

UNIT 2: NATURE OF ADOLESCENCE

INTRODUCTION:

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

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


UNIT TRAINING OBJECTIVE:

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




SPECIFIC LEARNING OBJECTIVES:

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

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

 *TOTAL TIME: 6 HOURS 35 MINUTES*

UNIT OVERVIEW:

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



WORK FOR TRAINERS TO DO IN ADVANCE:

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

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



MAJOR REFERENCES AND TRAINING MATERIALS:

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

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

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

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

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

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

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



TIME

60 min



METHODS

- Storytelling exercise
- Group discussion
- Brainstorm



MATERIALS NEEDED

- Red cards for each participant
- Flipcharts and markers



STEPS

Time: 30 minutes

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

Content: Abena's Story

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

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

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

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

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

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

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

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

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

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

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

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

Time: 15 minutes

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

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

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

Supplemental Content: Barriers for Adolescents

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

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

Internal Barriers

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

Legal Barriers

Laws and policies that:

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

Structural/Economic Barriers

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

Socio-cultural Barriers

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

Time: 15 minutes

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

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



Supplemental Content: Adolescence and Services for Adolescents

What is Adolescence?

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

Why do adolescents need specialized attention?

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

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

SPECIFIC OBJECTIVE 2.2: IDENTIFY THE CHANGES THAT OCCUR DURING ADOLESCENCE



TIME

1 hour 10 minutes



METHODS

- Brainstorm
- Trainer Presentation



MATERIALS NEEDED

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



STEPS

Time: 40 minutes

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

Time: 30 minutes

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

Content: Changes During Adolescence (Slides 2.1-2.2)

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

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

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

Slide 2.3: Physical Changes

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

Slide 2.4: Cognitive Changes

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

Slide 2.5-2.6: Social and Emotional Changes

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

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

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

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

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

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

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

TIME

2 hours 35 minutes

METHODS

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

MATERIALS NEEDED

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

STEPS

Time: 1 hour 15 minutes

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

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

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

Time: 10 minutes

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

Content: Evolving Capacity (Slides 2.8-2.10)

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

Slide 2.9-2.10: Evolving Capacity

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

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

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

Time: 1 hour

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

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

Content: Case Studies

Case Study 1:

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

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

Case Study 2:

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

Case Study 3:

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

relationship?

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

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

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

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

Get a job

Finish school

**Learn about sex and sexual
health**

Learn about contraception

**Start becoming interested
in the opposite sex**

Have a serious relationship

**Learn about puberty and
menstruation**

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

Have first kiss

**Have first sexual
experience**

Learn a trade

**Contribute to the
household income**

Leave home

Go to the market alone

Travel alone

Go to a dance club or bar

**Have close friends of the
same sex**

**Have close friends of the
opposite sex**

Visit a health provider

**Learn about sexual
orientation**

Explore masturbation

**Learn about sexual
pleasure**

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

TIME

1 hour 40 minutes

METHODS

- Trainer presentation
- Small group activity

MATERIALS NEEDED

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

STEPS

Time: 40 minutes

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

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

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

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

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

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

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

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

Slide 2.13: SRH Definitions

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

Source: World Health Organization

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

Source: UNFPA

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

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

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

and Reproductive Rights

Slide 2.15: Adolescents' Sexual and Reproductive Rights

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

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

Source: Amnesty International

Slide 2.16: Sexual Rights

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

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

Time: 1 hour

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

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

The right to decide freely and responsibly on all aspects of one's sexuality.

The right to information and education about sexual and reproductive health.

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

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

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

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

The right to audio and visual privacy and confidentiality when consulting health workers and doctors.

The right to be treated with dignity, courtesy, attentiveness, and respect.

The right to express views on the services offered.

The right to gender equality and equity, and to safe expression of one's gender identity.

The right to receive sexual and reproductive health services for as long as needed.

The right to feel comfortable when receiving services.

The right to choose freely one's life/sexual partners.

The right to celibacy.

The right to refuse marriage.

The right to say no to sex within marriage.

UNIT 2 SUMMARY



TIME

20 minutes



METHODS

- Reflection



MATERIALS NEEDED

- None



STEPS

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