information and services. Girls with disabilities often face multiple levels of discrimination based on their gender, youth, and disability and are often more disadvantaged by disability due to the intersection of gender norms and disability-related stigma.

Service providers play a critical role in ensuring that the SRH right and needs of all young people, including those with disabilities, are fulfilled. However, they often have limited understanding of the additional barriers adolescents with disabilities face when accessing SRH information and services. This unit is designed to raise service providers' awareness, strengthen their knowledge, and improve their skills for meeting the SRH rights and needs of adolescents with disabilities.

The present unit, however, is not designed to be taught as a standalone module and represents an appropriate tool to improve providers' skills and knowledge on disability-inclusive SRH only when is taught in combination with the other 14 units.

The information, guidance, principles and good practices included in the other 14 chapters are relevant to ensure better access to services for adolescents of all abilities. The present unit builds on the content of the other 14 units and provides additional guidance on how to better support young persons with different types of disabilities in need of SRH information and services. The inputs on service provider's attitudes, good communication, and the key principles of quality youth-friendly services introduced respectively in units 6 and 14, for example, represent an essential body of knowledge that trainees need to master before learning about the disability-inclusive communication techniques and service adaptations presented in this unit. Last but not least, each of the other 14 units includes additional disability inclusive components relevant to the specific subjects addressed in each unit that cannot be overlooked.


 **UNIT TRAINING OBJECTIVE:**

By the end of this unit, providers will have improved knowledge and skills for meeting the SRH rights and needs of adolescents with disabilities.




 **SPECIFIC LEARNING OBJECTIVES:**

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

1. Define disability using the appropriate language and concepts.
2. Discuss how sexuality, gender, and disability intersect, and the barriers adolescents with disabilities face in accessing SRH information and services.
3. Describe the main characteristics of disability-inclusive SRH services and how they can contribute to promote change.
4. Demonstrate improved knowledge and skills on how to communicate with adolescents with different types of disabilities.

 **TOTAL TIME: 8 HOURS 40 MINUTES**

UNIT OVERVIEW:

Session	Methods 	Materials 	Time 
16.1	Trainer presentation Group discussion	Flipcharts and markers Post-its Handout 16a	45 minutes
16.2	Group discussion Trainer presentation	Flipcharts and markers Handouts 16b-g	2 hours
16.3	Trainer presentation Role play	Flipcharts and markers Handouts 16h-i	2.5 hours
16.4	Trainer presentation Role play	Flipcharts and markers Handout 16j	2 hours
Unit Summary	Individual reflection	Handout 16k	45 minutes
Training Evaluation	Post-test Individual evaluation worksheet	Participant Handouts 16l-m	40 minutes



WORK FOR TRAINERS TO DO IN ADVANCE:

- Search for data on young persons with disabilities in your country, including data on sexuality and disability, and summarize them in a handout to be shared with the participants (specific objective 2).
- Become familiar with the local policies/regulations concerning access to SRH services for adolescents and find out if and how these policies, regulations and laws refer to young persons with disabilities.
- Become familiar with how this particular country defines disability within legislation and what disability language (i.e., “person with a disability,” “disabled person,” etc.) is used in the country. Become aware of the differences, if any, between this country-specific terminology and the language used by the Convention on the Rights of Persons with Disabilities (CRPD).
- If not already aware, find out if the country where you are delivering the training has ratified the CRPD.
- Prepare copies of Handouts 16a-m



MAJOR REFERENCES AND TRAINING MATERIALS:

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- Office of the High Commissioner on Human Rights (OHCHR), et al. (2014). *Eliminating forced, coercive and otherwise involuntary sterilization: An interagency statement – OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF and WHO*. https://apps.who.int/iris/bitstream/handle/10665/112848/9789241507325_eng.pdf?sequence=1
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- UNFPA and Women Enable International. (2018). *Women and young persons with disabilities: Guidelines for providing rights-based and gender-responsive services to address gender-based violence and sexual and reproductive health and rights for women and young persons with disabilities*. New York: UNFPA
- United Nations Joint Programme on HIV/AIDS (UNAIDS). (2017). *Disability and HIV*. Geneva: UNAIDS. https://www.unaids.org/sites/default/files/media_asset/JC2905_disability-and-HIV_en.pdf

WHO and World Bank. (2011). World report on disability. Geneva: WHO.

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- **Trainer's Note:** *This unit is intended to be delivered by trainers who have experience and knowledge on gender, age, and disability inclusive SRH (from now on, referred to as "inclusive SRH"). The trainers should be persons with disabilities. In many contexts, however, the number of trainers with disabilities with this profile is quite limited. If trainers with disabilities matching this profile cannot be identified, the inclusive SRH trainer should be accompanied by representatives of Organizations of Persons with Disabilities (DPOs) who have a background on gender, age, and disability. In both cases, the participation of young persons with different types of disabilities is essential.*

Refer to local DPOs that work with young persons with disabilities and/or on disability, gender, and sexuality-related issues to identify potential youth participants with disabilities.

The presence and meaningful participation of trainers and young persons with disabilities needs to be ensured by holding the meeting at an accessible venue and by offering accommodations as needed by the participants with different types of disabilities (i.e. sign language interpretation and/or Computer Aided Real-Time Transcription (CART)⁵, personal assistants, braille materials, large print materials, easy to read materials, etc.). Be aware that some trainees who will attend your session may also require special accommodations. Therefore, it is always important to ask and prepare in advance to ensure everybody is included.

⁵ CART is a method to provide access to spoken communication for people with hearing, cognitive or learning disabilities. CART refers to the instant translation of the spoken word into text using a stenotype machine, notebook computer and real-time software. The text produced by the CART service can be displayed on an individual's computer monitor, projected onto a screen, or made available using other display systems.

SPECIFIC OBJECTIVE 16.1: DEFINE DISABILITY USING THE APPROPRIATE LANGUAGE AND CONCEPTS



TIME

45 min



METHODS

- Trainer presentation
- Group discussion



MATERIALS NEEDED

- Flipcharts and markers
- Post-its
- Handout 16a



STEPS

Time: 10 minutes

Explore participants' understanding of disability

1. Ask each participant what disability means to them and to write their answers on a paper. It is important to stress that there are no right or wrong answers. This is about opinions and beliefs, and different people have different understandings and use different terms to describe disability.
2. Ask participants to share their answers with the group and discuss the different understandings of disability. Conclude by reminding participants there is not one definition of disability, and that over time, the understanding of disability has changed.
3. Introduce briefly the 3 major approaches that have been used in the last few decades to define, describe, and discuss disability: the charity, medical, and social models. Provide examples for clarification.

The charity model of disability:

The charity model depicts persons with disabilities as victims and as objects of charity or pity whose lives are tragic. It often depicts persons without disabilities as saviors who provide charitable resources to support persons with disabilities.

Example:

“My daughter is deaf. She will not find a husband who takes care of her when I am gone. My husband and I need to put money aside for her future and provide for her”.

The medical model of disability:

The medical model approaches disability primarily as a problem of the person, directly caused by disease, trauma, or other health conditions. The medical model sees medical professionals as experts in disability, medical care as the main issue, and finding a “cure” as the main aim.

Example:

“My son has cerebral palsy. He cannot walk and speak normally. He needs rehabilitation. Because of his impairment it is better if he does not have children, we want to prevent any risk of having grandchildren with physical problems”.

The social model of disability:

The social model sees disability as socially created and a relationship between the persons’ disabilities and the environment they live in. Adapting the environment by making all the modifications necessary for the meaningful participation and integration of persons with disabilities in all areas of life is considered a collective responsibility of society at large. Models such as universal design and reasonable accommodation are often used.

Examples:

“Yesterday, my younger brother went to the health clinic to ask about HIV prevention methods. He was very disappointed when the health worker gave him all the information on a regular printed leaflet and did not explain anything verbally. Accessible materials written in Braille were also unavailable. My brother is blind”.

“Last week, my younger sister Gloria, who has down syndrome, went to the health clinic to learn about contraceptive methods. She came home happy about the information she received. The health worker gave her all of the information in easy-to-read formats and spent time to explain its content, answering any questions she had.”

Show participants this short video to better illustrate the social model:
<https://www.youtube.com/watch?v=9s3NZaLhcc4>

4. Conclude the activity by asking participants:
 - If you have to choose the one(s) that best reflect(s) your understanding of disability, which model(s) would you choose?
 - If you have to choose the one(s) that are most widespread in the environment where you live and work, which model(s) would you choose?
 - If none of the models introduced above reflects your understanding of disability or the one widespread in the environment where you live and work, please share your thoughts with the other participants.

5. Allow time for a final discussion on differences and similarities in the answers provided by the participants, including time to reflect on their answers.

Time: 10 minutes

Disability and rights

6. Explain that in the last 2 decades, another very important perspective to discuss disability has emerged – the human rights perspective. This promotes the concept that persons with disabilities are entitled to the same rights as persons without disabilities, that disability rights are human rights and, as such, they need to be protected and promoted.
7. Ask the participants:
 - Do you think young persons with and without disabilities in your communities have rights to go to school, access health services, and access SRH information that are equally promoted and respected?
 - Do young persons with and without disabilities have the same access to school, health services, or SRH information?
 - If not, why?

Time: 10 minutes

Introduce the United Nations Convention on the Rights of Persons with Disabilities (CRPD)

8. Explain that the CRPD is a comprehensive human rights instrument which comprises 50 articles affirming the rights, freedoms and dignity of persons with disabilities, and calling upon states to take all appropriate measures to eliminate discrimination and ensure that persons with disabilities have equal enjoyment of rights in all spheres of life.
9. Explain that the CRPD was adopted in December 2006 and has so far been ratified by 177 states. This means that the Governments of these countries recognize that persons with disabilities should enjoy basic rights on an equal basis with others and commit their government to take all appropriate measures to protect these rights and transform discriminatory systems and practices.
10. Explain that the CRPD is legally binding for all signatory states.
11. Explain that the CRPD has introduced a new definition of “persons with disabilities” that appears below.

“Persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” (CRPD, Article 1).

12. Share the definition with the participants and explain that in this definition:

- Impairment refers to the biological factor, the medical condition. For instance, someone who cannot see properly or at all has a visual impairment.
- Impairments may be acquired through injury, illness, or congenital conditions and may have mild, moderate, or severe impacts on daily functioning depending on the nature of the impairment, as well as a wide range of personal, environmental, physical, social/cultural, and political factors.

These impairments—in interaction with various barriers—may make it difficult for people to participate equally in society thus leading to social exclusion.

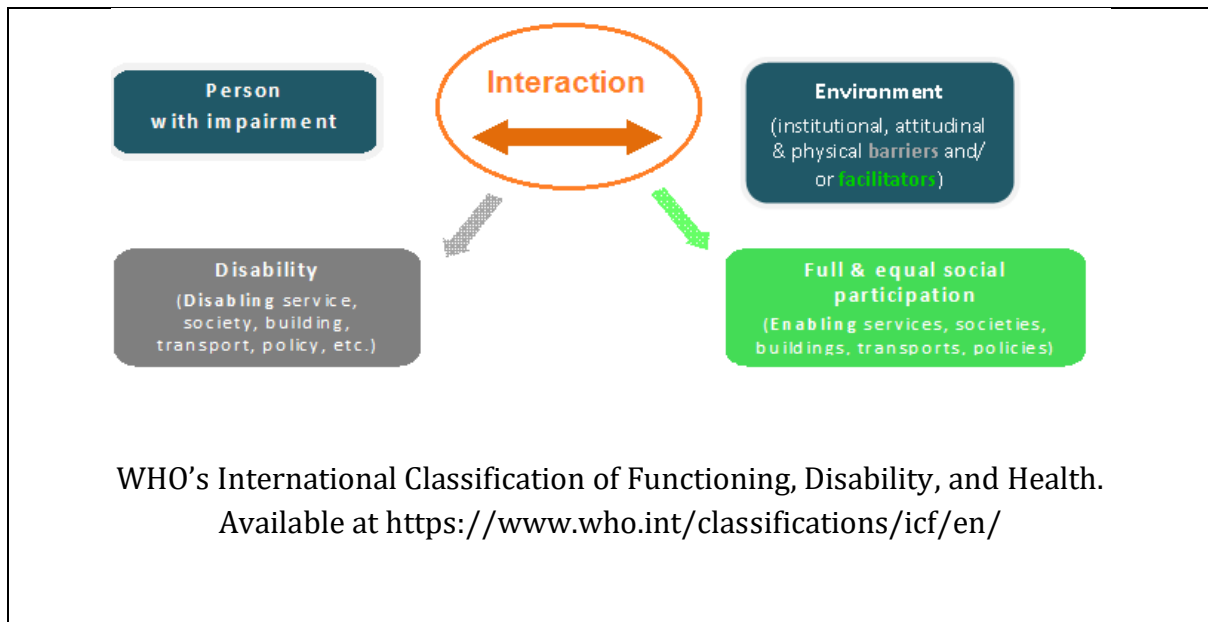
Time: 10 minutes

Then, what is a disability?

13. Explain that each country defines disability differently in its own laws and constitutions, and share the definition of disability you have identified for the country where you are providing the training.
 14. Explain that this may be different from the one provided by the CRPD even in countries that have ratified the Convention.
 15. Explain that there are many types of disabilities. Some disabilities can be seen, but others cannot. Types of disabilities might include:
 - Vision, hearing, or speech disabilities (sensory): people who experience difficulties to see (blind or low vision), to hear (deaf or hard of hearing), or to communicate.
 - Physical disabilities: people with mobility difficulties such as walking, going up/down stairs, standing for long periods of time, or limited use of their limbs.
 - Psychosocial disabilities - often referred to as mental health disabilities: depression, bipolar, and trauma.
 - Chronic health disabilities.
 - Intellectual, developmental, learning, neurological (i.e., epilepsy), and traumatic brain injuries.
 - Multiple disabilities including deaf, blind and Albinism.
 16. Highlight that this list is not exhaustive of the many types of disabilities that exist.
- **Note to trainers:** *Among the different types of disabilities, intellectual and developmental disabilities are often the least well-known. Some additional information on the subject may*

help participants to better welcome young people with intellectual and developmental disabilities and meet their needs. Please refer to Handout 16a for additional information and distribute it to the participants who ask for more details.

17. Use the below graphic to continue this introduction to disability and to emphasize that “Disability is not considered a static, fixed, and immutable trait of the person. It is the result of the interaction between the person and his/her environment” and consider the impact of an impairment on the social participation of the person.



18. Explain that this definition focuses on what creates a disabling situation and **do not provide strict and universal criteria to determine who persons with disabilities are**. Insist on this aspect as it may take time for an audience that is more familiar with the medical model to fully understand the implications of this concept. The aim is to overcome the idea that persons are labelled once and forever as disabled on the base of their impairment.
19. Explain that disability is an evolving concept and that the same impairment can lead to social exclusion or can have a very mild effect on a person’s life depending on how inclusive the environment is.
20. To better explain the above concepts, ask the participants to think about a 25-year-old young woman who was born with only 1 lower limb. Consider how her life would differ if she lived in 3 different circumstances:
- In the center of Copenhagen.
 - In a slum in Nairobi with his family.
 - In the countryside in Greece.
21. Ask participants to discuss:

- Will the risk of social exclusion be the same?
- Will she have equal access to SRH information and services?
- What makes the difference in her opportunities for social inclusion and access to SRH services? The fact that she was born with one leg? The environment where she lives?
- How can we influence that environment to ensure that everybody can access SRH information and services according to the needs?

Time: 5 minutes

The language of disability

22. Explain that language is important when referring to persons with disabilities and continues to evolve.
23. This training we choose to use the person-first language utilized by the CRPD: Adolescent with disability. This is because adolescents with disabilities are first of all adolescents. Take this opportunity to highlight that the definition of “adolescent” and all the information related to adolescents’ SRH introduced in the other units applies to all, including adolescents with disabilities.
24. However, there can be some exceptions when people prefer to use identity-first language (e.g. autistic person, deaf person, disabled person).
25. Most importantly: Explain that a person’s preference for how they wish to be described or addressed must be respected at all times, and it is always best to ask the person what he/she prefers.
26. Highlight that terms you may have heard such as “handicapped”, “crippled” or “mentally retarded”, frequently used to refer to persons with different disabilities, are now perceived as disrespectful and offensive by many. These outdated terms should always be avoided.
27. Tell participants that it is better to avoid the use of the acronym PWD to refer to Person with Disability because this is often perceived as undignifying.
28. Leave time for questions and answers as needed.

PARTICIPANT HANDOUT 16A: INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

There are many kinds of intellectual disabilities—and many causes. Intellectual disability is the most common developmental disability. For a comprehensive list of intellectual and developmental disabilities, please see: <https://www.specialolympics.org/about/intellectual-disabilities/what-is-intellectual-disability>

What is an intellectual disability?

Intellectual disability (or ID) is a term used when a person has certain limitations in cognitive functioning and skills, including communication, social and self-care skills. These limitations can cause a child to develop and learn more slowly or differently than a typically developing child. An intellectual disability can develop at any time during childhood up until the age of 18 years old, even before birth.

Intellectual disability is the most common developmental disability.

According to the American Association of Intellectual and Developmental Disabilities, an individual has intellectual disability if he or she meets three criteria:

- IQ is below 70-75
- There are significant limitations in two or more adaptive areas (skills that are needed to live, work, and play in the community, such as communication or self-care)
- The condition manifests itself before the age of 18

What causes an intellectual disability?

Intellectual disability – formerly called mental retardation – can be caused by injury, disease, or a problem in the brain. For many children, the cause of their intellectual disability is unknown.

Some causes of intellectual disability—such as Down syndrome, Fetal Alcohol Syndrome, Fragile X syndrome, birth defects, and infections—can happen before birth while the fetus is still developing in the womb. Some happen while a baby is being born or soon after birth.

Other causes of intellectual disability do not occur until a child is older; these might include severe head injury (also known as “Traumatic Brain Injury -TBI), infections, or stroke.

What are the most common causes?

The most common causes of intellectual disabilities are:

- **Genetic conditions.** Sometimes an intellectual disability is caused by abnormal genes inherited from parents, errors when genes combine, or other reasons. Examples of genetic conditions are Down syndrome, Fragile X syndrome, and phenylketonuria (PKU).
- **Complications during pregnancy.** An intellectual disability can result when the baby does not develop inside the mother properly. For example, there may be a problem with the way the baby’s

cells divide. A woman who drinks alcohol or gets an infection like rubella during pregnancy may also have a baby with an intellectual disability.

- **Problems during birth.** If there are complications during labor and birth, such as a baby not getting enough oxygen, he or she may have an intellectual disability.

- **Diseases or toxic exposure.** Diseases like whooping cough, the measles, or meningitis can cause intellectual disabilities. They can also be caused by extreme malnutrition, not getting appropriate medical care, or by being exposed to poisons like lead or mercury.

We know that intellectual disability is not contagious. You cannot catch an intellectual disability from anyone else. We also know it's not a type of mental illness, like depression. There are no cures for intellectual disability. However, children with intellectual disabilities can learn to do many things. They may just need to take more time or learn differently than other children.

How common are intellectual disabilities?

Approximately 1-3% of the global population has an intellectual disability—as many as 200 million people.

Intellectual disability is significantly more common in low-income countries—it occurs at a rate of 16.4 out of every 1,000 people.

Source: Adapted from Special Olympics - <https://www.specialolympics.org/about/intellectual-disabilities/what-is-intellectual-disability>

SPECIFIC OBJECTIVE 16.2: DISCUSS HOW SEXUALITY, GENDER, AND DISABILITY INTERSECT AND THE BARRIERS ADOLESCENTS WITH DISABILITIES FACE IN ACCESSING SRH INFORMATION AND SERVICES



TIME

2 hours



METHODS

- Trainer presentation
- Group discussion



MATERIALS NEEDED

- Flipcharts and markers
- Handouts 16b-16g



STEPS

Time: 30 minutes

Disability, health, and young people

1. Start by asking participants to reflect on their current knowledge on adolescents and disability. Divide participants in subgroups, ask young co-trainers with disabilities to join the groups and invite them to discuss the local context where they live and work.
2. Support the subgroups' discussions by asking the following questions:
 - Are you familiar with the living conditions of adolescents with disabilities and their families in your country/local context?
 - Do adolescents with disabilities go to school? Do they work? Do they have access to health services? Are they treated equally to adolescents without disabilities? If not why? Are boys and girls with disabilities treated differently? If yes, in what way? Why?
 - Do you know any organization of persons with disabilities in your area? Which type of relation do you have with them?
3. Share Handout 16b with participants "Key facts and figures on young persons with disabilities" and present the relevant information.
4. Share Handout 16c with participants "Key facts and figures on health and disability" and present the relevant information.
5. Highlight that although global health data disaggregated by age, gender, and disability is rare, the available data clearly show that persons with disabilities face additional barriers in accessing health information and services and that young people are not an exception. Refer participants to additional readings included in the list of references and materials for more information.

6. Leave time for additional questions from participants as needed.

Time: 30 minutes

YOUNG PEOPLE, SEXUALITY AND DISABILITY

7. Start by asking participants to reflect on their current knowledge about adolescents, sexuality, and disability. Divide participants in subgroups, ask young co-trainers with disabilities to join the groups and invite them to discuss the local culture, beliefs, and understanding of adolescents, sexuality, and disability.
8. Support the subgroup discussions by asking the following questions:
 - What is your opinion about adolescents with disabilities expressing their sexuality, being in intimate relationships, getting married, and having children?
 - Do you know whether young persons with disabilities are encouraged to get married and have children in the same way as their peers without disabilities?
 - Do you know if adolescents with disabilities access SRH information and services in your country? If not, why?
 - Do you think adolescents with and without disabilities have the same need for SRHR? If not, why?
9. To conclude this activity, share the handout you have prepared with the young co-trainers on young persons with disabilities in your country, including data on sexuality and disability.
10. Reinsure the participants that data on SRH and adolescents are still very scattered but the information available confirms that globally the SRHR of young persons with disabilities are largely violated and that they face significant barriers to access SRH information and services.

Time: 30 minutes

The CRPD affirms the SRHR of persons with disabilities of any age

11. Highlight that the CRPD (art. 16, 23, and 25) affirms the SRHR of persons with disabilities of any age. More specifically, the CRPD:
 - Calls for the elimination of discrimination against persons with disabilities in all matters relating to relationships, reproduction, marriage, family, and parenthood on an equal basis with others.
 - Acknowledges that persons with disabilities have the same rights of persons without disabilities to access SRH information and services.
 - Calls for the protection of persons with disabilities from all forms of exploitation, violence, and abuse, including gender-based discrimination, both within and outside the home, and for their prevention.
12. Distribute Handouts 16d, 16e, and 16f and allow time for the participants to read them and to ask for clarifications if needed. Then ask:

- Why, does article 25 highlight SRH among all the health sectors?
- What is your experience of providing SRH information and services to adolescents with disabilities? If no experience is reported, invite the participants to discuss why, in their opinion, young persons with disabilities are not using their services and what the main consequences are.

Time: 30 minutes

The SRHR of persons with disabilities, and especially young people, are largely violated

13. Highlight that although 177 countries have committed to the implementation of the CRPD, the SRHR of persons with disabilities, and especially young people, are largely violated.

14. Substantiate this statement by giving a short presentation on SRHR and disability following the script below. Before starting the presentation, share the “Young people, sexuality and disability” *handout* (Handout 16g) and refer to them for examples and additional information.

- Adolescents with disabilities are rarely regarded as subjects of sexual rights.
- Adolescents with disabilities are often assumed as asexual, not sexually active, or hypersexual.
- Adolescent with disabilities are often assumed as being unable to make decisions for themselves about their sexual life.
- Adolescent girls with disabilities are often denied the choice and autonomy/independence to make their own sexuality-related decisions on the basis of their disability.
- Adolescents with disabilities are often denied their reproductive autonomy.
- Adolescents with disabilities are particularly vulnerable to sexual harassment, violence, and abuse, but such incidents are rarely reported.
- In various countries, many persons with disabilities, particularly women with intellectual disabilities, have been subjected to forced abortion, involuntary sterilization, and long-term contraception which are often used as methods of fertility regulation on a precautionary basis.
- Reasons for higher rates of violence and abuse against persons with disabilities include but are not limited to stigma, discrimination, dependence, impunity, and negative cultural beliefs.
- Discrimination factors related to sexual orientation, gender identity, age, and disability intersect. As a result, LGBTQI adolescents with disabilities face more barriers in expressing their sexuality or gender identity. This is even more so for young persons with intellectual and developmental disabilities.
- Discrimination against and exclusion of people with disabilities, in particular women and girls with disabilities, increases their risk of HIV infection and limits their access to prevention, screening, and treatment services.

15. Ask participants how they feel about what they have just learned young people, sexuality, and disability, and allow time for questions and comments.
16. Conclude the presentation by highlighting that despite having equal needs and rights to access SRH services and being more exposed to the risk of HIV and SGBV, young people with disabilities continue to face higher barriers to accessing information and services. Types of barriers include but are not limited to:
 - **Attitudinal barriers:** Misconceptions and negative perceptions about disability and impairments such as stigma, prejudiced terminology, and behavior exhibited by family, society, cultural norms, and traditional beliefs.
 - **Communication barriers:** No accessible formats or easy to read/understand documents, no sign language interpreter.
 - **Institutional barriers:** Discriminative policies and programming tools, lack of disability inclusive implementation.
 - **Physical barriers:** Distance to services, stairs, inaccessible transportation, no lift, no ramps, no lighting, or no mobile services are available.
17. Explain that addressing and overcoming these barriers is at the core of what this curriculum refers to as “disability-inclusive SRH services”. This is discussed in the next section.

PARTICIPANT HANDOUT 16B: KEY FACTS AND FIGURES ON YOUNG PERSONS WITH DISABILITIES

According to the data currently available:

There are over 1 billion persons with disabilities living in the world today which account for about 15% to 20% of the world population. 80% of persons with disabilities live in a developing country.

According to the *World Health Organization (WHO) and World Bank's World Report on Disability*, the female disability prevalence rate worldwide is 19.2%. There are between 180 million and 220 million young persons with disabilities worldwide, predominantly in developing countries.

Children and adolescents with disabilities have little awareness of their rights and are far more likely than their peers without disabilities to be denied their basic human rights.

In most countries, boys are more likely to have disabilities than girls. Girls with disabilities, however, can face double discrimination based on their gender and disability and are often more disadvantaged by disability due to the intersection of gender norms and disability-related stigma.

Compared to their peers without disabilities, adolescents with disabilities:

- Experience higher rates of social isolation, stigma and exclusion.
- Experience poorer physical and psychosocial health.
- Have more limited access to general health information and services, including those related to sexual and reproductive health.
- Are three to four times more likely to experience violence. Girls with disabilities, especially those with intellectual and developmental disabilities and those living in conflict-affected areas, are particularly vulnerable to sexual violence.
- Experience more barriers in accessing protection mechanisms, report abuse, receive support services, and seek justice.
- Experience poorer access to education. It is estimated that 19 million out of the 58 million children who are out of school have a disability. Young people with intellectual and developmental disabilities are the most likely to be out of school.
- Have limited access to employment and social protection.

PARTICIPANT HANDOUT 16C: KEY FACTS AND FIGURES ON HEALTH AND DISABILITY

According to the *World Report on Disability*, persons with disabilities are:

- 2 times more likely to find health care providers' skills and facilities inadequate
- 3 times more likely to be denied health care
- 4 times more likely to be treated badly in health care facilities
- More than 50% of people with disabilities in the world cannot afford health care
- More than 50% of people with disabilities have an unmet need for rehabilitation

Source:

- Better Health for People with Disabilities. <https://www.who.int/disabilities/infographic/en/>
- WHO and World Bank. 2011. *World report on disability*. Geneva: WHO.

According to the *2018 United Nations Flagship Report on Disability and Development*

- Only 6 countries have explicit laws that guarantee access to healthcare to people with disabilities.
- 42% of people with disabilities perceive their health being poor versus 6% of people without disabilities. And the proportion of people with disabilities who perceive their health as poor goes up to 80% in countries with the lowest Gross Domestic Product (GDP) per capita and goes down to 20% in countries with high GDP.
- Women with disabilities are 3 times more likely to have unmet needs for health care than men without disabilities. Women with intellectual disabilities and those living in rural areas face additional barriers in accessing health services.

Source: UNDESA. 2018. *Realization of the Sustainable Development Goals by, for and with persons with disabilities*. *UN Flagship Report on Disability and Development*. New York: UNDESA.

*PARTICIPANT HANDOUT 16D: CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES
(CRPD) ARTICLE 16 – FREEDOM FROM EXPLOITATION, VIOLENCE AND ABUSE*

1. State Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.
2. State Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize and report instances of exploitation, violence and abuse. State Parties shall ensure that protection services are age-, gender- and disability-sensitive.
3. In order to prevent the occurrence of all forms of exploitation, violence and abuse, State Parties shall ensure that all facilities and programs designed to serve persons with disabilities are effectively monitored by independent authorities.
4. State Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation, and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity, and autonomy of the person and takes into account gender- and age-specific needs.
5. State Parties shall put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

Source: <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html#Fulltext>

PARTICIPANT HANDOUT 16E: CRPD ARTICLE 23 – RESPECT FOR HOME AND THE FAMILY

1. State Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that:

(a) The right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognized.

(b) The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognized, and the means necessary to enable them to exercise these rights are provided.

(c) Persons with disabilities, including children, retain their fertility on an equal basis with others.

2. State Parties shall ensure the rights and responsibilities of persons with disabilities, with regard to guardianship, wardship, trusteeship, adoption of children or similar institutions, where these concepts exist in national legislation; in all cases the best interests of the child shall be paramount. States Parties shall render appropriate assistance to persons with disabilities in the performance of their child-rearing responsibilities.

3. State Parties shall ensure that children with disabilities have equal rights with respect to family life. With a view to realizing these rights, and to prevent concealment, abandonment, neglect and segregation of children with disabilities, States Parties shall undertake to provide early and comprehensive information, services and support to children with disabilities and their families.

4. State Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. In no case shall a child be separated from parents on the basis of a disability of either the child or one or both of the parents.

5. State Parties shall, where the immediate family is unable to care for a child with disabilities, undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting.

Source: <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html#Fulltext>

PARTICIPANT HANDOUT 16F: CRPD ARTICLE 25 – RIGHT TO HEALTH

State Parties recognize that persons with disabilities have the right to the highest attainable standard of health without discrimination on the basis of disability. They shall take all appropriate measures to ensure their access to gender-sensitive health services, including rehabilitation services. In particular, State Parties:

- (a) Provide persons with disabilities with free or affordable health services covering the same range and quality as those provided to other persons, including sexual and reproductive health services and community-based public health programs;
- (b) Provide persons with disabilities with the health services they need specifically because of their disability, including early identification and, where appropriate, early intervention services, and services to minimize or prevent new disabilities, especially among children and the elderly;
- (c) Provide these services to persons with disabilities as close as possible to their communities, including in rural areas;
- (d) Require health professionals to provide persons with disabilities with care of the same quality as that provided to others, including obtaining the free and informed consent of the persons with disabilities concerned;
- (e) Prohibit discrimination against persons with disabilities in the insurance sector, who must be able to obtain health insurance and, in countries where it is permitted by national law, life insurance on fair and reasonable terms; and
- (f) Prevent any discriminatory refusal to provide medical care or services or food or liquids because of a disability.

Source: <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html#Fulltext>

PARTICIPANT HANDOUT 16G: YOUNG PERSONS, SEXUALITY AND DISABILITY

Key Facts

Young persons with disabilities have equal needs and rights to access SRH information and services. However, their rights are largely violated.

- Adolescents with disabilities are rarely regarded as subjects of sexual rights
- Adolescents with disabilities are often assumed as asexual, not sexually active, or hypersexual
- Adolescent with disabilities are often assumed as not able to decide by themselves about their sexual life
- Adolescent girls with disabilities are often denied the choice and autonomy/independence to make their own sexuality-related decisions on the base of their disability
- Adolescents with disabilities are often denied their reproductive autonomy
- Adolescents with disabilities are particularly vulnerable to sexual harassment, violence and abuse but such incidents are rarely reported.
- In various countries, many persons with disabilities, particularly women and those with intellectual disabilities, have been subjected to forced abortion, involuntary sterilization and long-term contraception which are often used as methods of fertility regulation on a precautionary basis.

Reasons for higher rates of violence and abuse against persons with disabilities include but are not limited to stigma, discrimination, dependence, impunity, and negative traditional beliefs.

Violence, abuse and young persons with disabilities

State Parties recognize that persons with disabilities have the right to the highest attainable standard of health without discrimination on the basis of disability. They shall take all appropriate measure to ensure their access to gender-sensitive health services, including rehabilitation services. In particular, State Parties:

- Provide persons with disabilities with free or affordable health services covering the same range and quality as those provided to other persons, including sexual and reproductive health services and community-based public health programs;
- Provide persons with disabilities with the health services they need specifically because of their disability, including early identification and, where appropriate, early intervention services, and services to minimize or prevent new disabilities, especially among children and the elderly;
- Provide these services to persons with disabilities as close as possible to their communities, including in rural areas;

- Require health professionals to provide persons with disabilities with care of the same quality as that provided to others, including obtaining the free and informed consent of the persons with disabilities concerned;
- Prohibit discrimination against persons with disabilities in the insurance sector, who must be able to obtain health insurance and, in countries where it is permitted by national law, life insurance on fair and reasonable terms; and
- Prevent any discriminatory refusal to provide medical care or services or food or liquids because of a disability.

LGBTQI young persons with disabilities key facts

Discrimination factors related to sexual orientation, gender identity, age and disability intersect. As a result, LGBTQI adolescents with disabilities face more barriers in expressing their sexuality or gender identity. This is even more so for young persons with intellectual and developmental disabilities.

- LGBTQI persons with disabilities' experience of systemic discrimination and exclusion are associated with reduced health and wellbeing, reduced access to SRH services and increased risk of harassment when accessing the services.
- LGBTQI adolescents with disabilities often experience discrimination from within both LGBTQI and disability communities compounding their sense of social marginality and isolation and contributing to their increased risk of mental health
- Persons with disabilities who identify as LGBTQI are more likely to report having experienced harassment or violence than those without disabilities.

Example: On LGBTQI populations with disabilities and violence in Australia

One study published in Australia in 2018 reported that 46% of LGBT people with a disability versus 33% without reported having experienced at least one form of harassment or violence in the last 12 months prior to completing the survey. LGBT respondents with disabilities were more likely to have been subject to verbal abuse than respondents without disabilities (32% versus 24%); more likely to have 'received written threats of abuse including emails and graffiti' (11% versus 5%); more likely to have been subject to harassment (21% vs 14%); and more likely to have been subject to threats of physical violence or physical assault such as being punched, kicked, or beaten (13% vs 8%).

Sources:

Leonard W. and Mann R. 2018. *The everyday experiences of lesbian, gay, bisexual, transgender and intersex (LGBTI) people living with disability*. La Trobe University.

Msekele, S. 2018. "Being Disabled, Black and Queer in South Africa: A Personal Journey." P. Chappell and M. De Beer (eds.), *Diverse Voices in Disabled Sexualities in the Global South*.

New York: Palgrave Macmillan; 127-130.

Young persons with disabilities and HIV

Global HIV data disaggregated by age, gender and disability are not yet available. UNAIDS, however, highlight that persistent discrimination against and exclusion of people with disabilities, in particular women and girls with disabilities, increases their vulnerability, including their risk of HIV infection and limit their access to prevention, screening and treatment services.

According to UNAIDS, persons with disabilities may not benefit fully from HIV and related sexual and reproductive health services because:

- Service providers may lack knowledge about disability related issues, or have misinformed or stigmatizing attitudes towards persons with disabilities.
- Services offered at clinics, hospitals and in other locations may be inaccessible to persons with disabilities.

Recent studies conducted in sub-Saharan Africa:

- Highlight an increased risk of HIV infection of 1.48 times in men with disabilities and 2.21 times in women with disabilities compared with men without disabilities.
- Confirm that the higher prevalence of HIV infection in people with disabilities reflects a higher exposure to HIV infection as well as the presence of disability-associated HIV infection.
- Point out that the susceptibility of persons with disabilities to HIV infection seems to be shaped by social and environmental factors.
- Confirm that persons with disabilities living with HIV also face additional barriers in accessing SRH services, counselling and HIV treatment

Sources:

De Beudrap P. et al. 2017. Prevalence of HIV infection among people with disabilities: a population-based observational study in Yaoundé, Cameroon (HandiVIH). *Lancet HIV*. April 4(4): e161-e168.

United Nations Joint Programme on HIV/AIDS (UNAIDS). 2017. Disability and HIV. Geneva: UNAIDS. https://www.unaids.org/sites/default/files/media_asset/JC2905_disability-and-HIV_en.pdf

SPECIFIC OBJECTIVE 16.3: MAIN CHARACTERISTICS OF DISABILITY-INCLUSIVE SRH SERVICES AND HOW SERVICE PROVIDERS CAN CONTRIBUTE TO PROMOTE CHANGES



TIME

2.5 hours



METHODS

- Trainer presentation
- Role play



MATERIALS NEEDED

- Flipcharts and markers
- Handouts 16h-i



STEPS

Time: 30 minutes

3 Pillars of disability-inclusive health services

1. Ask participants to brainstorm on how services need to be adapted to ensure they meet the need of all young persons, including those living with HIV, LGBTQI youth, and young persons with disabilities.
2. Ask participants to think about the key characteristics that disability-inclusive SRH services should have and to share their thoughts with the group.
3. Highlight that disability-inclusive services are not “special services” developed for the exclusive benefit of young persons with disabilities, but rather services designed to meet the needs of all young people, including persons with disabilities.
4. Introduce the 3 pillars of disability-inclusive health services. More details are provided below.

Time: 30 minutes

Pillar 1: Accessibility

5. Start by explaining that:
 - Accessibility refers to an environment, product, or service that is made available to meet the needs of everyone, including persons with disabilities.
 - Accessibility makes it possible to reach, enter, circulate throughout, and fully use a physical space whatever its nature and function. Accessibility can also enable individuals to receive, understand, develop, modify, share and disseminate information.

- Accessibility, whether physical accessibility or access to information and communication in an appropriate form, is a prerequisite for the inclusion of persons with disabilities in all aspects of life.
6. Continue by explaining that:
 - To ensure meaningful access to services for the widest variety of clients, including adolescents with disabilities and vulnerable individuals, services should follow the principles of Universal Design.
 - Universal Design highlights how products (services, devices, environments, systems, and processes) should be created to maximize their usability for people across the full range of abilities.
 - The accessibility of facilities that were not developed following the principles of Universal Design can be improved through accommodations.
 - Accommodations include different modifications and adjustments that ensure persons with disabilities can enter the facilities and use the services on an equal basis with others. These include but are not limited to: ramps, sign language interpretation, braille, large print, and easy to read materials.
 7. Emphasize that health personnel can play a key role in advocating for accessibility at the health facility, community, and government levels. They can also serve as a great ally for DPOs in advocacy to make health policies and systems more accessible to persons with disabilities.

Time: 30 minutes

Pillar 2: Inclusive Policies

8. Start by highlighting that **inclusive policies in hospitals/clinics are in place to guarantee respect to all including persons with disabilities.** Having specific guidelines on how to offer quality services accessible to persons with disabilities is essential to create good inclusive practices or to institutionalize those that already exist in health facilities.

Distribute Handout 16h that provides an example related to the work conducted by Humanity & Inclusion in a health facility in South Sudan and its positive results. Ask participants to read the handout in preparation to the next activity.

9. Ask the participants to discuss disability-inclusive policies and how these policies, could help make their services more accessible to young persons with disabilities. Divide the participants into small groups (maximum 4 persons per group) and ask the young co-trainers to join the groups. Ask them to nominate a representative to take notes and give a summary at the end of the exercise.
10. Provide the following discussion points/questions to the groups:
 - Does your program/facility have a disability-inclusive policy?

- If yes, share with the other members of your group how this helps in providing quality SRH services to young persons with disabilities and provide inputs on how the policy could be further strengthened.
 - If not, come up with two recommendations that could make the services more accessible to young persons with disabilities.
 - Do you intend to take any steps toward promoting disability inclusive policies in your work place?
 - If yes, what are these steps?
11. Ask the group representatives to share the key recommendations identified and the steps the participants are thinking about taking.
 12. Ask the youth co-trainers to comment and share final inputs to guide the future actions of the participants.

Time: 60 minutes

Pillar 3: Positive Attitudes

13. Start by asking participants to think about how service providers' attitudes can affect adolescents' access to SRH services and their overall experience. Ask 3 volunteers to share their thoughts.
14. Highlight that attitudes play a key role in preventing or facilitating persons with disabilities to access health services. For this reason, it is important that all health workers and other staff in facilities including security guards, receptionists, and record keepers, have respectful and welcoming attitudes towards all clients including persons with disabilities and are trained on disability-inclusion accordingly.
15. Explain that persons with disabilities, just like everyone else, are less willing to go to a hospital or a clinic where they have experienced mistreatment/disrespectful behavior or where staff is perceived as unwelcoming towards persons with disabilities.
16. Ask participants to think about examples of negative and positive attitudes and to raise their hand to share them with the group. If necessary, stimulate the discussion by mentioning that discrimination in the form of ignoring, nicknaming, insulting, being disrespectful, mistreating, and abusing can often reflect service providers' negative attitudes toward young persons with disabilities.
17. Point out that negative attitudes can keep persons with disabilities from preventing or detecting certain problems at an early stage and obtaining the information they need related to their SRH.

18. Share Handout 16i with the participants. Then ask them to divide into 3 groups and assign 1 case study to each group. Ask youth co-trainers to join the groups and have each group nominate a representative to take notes and give a summary at the end of the exercise.
19. Provide the following discussion points to the groups:
 - What do you think about the provider's attitude in your case study?
 - What are the benefits or potential consequences for the young person with disability?
 - What can we learn from the positive/negative attitudes described in the different case studies?
20. Ask the 3 representatives to provide a summary of the discussion.
21. Provide three additional discussion points for the entire group to discuss:
 - What are the roots of service providers' negative attitudes? Point out that negative attitudes towards young persons with disabilities are often based on prejudice, lack of knowledge of the rights of persons with disabilities, and limited understanding of disability. Ask participants' to share their opinion on the subject.
 - What do you think is needed to improve service providers' attitudes towards young persons with disabilities?
 - Has your attitude towards young persons with disabilities changed at all after this training? If yes, how?
22. Conclude by explaining to participants that:
 - Even when service providers have positive or supportive attitudes towards persons with disabilities, they may feel disempowered if the overall social environment is hostile or unfriendly. Some of them may go along with dominant social norms because it's easier or because they are afraid to go against the organizational culture or leadership of the facility. This is one of the reasons why policies are important.
 - With the right support, guidance, and training, health workers are in the position to create a positive and welcoming environment for persons with disabilities and to influence their colleagues and working environment.

Case Study from South Sudan – Humanity & Inclusion

Humanity & Inclusion carried out a full participatory accessibility audit in a South Sudanese hospital. This encompassed a baseline on attitudinal barriers from services provider, physical accessibility of the health facility, and accessibility to health information. The subsequent report and its recommendations were shared with local stakeholders, and an action plan for the monitoring of the relevant implementation was agreed upon. A steering committee with participants from local and international NGOs, DPOs, and persons with disabilities was created, and its role and responsibilities outlined and enforced. A series of hospital protocols were proposed to improve quality of services and accountability.

As a result of this initiative, the Hospital developed a policy to ensure that all members of the Hospital Community are aware of their rights and responsibilities to benefit all patients, visitors, employees, associates and volunteers by achieving accessibility for people with disabilities. According to the policy, this will be done by developing, implementing and enforcing accessibility standards concerning goods, services, accommodation, facilities, buildings and employment. The policy was designed to bring about systemic and organizational changes to foster the conditions that create a healthy, respectful and positive hospital and work environment. More specifically, this policy was designed to accomplish the following outcomes:

- Foster a positive hospital environment through proactive measures, barrier free systems analysis and enforcement;
- Ensure that all members of the hospital community are treated equitably and with dignity and respect;
- Address breaches of this policy and settle disputes quickly, fairly and as close to the source as possible;
- Ensure that all members of the hospital community are aware of their rights and responsibilities under this policy
- Provide proactive education, organizational training and development at the Hospital is aimed at providing an environment that is accessible.



HANDOUT 16I: CASE STUDIES-SERVICE PROVIDERS' ATTITUDE

Case Study 1

Aisatu is a 19-year-old girl. She suffers from epilepsy and has frequent seizures. She has been living with her boyfriend in the streets of a big city since she turned 17 and was diagnosed with epilepsy. Her father said that she was possessed by a demon and that she will never be a bride. Aisatu doesn't want to get pregnant by her boyfriend who is the same age and lives in the streets, so they use condoms. As they struggle to buy condoms, Aisatu and her boyfriend heard of a form of long-acting, reversible form of contraception (implants). When Aisatu went to the dispensary to get her medicines for epilepsy, she asked the usual nurse if she could get the implant. The nurse told her that the medicines that she is taking "are not good" if she wants an implant and did not offer any alternative. Aisatu went back to the street with a dilemma: either she keeps taking her epilepsy medicines and risks having a baby or stops taking her medicines, gets the implant but risks having life-threatening seizures.

Case Study 2

Giorgina is 14 years old and she has Down Syndrome. She wants to be a mother one day. She has been studying sexuality education at school and is well informed about puberty and the related physical and psychosexual development. She is also well informed about pregnancy. One evening, Giorgina overhears part of a conversation between her parents. They are concerned about Giorgina's desire to become a mother in the future, her risk having a child with a disability and the related consequences. Giorgina only heard the last part of the conversation when they concluded that "It is better for Giorgina to never be a mum!". Giorgina is very confused and the day after, she decides to go to the school nurse to ask about her ability to have children and why her parents do not want her to become a mum when she grows up. The nurse is taken completely unprepared by Giorgina's question and feels the need to learn more about the experience of girls with Down Syndrome becoming mothers before providing an answer. She also wants to consult with Giorgina's parents. She recognizes that Giorgina is a bit agitated, so she takes the time to talk to her in a kind and relaxed way to calm her down before giving her an appointment for the following day.

Case Study 3

John is 16 and has a physical disability due to polio. John has a boyfriend, Brian, with whom he has unprotected sex. He does not have a disability. John enjoys being with Brian but suspects he has been unfaithful. His friends say he should be careful because promiscuity brings HIV but he does not know what 'being careful' really means. John starts being worried and decides to go to the clinic near his school to ask for support. Initially, the receptionist did not pay attention to him and asked "are you sure you are in the right place? This is an SRH clinic". When finally John manages to tell the nurse that he has a boyfriend and he is afraid of contracting HIV, the nurse turned to his colleague and said loudly: "how can he be disabled and gay?" John felt bad and ended up leaving without obtaining the information he was looking for.

SPECIFIC OBJECTIVE 16.4: SKILLS ON HOW TO COMMUNICATE WITH ADOLESCENTS WITH DIFFERENT TYPES OF DISABILITIES



TIME

2 hours



METHODS

- Trainer presentation
- Group discussion
- Role play



MATERIALS NEEDED

- Flipcharts and markers
- Handout 16j



STEPS

Time: 30 minutes

1. Start by asking participants to share why, in their opinion, good communication is a key component that can affect adolescents' access to SRH services and their overall experience.
2. Remind participants that health care providers who use good communication skills ensure adolescents obtain accurate and unbiased SRH information, which can both educate young people and facilitate their ability to make responsible decisions.
3. Point out that marginalized young people face additional barriers to accessing accurate and quality information and that young persons with disabilities face additional communication barriers that could vary according to the type of disability.
4. Explain that service providers should consider the following good practices and principles for good communication when attending to young persons with disabilities:
 - Accommodation is needed to ensure good communication:
 - Sign language interpretation or subtitles in video materials for young persons with hearing disabilities.
 - Braille, large print. or audio materials for young persons with low vision or visual disabilities.
 - Easy to read/simplified materials and pictures for young persons with intellectual and developmental disabilities.
 - In low-resource settings, the use of other simple methods is recommended to ensure good communication:

- Lip reading or exchange of written messages and images with persons with hearing disabilities.
 - Reading aloud the information included in written materials that is inaccessible for persons with visual disabilities.
 - The use of simplified language and images to communicate with persons with intellectual and developmental disabilities.
- In all circumstances the most important resource for providers is time, patience, and willingness to establish good communication with persons with disabilities.
5. Explain that service providers should not make assumptions about young persons' sexuality based on their disability. He/she should listen to what the young person has to say in relation to their sexuality and experience.
 6. Remind participants that service providers should avoid focusing on the disability of the client. Instead they should stay focused on the SRH experience/problem the young person is interested in discussing.
 7. Point out that since many services are not accessible, young persons with disabilities are often accompanied by a family member or caregiver to help them overcome physical or communication barriers. In these circumstances, service providers should find out if the young client with disabilities would like the accompanying person to stay or to wait outside the consultation room. If the adolescent client asks for the accompanying person to stay, service providers should make sure the young person remains the main interlocutor and prevent the accompanying person from speaking or making decisions on behalf of the person with disability.
 8. Conclude the session by sharing Handout 16j that summarizes some key points on "disability etiquette". Explain that in addition to the general principles introduced so far, it is important to learn more about the specificities of communicating with young persons with different types of disabilities.

Time: 30 minutes

Communicating with young persons with hearing disabilities

9. Explain that one of the biggest barriers for young persons with hearing disabilities to access SRH services independently is communicating with the relevant staff including receptionists and nurses as well as doctors.
10. Explain that the expression "communicating with persons with hearing disabilities" is often automatically associated with sign language. However, not all persons with hearing disabilities know sign language and most persons without a hearing disability do not know sign language.

11. Explain that if communication is supported by a sign language interpreter, it remains important to talk directly to the adolescent client, not the interpreter.
12. Explain that persons with hearing disabilities may use hearing aids. This will certainly help communication, but it doesn't mean they can hear everything.

Explain that regardless of whether the communication is facilitated through sign language interpretation or hearing aids, it is always important to understand the techniques that can enhance communication with a person with hearing disabilities listed below:

- When talking to a group that includes young persons with and without hearing disabilities, don't just focus on the hearing youth.
- Don't shout. It can be uncomfortable for hearing aid users and it looks aggressive.
- Take the time to find out what the best way is to communicate with each client and to adjust the communication style to what she/he is most comfortable with as every person with hearing disabilities is different.
- Be imaginative and use all the available resources such as written messages, text, WhatsApp messages, gestures, pictures, and lip-reading. Keep in mind that young persons with disabilities may be illiterate and this would eliminate the utility of written messages.
- If using lip-reading⁶:
 - Find a suitable place to talk, with good lighting and away from noise and distractions. Make sure to have face-to-face contact with the person.
 - Get the listener's attention before starting speaking, maybe by waving or tapping them on the arm.
 - Don't cover your mouth with your hands or clothing while talking.
 - Speak clearly but not too slowly, and don't exaggerate your lip movements – this can make it harder to lip-read.
 - Use natural facial expressions and gestures.
 - If someone doesn't understand what you've said, don't keep repeating it. Try saying it in a different way instead.
 - Check that the person you're talking to is following you during the conversation. Use clear, plain language. Avoid jargon and unfamiliar abbreviations.

Let's practice:

13. Ask the youth trainers with hearing disabilities in the room to play the role of the client and ask for volunteers who are willing to go through a mock counseling session and play the role

⁶ Adapted from version of Action on Hearing Loss, 2016.

of the health worker. If no youth trainers with hearing disabilities are available, ask for volunteers to engage in a sensitization activity and attempt to learn about the lived experience of having a hearing disability in this setting. Have the volunteer ensure she/he cannot hear the voice of his/her partner by using earplugs, wadded up cotton wool, fingers in the ears, or any other safe tool available.

14. Assuming that sign language interpretation is not available and that the person with a hearing disability is not wearing hearing aids, ask the participants who play the role of the health workers to use all the resources they can think of to communicate with the client.
15. At the end of the role play, ask the participants to share their experience.
16. Ask for comments and observations from the rest of the group.
17. Ask if any additional inputs should be added to the above list of tips.

Time: 30 minutes

Communicating with persons with visual disabilities

18. Explain that when communicating with persons with visual disabilities, it is important to pay attention to some details to ensure mutual understanding⁷:
 - Identify yourself – don't assume the person will recognize you by your voice.
 - Speak naturally and clearly. Loss of eyesight does not mean loss of hearing.
 - Continue to use body language. This will affect the tone of your voice and give a lot of extra information to the person with a visual disability.
 - Use everyday language. Don't worry about avoiding words like "see" or "look" or talking about everyday activities such as watching TV or videos.
 - Introduce and describe what the consultation will include and the different actions before putting them in place. For example: I am going to take your blood pressure, I am going to collect a sample of blood, etc.
 - Name the person when introducing yourself or when directing conversation to them in a group situation.
 - Never channel conversation through a third person.
 - In a group situation, introduce the other people present.
 - Never leave a conversation with a person without saying so and always announce if you are leaving the room.
 - Use accurate and specific language when giving directions. For example, "the door is on your left", rather than "the door is over there".

⁷ Adapted from Vision Australia, 2016.

- Avoid situations where there is competing noise.

Let's practice:

19. Ask the youth trainers with visual disabilities in the room to play the role of the client and ask for volunteers who are willing to go through a mock counseling session and play the role of the health worker. If no youth trainers with visual disabilities are in the room, engage in a similar sensitization activity as the hearing disability listed above and ask for volunteers to be blindfolded. Ask the other participants to observe the role play.
20. Conclude the exercise by asking those involved in the role play to share their experience with the rest of the group.
21. Ask for comments and observations from the rest of the group.
22. Ask if any additional inputs should be added to the above list of tips.

Time: 30 minutes

Communicating with young persons with intellectual and developmental disabilities

23. Highlight that all adolescents with disabilities, including adolescents with intellectual and developmental disabilities, have the right to access information about their health status and to make decisions about their own health, including sexual and reproductive health.
24. Explain that it may be necessary to spend more time with adolescent clients with intellectual and developmental disabilities to ensure information is well understood and clients have the opportunity to ask all the relevant questions. This is because young persons with intellectual and developmental disabilities may find it difficult to interact with service providers and may need extra time to read, write, understand, learn, focus, or memorize information.
25. Clarify that every person is different and the time and style of communication may require some adaptation according to the level and severity of the impairment. But in general, the following actions are always recommended:
 - Speak slowly without acting like you are speaking with a child. Try to be as clear as possible without being offensive.
 - Use short sentences and simple words prioritizing key information.
 - Repeat multiple times using different words if necessary.
 - Ask short questions that require short answers or a nod of the head. Complex questions might trouble the person to finding the right answer.
 - Integrate pictures with key words if needed.

- Instead of asking the client if she/he understood, ask them to tell you what they have learned in their own words.
- Listen attentively and do not interrupt. Wait for the clients to finish. Giving them more time will allow you to gather more information and show that you respect them.
- Never pretend to understand. Instead repeat what you have understood and allow the person to respond.
- Speak directly to the client rather than to their companion who may be present.
- Address the person by their first names only if you would extend that same familiarity to all others.
- Walk them through the different choices and decisions to make. Do not decide for them, but do help them to make their own informed decisions.
- When possible, provide any materials in advance so the individual can review and become familiar them beforehand.

Let's discuss:

26. If youth with intellectual and developmental disabilities are in the room, ask them to share experiences on accessing SRH information and services. Ask participants how they feel about what they have heard and to react to their inputs.
27. Ask participants how they personally have interacted with persons with intellectual and developmental disabilities or what they have observed in terms of good or poor practices.
28. Discuss any additional communication tips that could be included in the list above.



HANDOUT 16J: DISABILITY ETIQUETTE SNAPSHOT

Person-first language	
DON'T SAY	DO SAY
A handicapped person, the disabled, PWD, PwD	Person with a disability, people with disabilities
A normal person, people living normal lives	A person without a disability
A crippled, physically challenged, infirm	A person with a physical disability
Wheelchair bound	A wheelchair user
The blind	A person with low vision / A person who is blind/ A person with a visual impairment
The deaf, the hard of hearing	A person who is hard of hearing / A deaf (Deaf) person
Mentally retarded, mentally challenged	A person with an intellectual disability
Insane, lunatic, mentally sick, mentally imbalanced, mad person, mentally ill person, psycho, crazy people	A person with a mental condition A person living with Schizophrenia A person living with bipolar disorder

Interactions with Persons with Disabilities

DON'T	DO
Talk only to family, and ask them to tell you how the person with a disability feels, what they think	Talk directly to the person, rather than through their support staff or other caregiver
Refer to the person as a 'patient' or 'disabled'	Refer to the person by their name
Display impatience	Be understanding of other people's needs
Ask negative questions like "What's wrong with you?" or "Have you always been like that?"	Ask positive questions such as "Do you face any difficulties with different activities?" or "How long have you faced these difficulties?"
Assume all persons with disabilities cannot shake hands	Shake hands. You can ask first if it is okay, or to inform someone with low vision that cannot see your hand
Assume all persons with disabilities need help, and that you know how to help	Ask if a person needs assistance with something, and how you can help

UNIT 16 SUMMARY



TIME

20 minutes



METHODS

- Reflection



MATERIALS NEEDED

- Handout 16k



STEPS

1. Conclude this section by emphasizing that:
 - DPOs working at the local level can be strategic allies when it comes to learning about persons with disabilities and their living conditions. Although not all of them have experience in working with adolescents and their SRH, joining forces with these organizations can optimize your ability to raise the awareness of adolescents with disabilities on SRHR, identify adolescents with disabilities who are in need of SRHR services, better address their needs, and promote both their SRHR as well as disability-inclusive services.
 - More data disaggregated by age, gender and disability is needed to better understand and address the SRH needs of young persons with disabilities. Highlight that collecting data at the service provision level is an essential step. This can be done by the health information systems by integrating a short set of questions developed by the Washington Group available in Handout 16k. It is important to ensure that staff responsible for administering this questionnaire are trained on how to use this tool. Direct the participants to the website <http://www.washingtongroup-disability.com/washington-group-question-sets/short-set-of-disability-questions/> for more information.
 - With the right support, guidance, and training, health workers are in the position to create a positive and welcoming environment for persons with disabilities and to influence their colleagues and working environment. They can also be great allies of DPOs in advocacy actions aiming at making health policies and systems more disability inclusive.
2. Give space for final questions if needed.
3. As a conclusion, ask participants:
 - Do you feel better-equipped to welcome young persons with disabilities in their facilities then when they started this training?
 - What did you find most useful in this module?
 - What would you like to know more about?



HANDOUT 16K: THE WASHINGTON GROUP SHORT SET OF QUESTIONS ON DISABILITY

The next questions ask about difficulties you may have doing certain activities because of a HEALTH PROBLEM.

1. Do you have difficulty seeing, even if wearing glasses?
 - a. No – no difficulty
 - b. Yes – some difficulty
 - c. Yes – a lot of difficulty
 - d. Cannot do at all

2. Do you have difficulty hearing, even if using a hearing aid?
 - a. No – no difficulty
 - b. Yes – some difficulty
 - c. Yes – a lot of difficulty
 - d. Cannot do at all

3. Do you have difficulty walking or climbing steps?
 - a. No – no difficulty
 - b. Yes – some difficulty
 - c. Yes – a lot of difficulty
 - d. Cannot do at all

4. Do you have difficulty remembering or concentrating?
 - a. No – no difficulty
 - b. Yes – some difficulty
 - c. Yes – a lot of difficulty
 - d. Cannot do at all

5. Do you have difficulty (with self-care such as) washing all over or dressing?
 - a. No – no difficulty
 - b. Yes – some difficulty
 - c. Yes – a lot of difficulty
 - d. Cannot do at all

6. Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?
 - a. No – no difficulty
 - b. Yes – some difficulty
 - c. Yes – a lot of difficulty
 - d. Cannot do at all

Source: <http://www.washingtongroup-disability.com/washington-group-question-sets/short-set-of-disability-questions/>

TRAINING COURSE POST-TEST AND EVALUATION



TIME

40 minutes



METHODS

- Quiz
- Individual worksheet



MATERIALS NEEDED

- Participant Handout 16l: SRH Services for Adolescents Post-Test
- Participant Handout 16m: Participant Evaluation Form



STEPS

1. Distribute **Participant Handout 16l: SRH Services for Adolescents Post-Test**.
2. Remind participants that the purpose of the post-test is to evaluate the training, not the participants, so there is no need to put their names on the test forms. Allow **30 minutes** for participants to complete the test.
3. Instruct participants that when they finish the test, they should bring it to you and collect **Participant Handout 16m: Participant Evaluation Form**. They should then return to their seats and fill out the evaluation.
4. Tell participants that they can take as much or as little time as they want to fill in the evaluation form: their responses will help improve future trainings.
5. **Thank participants for bringing their time and their energy over the course of the training.**



PARTICIPANT HANDOUT 16L: SRH SERVICES FOR ADOLESCENTS POST-TEST

Instructions: Write in “V” for very young adolescents (10-14) “O” for older adolescents, or “B” for both.

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

- ___ reaches physical and sexual maturity
- ___ focused on the present with little future-planning
- ___ growth in capacity for abstract thought
- ___ concern about being “normal” and comparison of self to others in peer group
- ___ rapidly changing sense of sexuality and gender

Instructions: Circle all 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. Understanding the sociocultural pressures on adolescents can help providers address adolescent risk-taking.
- c. Adolescents need different services from adults.
- d. Life-long health habits are established during adolescence.
- e. Adolescent clients may ask to see a training certificate.

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

- a. Heart conditions.
- b. Anemia.
- c. Depression and self-harm.
- d. Injuries.
- e. 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. Adolescents face sociocultural barriers to health information and services.
- c. Young people have less power to make decisions about their sexual behavior.
- d. Adolescents are more susceptible to colds, flu, and other infections.
- e. Services for adolescents are too expensive.
- f. Services are not accessible

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. Some appropriate prevention strategies for adolescents to reduce risk of STI transmission include:

- a. Only abstinence from all sexual activity.
- b. Vaccination for HPV.
- c. Consistent and correct use of male and female condoms.
- d. Regular testing between partners.

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

- a. IUD
- b. Combined oral contraceptives
- c. Progestin-only contraceptive (progestin-only pills, implants, injectables)
- d. Lactational amenorrhea method

8. You can assess the capacity of an adolescent client to make health decisions by:

- a. Watching for signs that the client is nervous or refusing to provide information.
- b. Looking for decisions the adolescent has made independently about their health care.
- c. Allowing the adolescent to express their opinion about their health care and considering that opinion in your advice.
- d. Their age alone.
- e. Their disability alone

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 labour.
- c. Spontaneous abortion.
- d. Still birth.
- e. Anemia.
- f. Delivery complications

10. Which rights do adolescents have?

- a. The right to information and education about sexual and reproductive health.
- b. The right own, control, and protect ones' own body.
- c. The right to sexual pleasure.
- d. The right to privacy and confidentiality when accessing health services.
- e. The right to choose one's sexual and romantic partners.
- f. The right to make decisions about their sexual and reproductive health.

11. What responsibilities does a provider have to disclose an adolescent client's HIV status?

- a. To disclose to the adolescent's parent/guardian.
- b. To disclose to the adolescent.
- c. To disclose to the adolescent's sexual or romantic partners.
- d. To disclose to the parent/guardian of the adolescent with disability.

12. Which methods of contraception may not be suitable to the adolescent client?

- a. Emergency contraception
- b. Combined oral contraceptives
- c. Sterilization
- d. Condoms
- e. IUDs

13. Which of the following reactions are appropriate when an adolescent client is struggling with sexual orientation or gender identity?

- a. Suggesting counseling to help "fix" the problem or make it go away.
- b. Offering non-judgmental counseling and support.
- c. Electro-shock or invasive sexual treatments.
- d. Providing SRH counseling and services with an open clinical manner.

14. 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.
- e. Dismissing the rumor as "stupid" or "obviously wrong."

15. Which of the following reactions are appropriate when dealing with adolescent clients with visual disabilities?

- a. Raising the tone of your voice
- b. Offering non-judgmental counseling and support.
- c. Focusing on the origin of their impairment
- d. Providing accessible information and materials

Instructions: Write in the correct answers.

16. Name two common sources of sexual and reproductive health information for adolescents.

17. Name a model of youth-friendly service delivery that is accessible for out-of-school adolescents.

18. What does dual protection mean?

19. Name the major barriers to SRH information and services youth with disabilities face

20. What does universal design mean?

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

21. ___ International policies agreed to by a majority of the world's countries call for sexual and reproductive health information and services to be available to adolescents.

22. ___ Rape only happens to women.

23. ___ International conventions signed by a majority of the world's countries call for sexual and reproductive health information and services to be available to persons with disabilities.

24. ___ STIs cannot be transmitted through oral sex.

25. ___ Rape does not happen to youth with disabilities.

26. ___ Young persons with and without disabilities have equal rights to access sexual and reproductive health information and services

27. ___ Young persons with disabilities are asexual

28. ___ Young persons with disabilities are more vulnerable to contract HIV

PARTICIPANT HANDOUT 16M: PARTICIPANT EVALUATION FORM

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 course 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 role plays and case study practices were 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 the needs of adolescents. 5 4 3 2 1
- Dispel rumors and misconceptions about SRH. 5 4 3 2 1
- Dispel rumors and misconceptions about sexuality and disability 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 and 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?

Do you feel that the disability-related information provided was helpful for you to learn how to better support youth with disabilities? What would you have liked to learn more?