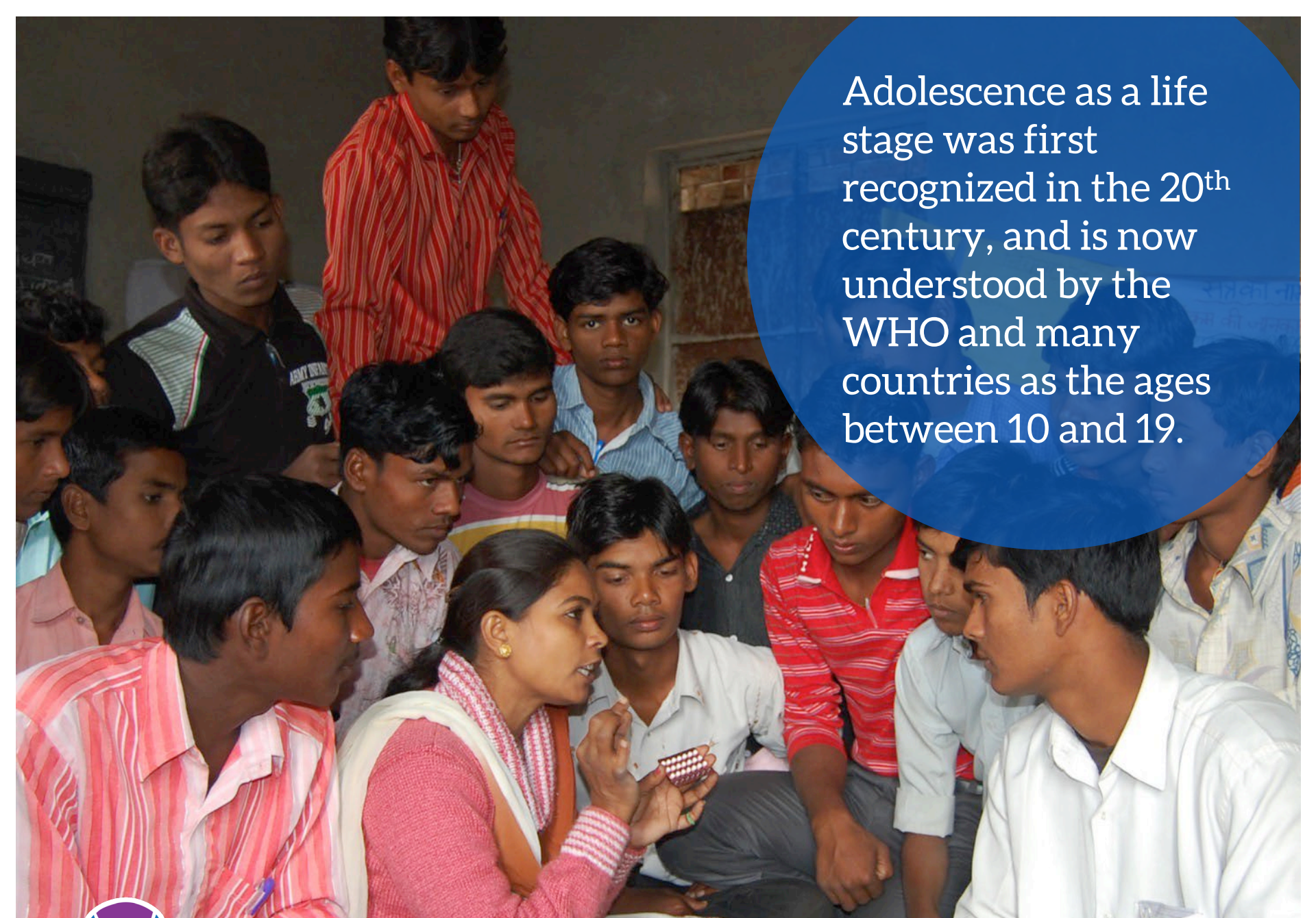




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Unit 2: Nature of Adolescence

Changes during Adolescence



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





Adolescence is a stage of life characterized by changes in young people's physical, cognitive, and social and emotional development.



PHYSICAL CHANGES

- *Early Adolescence:*
 - 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:*
 - physical growth slows for girls;
 - physical growth continues for boys.



COGNITIVE CHANGES

- *Early Adolescence:*
 - growth in capacity for abstract thought;
 - mostly interested in present with little thought for future;
 - expansion of and increased importance placed on intellectual interests;
 - deepening of moral thought.
- *Late Adolescence:*
 - 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, community;
 - questioning of faith, beliefs, and meaning of life;
 - growing interest in social justice, equity, and fairness.



SOCIAL AND EMOTIONAL CHANGES

- *Early Adolescence:*
 - Struggle with sense of identity;
 - feel awkward about themselves and their body;
 - worry about being ‘normal’;
 - developing critical lens of and heightened conflict with parents;
 - increasing identification with peer group;
 - increase in desire for independence;
 - prone to mood swings;
 - beginning to test rules and boundaries;
 - increased interest in privacy;
 - increased awareness of sexual desire.



SOCIAL AND EMOTIONAL CHANGES

- *Late Adolescence:*
 - Intense self-involvement, alternating between high expectations and poor self-identity;
 - adjustments to changing body and corresponding swings in self-esteem and confidence;
 - worry about being ‘normal’ and comparing self to others in peer group;
 - occasionally fluid or rapidly changing understanding of sexuality and gender;
 - heightened sense of justice and fairness;
 - increased drive for independence with resultant distance from parents or other authority figures;
 - increasing awareness of responsibilities to family and community;
 - greater reliance on friendship networks and peer group;
 - heightened capacity for emotional regulation;
 - experience feelings of love and passion;
 - increasing interest in sex.



- 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.



Evolving Capacity



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.



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.



EVOLVING CAPACITY

- 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.





**Sexual
Rights and
Reproducti
ve Rights**



SEXUAL RIGHTS AND REPRODUCTIVE RIGHTS

- 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.



SEXUAL RIGHTS AND REPRODUCTIVE RIGHTS

- 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.



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



SOURCES FOR SEXUAL & 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



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



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.





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Unit 3: Adolescent vulnerabilities, risk- taking Behaviors, and consequences

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.



REASONS FOR RISK-TAKING

- **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.



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.



COMMON VULNERABILITIES

- 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.



COMMON VULNERABILITIES

- 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.



COMMON VULNERABILITIES

- 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.



COMMON VULNERABILITIES

- 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.
 - Adolescent 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.



COMMON VULNERABILITIES

- Disability-based discrimination
 - 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.



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



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





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Unit 4: Adolescent Behavior and Social Issues

Challenges for Adolescent SRH Services

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.



GENDER ROLES CONTINUED

- 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.
- Boys are expected to express dominance in social and sexual relationships. This sometimes leads to interpersonal or sexual violence.
- 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 may be expected to remain home and take on more household responsibilities.
- 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.
- Girls are expected to give, be accommodating, and be more emotional.



GENDER ROLES AND DISABILITY

- 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.



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.



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.



RELATIONSHIPS WITH PARENTS AND FAMILY

- 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.



RELATIONSHIPS WITH PARENTS AND FAMILY

- 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.



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.



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.



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.



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.



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.



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.”



ASSERTIVE COMMUNICATION

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



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?



DECISION-MAKING AND SELF CONTROL

- 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.





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Unit 5: Very Young Adolescents

Challenges for Adolescent SRH Services

SRH NEEDS OF VERY YOUNG ADOLESCENTS

- 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.



SRH NEEDS OF VERY YOUNG ADOLESCENTS

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.



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.



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.



EARLY/CHILD MARRIAGE

- 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.



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 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.



PROTECTIVE SCREENING

- 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).



PROTECTIVE SCREENING

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.



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.





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Unit 6: Sexual Orientation and Gender Identity and Expression

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.



CONCERNS OF LGBTQI ADOLESCENTS

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.



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.



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.



HARASSMENT AND DISCRIMINATION

- 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 *or perceived* sexual orientation or gender identity.
- 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)
- 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.



HARASSMENT AND DISCRIMINATION

- 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)
- Adolescents who identify as LGTBQ may be forced into emotionally abusive or damaging “reparative” therapies or may be subject to “corrective” rape or sexual violence.
- 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)



HARASSMENT AND DISCRIMINATION

- People who identify as transgender or have gender identities or expressions which are not considered “normal” by their communities are particularly targeted for violence.
- Between January 2008 and October 2014, there were 1,612 reported killings of transgender people in 62 countries.
- Persons with disabilities who identify as LGBTQI are more likely to report having experienced harassment or violence than those without disabilities.



HARASSMENT AND DISCRIMINATION

- 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)



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.



ADVICE FOR HEALTH PROVIDERS — *(SOURCE: SAHM 2013)*

- 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 LGTBQI patients with and without disabilities and members of the community.



SCREENING FOR HARASSMENT, DISCRIMINATION & 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.



SCREENING FOR HARASSMENT, DISCRIMINATION & VIOLENCE

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.



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.



A woman with dark hair, wearing a bright green sari, is speaking into a silver microphone. She is looking slightly to her left. In the background, a large group of children, mostly girls, are looking towards her. The scene appears to be an outdoor gathering or a school event. A large purple circle is overlaid on the left side of the image, containing the text 'Defining Gender and Sex'.

Defining Gender and Sex



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.



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.



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.



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.



HEALTH PROVIDERS AND PARENTS

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*).



SPECIFIC CARE STRATEGIES: INTERSEX ADOLESCENTS

- 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.

(Source: Frader et al, 2004)



PREVENTATIVE AND BASIC SERVICES

- 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.



PREVENTATIVE AND BASIC SERVICES

- 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.

(Source: Wylie et al, 2016)





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Unit 7: Communicating with the Adolescent Client

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..



TRUSTWORTHY COUNSELING

- 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.



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.



TIPS FOR GOOD COMMUNICATION

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.



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.



FOSTERING COMFORT

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.



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.



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.



A woman with dark hair, wearing a bright green sari, is speaking into a silver microphone. She is looking towards the left of the frame. In the background, a large group of children, mostly girls, are looking towards her with various expressions of interest and attentiveness. The scene appears to be an outdoor or semi-outdoor community gathering.

Counseling
about
Sexuality and
SRH



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.



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.



COMMUNICATING ABOUT SEXUALITY

- 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.



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.



UNDERSTANDING ADOLESCENT DECISION-MAKING

- 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.



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?”*





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Unit 8: The SRH Visit and the Adolescent Client

Challenges for Adolescent SRH Services

Screening for adolescents for SRH services can be sensitive in nature, in part due to cultural or social pressures on adolescent sexuality.



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.



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.



TIPS FOR CONDUCTING AN ASSESSMENT OF AN ADOLESCENT CLIENT

- *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.



TIPS FOR CONDUCTING AN ASSESSMENT OF AN ADOLESCENT CLIENT

- 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.



TIPS FOR CONDUCTING AN ASSESSMENT OF AN ADOLESCENT CLIENT

- *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)



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.



HEADSSS 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
- Education/Employment
- Eating
- Activity
- Drugs
- Sexuality
- Safety
- Suicide/Depression



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?



EDUCATION & EMPLOYMENT

- Do you go to school?

If the answer is yes:

- 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?



EATING AND EXERCISE

- 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.



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?



DRUGS AND SUBSTANCES

- 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?



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?



SEXUALITY

- 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?



SEXUALITY

- 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?



SUICIDE/DEPRESSION

- Have you felt more stressed or anxious than usual?
- 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?



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?



WRAP UP

- 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.



ASSESSING SRH IS AN IMPORTANT ASPECT OF ADOLESCENT HISTORY TAKING

- The HEEADSSS 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.



SGBV SCREENING

- 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.



Adolescent Physical Exams



BEFORE THE PHYSICAL EXAM

- Explain why the visit is important.
- Respect the adolescent's sensitivity about privacy. If the adolescent is with an accompanying 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 possible or 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, 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. Try to establish trust.



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.



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.



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.



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.



GENERAL ELEMENTS OF A PHYSICAL EXAM

- 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.



GENERAL ELEMENTS OF A PHYSICAL EXAM

- 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.





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Unit 9: Contraception and Risk Reduction Counseling for Adolescents

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.



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.



MISCONCEPTIONS

- 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.



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.



METHODS FOR COUNTERACTING RUMORS AND MISCONCEPTIONS

- 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.



Adolescent SRH Landscape



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).



GLOBAL STATISTICS

- 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.



GLOBAL STATISTICS

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.



ABSTINENCE

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.



ABSTINENCE

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.



ABSTINENCE

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.



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.



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.



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.



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.



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.



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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.



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.



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.



SIDE EFFECTS AND THEIR EFFECT ON CLIENTS

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 AND THEIR EFFECT ON CLIENTS

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.





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Unit 10: Safe Abortion and Post-Abortion Care for Adolescents

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.



REASONS THAT ADOLESCENTS SEEK UNSAFE OR LATE ABORTION

- 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)



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)



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)



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.



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*.



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.



ADDRESSING HEALTH SYSTEM BARRIERS

- 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.



Considerations for Counseling Adolescent Clients



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.



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)



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 PAC COUNSELING

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)





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Unit 11: STIs, HIV, and Adolescents

Adolescent-Friendly Language

INFORMATION ENVIRONMENT

Adolescents and young people navigate a complicated world of stereotypes, half-truths, and taboos when it comes to finding information about gender, sexuality, sexual health, STIs, and HIV. Even well-meaning adult sources of information for adolescents, such as parents, teachers, and local media, may not have all the latest medical or scientific information or be trained or comfortable explaining complicated and sensitive issues to young people.

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. Remember from Unit 1: adolescents are incredibly sensitive to dishonesty, unfairness, or judgment from adults, and respond more positively to honesty and direct language.



COMMON STATEMENTS ABOUT ADOLESCENTS

- Youth lack self-control around sexual decision-making and have unplanned sex.”
- “Adolescents lack basic knowledge on the, transmission, and treatment of STIs.”
- “Experimentation with drugs and alcohol is common among adolescents and often leads to irresponsible decisions, including having unprotected sex.”
- “Young people often confuse sex with love and engage in sex before they are ready in the name of ‘love.’”



There are some social dynamics and factors that affect adolescents' risk for STI and HIV infection that providers should be aware of.

- Gender norms that drive power imbalances and inequality can make adolescents more susceptible to gender based and sexual violence, as well as sexual coercion.
- The growing need to belong to a social group that adolescents experience may also increase the likelihood of sexual coercion and/or social pressures to have sex.
- Many cultures expect adolescent sexuality to be hidden or non-existent, in particular the sexuality of young people living with HIV or other minority young people.
- Taboos that prevent young people from seeking accurate information on sexuality and sexual health also leave them with questions and assumptions about the level of sexual activity and risk common among their peers.
- Young people are frequently disenfranchised and disempowered in their homes and communities, and sometimes this increases their vulnerability for being forced into early marriage, female genital mutilation/cutting, or violent, coercive, or transactional sexual relationships.
- Adolescents may be afraid to seek testing or treatment for STIs or HIV because of the social stigma attached to a positive test result.



A smiling woman with dark skin and short hair is holding a baby wrapped in a pink cloth. She is wearing a colorful patterned top and a beaded necklace. The background is a thatched structure made of sticks and straw. A blue circular graphic is overlaid on the right side of the image.

STI Prevalence and Testing



STI PREVALENCE

Sexually transmitted infections, or STIs, are increasingly common among all people, including adolescents, worldwide. The WHO and the Center for Disease Control in the US now estimate that:

- Most sexually active adults will contract some strain of HPV at least once in their lifetime.
- More than 500 million people have genital infection with HSV.
- There are an estimated 357 million new infections each year with one of four bacterial STIs: chlamydia, gonorrhea, syphilis, and trichomoniasis.



Many STIs have mild or infrequent symptoms, and due to lack of education and access to information combined with cultural stigmas and taboos, many adolescents, young people, and adults fail to access sexual health services when symptoms do appear.



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 larger 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.

Where testing is available, it is often expensive or geographically inaccessible, creating unacceptably long delays or extra burden for clients to receive their results. Low-cost, rapid tests are available for HIV and syphilis, though the test for syphilis is newer and may not be in widespread use in youth clinics.



EFFECTIVE TREATMENT OF STIS

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 single-dose regimens of antibiotics.
- For herpes and HIV, the most effective medications available are antivirals that can modulate the course of the disease, though they cannot cure the disease.
- 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 2 STIs: hepatitis B and HPV. These vaccines have represented major advances in STI prevention. The vaccine against hepatitis B is 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.



STI DRUG RESISTANCE

Resistance of STIs—in particular gonorrhoea—to antibiotics has increased rapidly in recent years and has reduced treatment options. The emergence of decreased susceptibility of gonorrhoea to the “last line” treatment option (oral and injectable cephalosporins) together with antimicrobial resistance already shown to penicillins, sulphonamides, tetracyclines, quinolones and macrolides make gonorrhoea a multidrug-resistant organism. Antimicrobial resistance for other STIs, though less common, also exists, making prevention and prompt treatment critical.



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 often relies on clinical algorithms, allows health workers to diagnose a specific infection on the basis of observed 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 syndromes - the majority of STIs globally.



CHALLENGES WITH SYNDROMIC MANAGEMENT

In addition to the challenge of diagnosing and treating STIs with few or mild symptoms, many STIs present with symptoms that are identical to or mimic other health issues.

EXAMPLE: Vaginal Discharge

- Often vaginal discharge is either normal or related to vaginal infections.
- In many settings, 40-50% of women will say "yes" when asked if they have discharge. This can lead to massive overtreatment of STIs, which can increase risk of developing drug resistance.
- Studies of the validity of syndromic management have shown that vaginal discharge should not be used as a routine screening tool. There is some evidence that syndromic management of vaginal discharge can be improved by examination of the cervix to determine whether there is a cervical discharge or inflammation, but this requires training, tools, time, and supplies.





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Unit 12: Adolescents Living with HIV

Adolescent-Friendly Language

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.



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.



DISCLOSURE TO ADOLESCENTS

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.



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.



TIPS FOR DISCLOSING TO AN ADOLESCENT CLIENT

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.



TIPS FOR DISCLOSING TO AN ADOLESCENT CLIENT

- 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.



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.



LEGAL DISCLOSURE REQUIREMENTS

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.”



LEGAL DISCLOSURE REQUIREMENTS

- 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.



LEGAL DISCLOSURE REQUIREMENTS

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.



LEGAL DISCLOSURE REQUIREMENTS

- 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.
- 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?





Adolescents Living with HIV



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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.



MODES OF TRANSMISSION

The specific needs and challenges of three groups should be considered:

- *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.



MODES OF TRANSMISSION

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.



MODES OF TRANSMISSION

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.

(Source: Adapted from WHO 2013a)





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Unit 13: Sexual and Gender Based Violence

Adolescent-Friendly Language

Screening for Gender- Based Violence



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.

- Globally, about 1 in 3 of all women have experienced either physical and/or intimate partner violence in their lifetime.
- 1 in 4 women aged 15 to 19 worldwide report sexual violence since the age of 15.
- As many as 70% of adolescent women report their first sexual experience as forced.
- 1 in 3 girls aged 13 to 15 experience regular bullying.
- Globally, 40-68% of young women with disabilities and 16-30% of young men with disabilities experience sexual violence before the age of 18.



CULTURAL ENVIRONMENT

- More than 200 million girls and women alive today have undergone female genital mutilation.
- 1 in 3 girls in the developing world are married before the age of 18.
- 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)



SCREENING ENVIRONMENT

What do you do if you suspect that an adolescent client has experienced sexual or gender-based violence?

- Do not raise the issue in front of partners, parents, or caretakers. Only ask about violence when the client is alone.
- Establish a safe, private, and confidential environment for the client.
- Use empathetic, non-judgmental body language and words.
- Use words that are appropriate and relevant, and that the client is most comfortable using.
- 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. Avoid distraction and interruption.



SCREENING ENVIRONMENT

- 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.*
- Maintain respectful attitude, calm voice, and eye contact as culturally appropriate.
- Avoid distraction and interruption.
- Take time to collect all needed information



SCREENING QUESTIONS

Here are some simple and direct questions you can pose if you suspect a client is experiencing SGBV:

- Are you afraid of your parents/husband/wife/partner/caregiver?
- Has anyone ever threatened to hurt you or physically harm you in some way? When did it happen?
- Does someone at home or in your life bully or insult you?
- 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?
- Has anyone forced you or pushed you to have sexual contact that you didn't want at the time?
- Has anyone threatened to kill you?

(Source: WHO 2014)



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.

- Give the client time and make sure they know they can come back for any reason.
- Tell them about services that are available if they need or decide to use them.



A woman with dark hair, wearing a bright green sari, is speaking into a silver microphone. She is looking slightly to her left. In the background, a large crowd of people, including children and adults, are visible, some looking towards the speaker. A large purple circle is overlaid on the left side of the image, containing the text 'SGBV Screening'.

SGBV Screening



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.



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.



EMOTIONAL NEEDS

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.



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

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Slide 13.10

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.



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.



PHYSICAL EXAM

- 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).



PHYSICAL EXAM

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.

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



PHYSICAL EXAM

- Ask if there is any additional or specific support that the client desires such as a friend or family member.
- Ask if the client is comfortable with a male provider examining her. If not, find a female provider.
- 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.



PHYSICAL EXAM

- 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.
- Close the presentation by asking if there are any questions about screening or the counseling environment for adolescents who have experienced SGBV.



Services for Survivors



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.



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



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.



TREATMENT

- **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.



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.



SERVICES FOR ADOLESCENT SURVIVORS OF CHILDHOOD SGBV

- **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.





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Unit 14: Adolescent Birth, Postpartum care, and Parenting

Adolescent-Friendly Language

Antenatal Care for Adolescents



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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)



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?



ADOLESCENT RISK ASSESSMENT

- 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



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.



THE ANTENATAL VISIT

- 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.



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)



DEVELOPING A BIRTH PLAN

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)



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?



Support during Birth and Postpartum



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.



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.



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.



POSTPARTUM PERIOD

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)



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.





Adolescent Parenting



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.



WHAT ADOLESCENT FATHERS NEED

- 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.



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.



WHAT ADOLESCENT MOTHERS NEED

- 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.



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.



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 is 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.



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.



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.



ADOLESCENTS AND BREASTFEEDING

- 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.



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.



PARENTING: BOTTLEFEEDING

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.





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Unit 15: Designing Adolescent Services

Adolescent-Friendly Language

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 disabilities, 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.



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 disabilities and provide them accommodations as needed. More information available in the “Adolescents with disabilities” 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.



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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 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: 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.



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.



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.



DESIGN CHARACTERISTICS

- 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.



Different YFS Models



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.



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.



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.



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.



MODEL 4: MOBILE OUTREACH SERVICES

- 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.



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.



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.



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.





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