

UNIT 7:

COMMUNICATING WITH THE ADOLESCENT CLIENT

INTRODUCTION:

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

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

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

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

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

 **UNIT TRAINING OBJECTIVE:**

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




 **SPECIFIC LEARNING OBJECTIVES:**

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

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

 **TOTAL TIME: 7 HOURS**

UNIT OVERVIEW:

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

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

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

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

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



TIME

1 hour



METHODS

- Warm Up
- Group Brainstorm
- Communication Exercise



MATERIALS NEEDED

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



STEPS

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

Time: 20 minutes

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

say “The End.”

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

Time: 20 minutes

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

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

Supplementary Content: Feelings of the Adolescent

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

- ***Shy*** about being in a clinic (especially for SRH) and about needing to discuss personal matters.
- ***Embarrassed*** to be seeking SRH care.
- ***Worried/Concerned*** that someone they know might see them and tell their parents, family, or caretakers, or spread rumors about them at school or in the community.
- ***Unprepared*** to describe their concerns, and poorly informed about SRH matters in general.
- ***Anxious or afraid*** that they have a serious condition that has significant consequences (e.g. STI, HIV, unintended pregnancy).
- ***Intimidated*** by the medical facility and/or the many “authority figures” in

the facility.

- **Defensive** about being the subject of the discussion or because they are there against their will.
- **Resistant** to accepting help because of discomfort or fear, or lack of trust in the health provider.
- **Fearful** of being mistreated, judged, or turned away by clinic staff.

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

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

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

Time: 20 minutes

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

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

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



PARTICIPANT HANDOUT 7A: VERBAL AND NON-VERBAL COMMUNICATION

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

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

Positive nonverbal cues include:

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

Negative nonverbal cues include:

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

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

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

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

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

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

S = Smile

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



TIME

1 hour 45 minutes



METHODS

- Trainer presentation
- Small group discussion



MATERIALS NEEDED

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



STEPS

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

Time: 40 minutes

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

Slides 7.1-7.2: Trustworthy Counseling

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

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

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

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

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

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

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

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

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

Slides 7.3-7.4: Tips for Good Communication

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

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

The following tips facilitate **good communication**:

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

Slides 7.5-7.7: Fostering Comfort

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

continue making healthy decisions.

Three factors contribute to the comfort of the adolescent client:

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

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

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

When should one break confidentiality?

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

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

Slide 7.8: Building Trust and Rapport

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

Important conditions for trust and rapport include the following:

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

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

Time: 1 hour 5 minutes

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



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

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

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

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

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

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



TIME

2 hours 15 minutes



METHODS

- Trainer presentation
- Values clarification
- Role play



MATERIALS NEEDED

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



STEPS

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

Time: 30 minutes

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

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

Slide 7.9: Benefits of a Positive Counseling Experience

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

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

Slides 7.10-7.11: Communicating about Sexuality

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

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

- Help the adolescent plan how to implement their choice.

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

Slides 7.12-7.13: Understanding Adolescent Decision-Making

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

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

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

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

Time: 60 minutes

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

to their response.

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

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

Content: Clarifying Sexual Values

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Time: 45 minutes

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

Slide 7.14: Types of Questions

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

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



PARTICIPANT HANDOUT 7C: CLARIFICATION TECHNIQUE

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

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

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



TIME

1 hour 40 minutes



METHODS

- Simulated skills practice
- Group discussion



MATERIALS NEEDED

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



STEPS

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

Time: 10 minutes

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

Time: 1 hour 30 minutes

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

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

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

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

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

Service Providers:

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

Clients

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

Programmatic Factors

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

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

PARTICIPANT HANDOUT 7E: COUNSELING SKILLS CHECKLIST

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

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

ROLE CARDS: ADOLESCENT CLIENTS

Role 1: Mohammed

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

Role 2: Maria

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

Role 3: Gabriel

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

Role 4: Amina

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

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

Role 5: Gloria

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

UNIT 7 SUMMARY



TIME

15 minutes



METHODS

Group check-in



MATERIALS NEEDED

None



STEPS

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