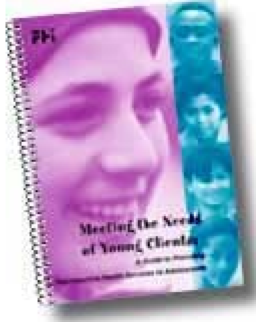
In July 2011, FHI became FHI 360.

FHI 360 is a nonprofit human development organization dedicated to improving lives in lasting ways by advancing integrated, locally driven solutions. Our staff includes experts in health, education, nutrition, environment, economic development, civil society, gender, youth, research and technology – creating a unique mix of capabilities to address today's interrelated development challenges. FHI 360 serves more than 60 countries, all 50 U.S. states and all U.S. territories.

Visit us at www.fhi360.org.



Meeting the Needs of Young Clients: A Guide to Providing Reproductive Health Services to Adolescents

Preface: Using This Handbook

Adolescents are the forgotten millions in reproductive health programs. Although the numbers of young people who need information and services are enormous, services are scarce, fragmented or nonexistent.

This manual will help service providers and health workers strengthen the reproductive health care and services offered to young women and men. The focus is on two important aspects of reproductive health:

- Prevention of unplanned pregnancies.
- Prevention of sexually transmitted infections (STIs), including HIV/AIDS.

It can also be used as a tool for designing, improving and implementing adolescent health programs by:

- Health workers. (We use the terms "health worker" and "service provider" interchangeably in this document.)
- Workers in nongovernmental organizations (NGOs) that offer health services to young adults.
- Program managers and planners.
- Health educators who work with youth.

This manual emphasizes that:

- Adolescents both male and female have a right to accurate reproductive health information and quality services.
- Adolescents are capable of making informed choices about whether to use contraception, which methods to use and how to prevent STIs.
- All contraceptive methods are medically safe for adolescents, although some may be more appropriate for this age group than others.
- Reproductive health is a lifelong process the decisions young people make have an impact on their current and future health.
- Young people view sexual issues in the context of the larger social, cultural and economic climate in which they live.
- AIDS is a real threat to young people. Because there is no cure, prevention is key.

The following chapters will:

- Explore the vast need for adolescent reproductive health services.
- Identify the barriers young people encounter in obtaining health care, including service providers' attitudes about adolescent sexuality.
- Provide updated information on pregnancy and STI prevention, post-pregnancy services and other reproductive health issues.
- Provide guidance on counseling for adolescents.
- Consider ways in which family planning programs can better meet the health-care needs of young women and men.

Section I provides background information on adolescents' needs and technical information on contraception, STIs and HIV/AIDS. **Section II** focuses on service delivery, particularly counseling. As you read this manual, remember that young people need a variety of reproductive health services. Integrating contraceptive services, STI prevention and treatment programs and prenatal care will help young people receive the comprehensive services they need.

At the end of each chapter are questions for health-care providers and program managers. These questions are designed to help you:

- Identify services already in place for young people.
- Evaluate what works well in your community and what does not.
- Develop new approaches to close gaps in service delivery.

You may answer the questions individually or discuss them with colleagues or other program staff. Space has been provided at the end of the handbook for your answers and for other note-taking.

Chapter 1: Adolescents: An Underserved Population

Adolescence is the transition from childhood to adulthood, marked by profound physical, emotional, mental and social changes.

In this manual, we define adolescence as the time period from ages 10 to 24. We use the terms "adolescents," "youth," "young adults" and "young people" interchangeably. In such a broad age range, reproductive health needs can vary greatly. The needs of a 10-year-old who has not yet reached puberty and who is not sexually active will be considerably different from those of an 18-year-old who is newly married, or a 24-year-old with two children. As a health-care provider, you should individually assess the reproductive health status, goals and needs of each adolescent.

"We believe that information should be given as early as age 10 to 12 because they are practicing sex at an early age."

-- Peer health educator in Ethiopia

Change is the hallmark of adolescence. Physical changes, such as growth of facial hair for boys and onset of menstruation for girls, take place during puberty, which occurs mostly from ages nine to 14 for boys and ages eight to 13 for girls. Emotionally, young people move toward independence from their parents or elders and establish new interests and relationships.

As adolescents become adults, they consider sexual relations, marriage and parenthood as signs of maturity. They seek information and clues about sexual life from a variety of sources parents, peers, religious leaders, health providers, teachers, magazines, books and mass media. While youth receive a wealth of information from diverse sources, a good deal of that information is incorrect, incomplete or misleading.

Adolescents obtain information and make decisions within the context of the culture in which they live. Decisions and actions may be affected by violence, drug and alcohol use, school attendance, work, economic opportunities, self-image and autonomy in decision-making.

As a service provider, you can be a valuable source of accurate information for young women and men. You can offer facts and reassurance, answer questions and provide a variety of health services.

"You have to invest in education for young people. Especially sexuality education."

Health project manager in Haiti

There are two main reasons reproductive health programs should offer information and services to adolescents:

- Young people have a *right* to quality reproductive health services.
- Young people *need* reproductive health services.

Adolescents' needs for reproductive health services are often misunderstood, unrecognized or underestimated. Consider:

- Nearly half the world's population is under age 25.
- Adolescents account for approximately 10 percent of all births worldwide. Each year 15 million girls ages 15 to 19 have babies.
- Girls under 16 years old are twice as likely to die in childbirth as women in their early twenties.
- Two to four million adolescents in developing countries have unsafe abortions each year.
- Eleven percent of young women ages 15 to 19 have an unmet need for contraception.
- Nearly half of all HIV infections worldwide occur in people under age 25.
- Seven in 10 new STIs occur among individuals 15 to 24 years old.

Young people's reproductive health needs vary. Depending on their individual situation, they may need:

- Skills and motivation to help them postpone sex.
- Information, skills and contraceptives to protect themselves against STIs and unplanned pregnancies.
- Counseling to encourage them to change risky behaviors.
- Information to help them delay and space pregnancies.
- Information about and support for prenatal care, child nutrition and breastfeeding.
- Information and support during labor and delivery.
- Protection from violence, forced sex or sexual coercion.

Health services can help adolescents:

- Protect and improve their current health.
- Understand their sexuality and reproductive health needs.
- Learn to take active responsibility for their reproductive health.
- Prevent unplanned pregnancies.
- Prevent serious health problems and premature deaths due to complications from a too-early pregnancy or an unsafe abortion.
- Avoid STIs.
- Make informed choices about reproductive health.
- Ensure a healthy future.

Questions for Providers and Program Managers about Underserved Adolescents

? How is adolescence defined in your community?

? Where do adolescents in your community obtain information about sexuality and reproductive health? Who are the most credible sources of information? Do adolescents receive most of their information from these credible sources?

? What percentage of your clients are adolescents?

? What percentage of adolescent clients are married? What percentage are unmarried?

? What reproductive health services do you think adolescents in your community need?

? What types of services do you offer for adolescents? Do you offer education, services or both?

Chapter 2: Barriers to Good Reproductive Health Care

Adolescents' reproductive health needs are immense, but so are the obstacles young people face in trying to maintain good reproductive health. Lack of knowledge, information and services all create barriers.

Young people may be at risk for reproductive health problems because they:

Lack knowledge and information.
Lack access to services and programs.
Are limited by psychological or social barriers.

"We are adolescents who don't have the courage to go to family planning centers to talk about such things."

Young man in Senegal

Lack of knowledge and information

- Young people lack basic knowledge of reproductive anatomy and physiology, how pregnancies or STIs occur, how to prevent them and where to obtain protection.
- Parents may feel ill-prepared, uncomfortable or embarrassed to talk about sex with their children.
- Well-meaning parents and other adults, eager to protect their children, may believe that education about sexuality and reproductive health will encourage young people to become sexually active.

"I tried hard to get some tablets, but I was chased from the clinic. I think it was because I looked very young at the time."

University student in Zimbabwe

Lack of access to services and programs

- Youth may have little or no money to pay for services, lack transportation or do not know how to use services.
- Health workers may hold judgmental attitudes toward adolescent sexual activity.
- Health workers may not have up-to-date scientific information on contraceptive safety for adolescents.
- Health clinics may not be open at hours that are convenient for young people.
- Clinics often are designed for married women rather than single women, men or adolescents.
- Requirements for medical tests and pelvic exams may discourage young people from seeking contraception.*
- National health policies may present legal barriers to youth seeking reproductive health information or services.

* In most cases, medical tests are not necessary for contraceptive use. A pelvic exam is necessary for diaphragm fitting and intrauterine device (IUD) insertion. However, pelvic exams, laboratory tests and breast exams are not essential for the use of pills, injectables, implants, most barrier methods or natural family planning. Blood pressure checks are advisable before pill use.

Psychological or social barriers

- Adolescents may be afraid to admit they are having sex.

- They may hold unrealistic views of individual pregnancy and STI risks the "it cannot happen to me" syndrome.
- They worry that contraception will damage their health and future fertility.
- They are vulnerable to sexual violence, coercion and abuse.
- Girls may be reluctant to discuss reproductive health issues, fearing knowledge will be interpreted as promiscuity.
- Boys may be reluctant to ask questions about sexuality, fearing that lack of knowledge will mean loss of status among their peers.
- Motherhood may be a means for girls to gain status and respect in their families and communities.
- Sexual activity is often seen as a way for boys to gain status among their peers.
- Sex is a survival tool for young people who live on the street or who are poor.
- They fear they will be shunned or stigmatized if they admit homosexual or bisexual behavior or desires.
- Young people may be afraid or embarrassed to seek help for rape or incest.
- Mass media tend to emphasize fun but not responsibility or consequences of sexual behavior.

Questions for Providers and Program Managers about Barriers to Reproductive Health Care

? What obstacles do young people in your community face in trying to obtain health information or services?

? How can you educate and inform young people in your community about reproductive health?

? How can you educate and inform adults in your community about young people's reproductive health needs?

? What internal policies in your clinic or program discourage young people from seeking reproductive services? How can these policies be modified or removed?

? What national policies discourage provision of information and services to young people?

? How do gender norms societal views on what is appropriate behavior for women and men affect young women's access to health services? How do they affect young men?

? What can your clinic do to help minimize or eliminate barriers to adolescent health education and services?

Chapter 3: Preventing Pregnancy

As a service provider or program manager, you can play a vital role in helping young people prevent too-early pregnancies. You can

- Educate young people about how their bodies function, what changes accompany puberty and how pregnancy occurs.
- Inform youth that reproductive health is a lifelong process.
- Empower youth to delay sexual relations until they feel ready to accept sexual responsibility.
- Help young people develop decision-making skills and feel confident and empowered to follow through on decisions.
- Provide adolescents with information about the health, emotional and socioeconomic risks of adolescent pregnancy.
- Provide referrals and help for young people who feel powerless to determine when they have sex and with whom.
- Offer access to safe, effective and affordable contraception.

As you begin to work with adolescents, you may find your goals are different from the young people you serve. You may want to encourage adolescents to delay sexual activity, but young people may already be sexually active when they come to visit you. You may want couples to consider birth spacing, but young women and men may not want to use contraception until they have reached their desired family size. However, it is important to guard against letting personal biases influence professional behavior. You need to support and encourage young people to make their own decisions and good choices for their future, based on their knowledge and reproductive goals.

When counseling youth about reproductive health, you should explain that adolescent pregnancy carries special health risks. Even when a pregnancy is wanted and planned, the risks are higher for adolescent mothers and their infants. You can explain that there are both health and socioeconomic reasons to delay childbearing until a woman is in her twenties.

Why Delay Childbearing?

Several studies have shown that the outcomes for adolescents who receive good prenatal care are no different from those of older women. However, prenatal care may not be available, and even if it is available, adolescents are less likely to get prenatal care, or they seek treatment later in their pregnancies. They may not recognize the signs of pregnancy, may want to hide a pregnancy, may not realize care is available or may not be able to afford care.

There are several reasons, both medical and socioeconomic, to delay childbearing.

Medical reasons to delay childbearing

A young woman under age 16 has not reached physical maturity. If her pelvis is too small, she may suffer prolonged labor or obstructed delivery, which can result in hemorrhage, infection, fistulaor* death of mother or infant.

Young women, especially those under age 15, are more likely than women ages 20 and older to experience premature labor, spontaneous abortion and stillbirths.

First births are typically more risky than subsequent births. Women giving birth for the first time have a higher probability of developing hypertensive disorders, including preeclampsia and eclampsia, conditions marked by protein in the urine, high blood pressure and edema.

Infant death rates are typically higher for adolescent mothers than for older women.

Socioeconomic reasons to delay childbearing

Delaying childbearing can give young women the opportunity to pursue formal education and work outside the home.

Men who delay the start of their families can pursue educations and jobs without the pressure of providing for a family.

Delayed pregnancy can mean smaller families and can offer economic benefits for the couple.

* A fistula is an abnormal passage created between two internal organs or between an internal organ and a body surface. In prolonged or obstructed labor, fistulas may occur between the vagina and rectum or urethra, leading to incontinence and other health problems.

Contraceptive Methods

Adolescents can safely use any contraceptive method. However, while all methods are medically safe for young people, some may be more appropriate than others. Sterilization is not recommended for young people because it is permanent and because the younger the client, the stronger the likelihood of regret. The following charts offer information on contraceptive methods and their use by adolescents.

As always, you should help the young woman or man consider all contraceptive options, but the final decision rests with the client. For more guidance on how to help young people make informed choices about contraception, see Chapter 6, "Counseling Young People about Reproductive Health."

Contraceptive Methods for Adolescents		
Method Pregnancy Rate*	**Appropriate and Safe for Adolescents?**	**Counseling Issues**
Abstinence	Yes, appropriate for those who have not yet begun sexual activity, as well as for those who have.	• Surest way to prevent pregnancy and STIs. • Requires high degree of motivation, self-control and commitment from both partners.
Periodic abstinence 25%	Yes, when regular menstrual cycles are	• Training is essential to help young people understand fertility and menstruation and

	established. Does not protect against STIs/HIV.	to identify fertile and non-fertile times. • Requires high degree of motivation, self-control and commitment from both partners. • Irregular menstrual cycles, such as in months following menarche or pregnancy, complicate use. • Can be used alternatively with other contraceptives (such as condoms or diaphragms) during fertile days. • Not as effective as some other methods.
Lactational Amenorrhea Method (LAM) **2%** *(first 6 months after birth)*	Yes. Does not protect against STIs/HIV.	• Appropriate for women who are less than six months postpartum, fully or near-fully breastfeeding and amenorrheic. • 98% effective if women meet all three criteria. • If any criteria change, client may not be protected from pregnancy. • Client should discuss other contraceptive options before LAM criteria expire and receive chosen method in advance. (Breastfeeding women should avoid methods containing estrogen since the hormone can affect breastmilk production.
Withdrawal 19%	Yes. Does not protect against STIs/HIV.	• Can be used by a man at any age if he can predict ejaculation and ensure ejaculate will not come in contact with his partner's genital area. • Requires a high degree of motivation, self-control and commitment from both partners. • Not as effective as some other methods.
Male condoms 14%	Yes. Condoms are typically accessible, available and affordable to young people. Protect against STIs/HIV.	• Must be used correctly and consistently with each act of intercourse. • Because of potential for human error, can be less effective than other contraceptives. • Can be used alone or in combination with other contraceptives. • No systemic effects, although some individuals are allergic to latex. • Clients should be instructed to use

		emergency contraceptive pills (ECPs) as a backup method when condom breaks or slips. ECPs can be given in advance.
Spermicides*includes foaming tablets, foams, films, gels and creams 5-50%*	Yes, although they do not provide good protection from pregnancy and STIs. They should be used only when other methods are not available.	• Must be used consistently and correctly with each act of intercourse. • Not as effective as some other methods. • Clients must follow directions about how to place high in vagina and how long to wait before intercourse can begin. • New application of spermicide is necessary for repeated acts of intercourse. • Must be left in place at least six hours after intercourse (douching or rinsing the vagina is not recommended). • Can be used simultaneously with condoms, used as a backup for other contraceptives or used when a couple changes from one method to another. • Side effects include vaginal or penile irritation; switching to another type of spermicide can help. No systemic effects.
Female barrier methods *21% female condom* *20% diaphragm 5-50% cervical cap, sponge*	Yes. Female condom provides protection from STIs/HIV.	• Must be used consistently and correctly with each act of intercourse. • Because of potential for human error, can be less effective than other contraceptives. • Can be used alone or in combination with other contraceptives. • No systemic effects.
Progestin-only pills (POPs) *0.5% (perfect use rate)*	Yes. Does not protect against STIs/HIV.	• Must be taken daily to be effective; should be taken within three hours of the same time every day. • Good choice for breastfeeding women because they do not contain estrogen. • Fertility returns quickly when pills are discontinued. • Clients must be instructed about what to do if pills are missed. • Possible side effects: irregular menstrual cycles, spotting and bleeding between periods, amenorrhea. • Noncontraceptive benefits: reduced risk of

		ovarian cancer, endometrial cancer and pelvic inflammatory disease.
Combined oral contraceptive pills (COCs) *contain estrogen and progestin 6-8%*	Yes. Does not protect against STIs/HIV.	• Must be taken daily to be effective. • Fertility returns quickly when pills are discontinued. • Clients must be instructed about what to do if pills are missed (see box). • Possible side effects: nausea, headache, breast tenderness, spotting. • Noncontraceptive benefits: regular and less painful menses, reduced risk of ovarian cancer, endometrial cancer and pelvic inflammatory disease. • Not recommended for breastfeeding women.
Injectables *includes progestin-only injectables and injectables containing estrogen and progestin0.3%*	Yes. Concerns exist about effects of progestin-only injectables on bone density when given during adolescence, but benefits generally outweigh risks. Does not protect against STIs/HIV.	• Common side effects: irregular menstrual bleeding, prolonged bleeding, heavier bleeding, amenorrhea. • Less common side effects: weight gain, headaches, dizziness and mood changes. • Noncontraceptive benefits: decreased risk of pelvic inflammatory disease, ectopic pregnancy and endometrial cancer. • Pregnancy may not occur for up to nine months after discontinuation. • Clients must remember to return for reinjections.
Subdermal implants (Norplant) 0.5%	Yes. Does not protect against STIs/HIV.	• Offers five to seven years of contraceptive protection. • Possible side effects: amenorrhea, irregular bleeding. • Implant insertion and removal are surgical procedures requiring a trained provider.
Intrauterine devices (IUDs) 0.8%	Intrauterine devices (IUDs)*0.8%*	• Safe, effective and requires little effort on the part of the user once inserted. • Copper T IUD offers pregnancy protection for at least 10 years. • Side effects of copper IUDs include spotting, heavier menses, cramping.

		• User should check IUD strings monthly to make sure device remains in place. • Clients should be told to come back immediately if they have abdominal pain with or without fever, chills, delayed menses or missing string.
Surgical sterilization *Pregnancy rate:** *0.5% tubal ligation* *0.15% vasectomy*	No medical reason to deny sterilization to youth, but generally not recommended for people at the beginning of childbearing years. Does not protect against STIs/HIV.	• Not recommended for adolescents; young age and low parity are associated with high levels of regret. • Any individual seeking sterilization should be counseled that it is a permanent method.
Emergency contraceptive pills (ECPs) *Effectiveness:*** ***POPs** ? 85% effective if used within 72 hours; 95% if used within 24 hours.* ***COCs** ? 57% effective if used within 72 hours; 85% if used within 24 hours.*	Yes. Effective method of pregnancy prevention for couples who have unplanned sexual intercourse, who forget to use a method or who experience condom breakage or slippage. Can be used by women and girls forced or coerced into sexual activity. Does not protect against STIs/HIV.	• Counsel about proper pill dosage (see pages 35-36). • Possible side effects for ECPs containing estrogen: nausea and vomiting. • Antiemetic drugs can help reduce nausea. • Nausea and vomiting less common with progestin-only ECPs. • Start within 72 hours after unprotected intercourse. The earlier the method is started, the greater the effectiveness. • Counsel to have a pregnancy test if menstruation is more than one week late. • Counsel about the use of a regular contraceptive method. • Clients can receive ECPs in advance and use them as needed. • POPs are more effective as ECPs than COCs in preventing pregnancy.

* Percentage of women typically experiencing pregnancy in first year of use (U.S. data).
** World Health Organization

Contraceptive Methods: Other Issues

There are several other issues when dealing with contraception for adolescents that will be discussed now. These include:

Abstinence

What to do about missed pills

Dual protection

Emergency contraceptive pills (ECPs)

Postpartum and postabortion contraception

Abstinence

Saying no to sex can be difficult for many young people. There may be pressure from peers who claim "everyone" is having sex, or pressure from partners who argue that sex is the best way to prove love and affection, or pressure from older friends and relatives who say having sex is a way to show that you are an adult.

Adolescents may not feel they have many choices, but as a provider, you can explain to young people that they can say no to sex if they are not ready. You can help them develop "refusal skills" by counseling them about abstinence or delaying sexual activity. One way to do this is to help them imagine situations in which they might find themselves and help them practice saying no. Following are some examples of how to empower youth to say no if they are not ready for sex.

Role-plays: Saying No to Sex*

You can ask adolescents to think how they would respond if someone used the following arguments to try to convince them to have sex:

- "If you have sex, you will be more popular."
- "You do not have to be in love to have sex; you can have sex just for physical pleasure.
- "If you do not have sex, people will think you are homosexual."
- "Everybody is having sex. You should, too."
- "You should have sex for the first time just to get it over with."
- "Your parents told you not to have sex? You must be a baby to listen to them."
- "There is no good reason to wait to have sex. You should do it now."
- "If you really loved me, you would have sex with me."

When discussing these scenarios with young clients, you can help them recognize that:

- Sex is a very personal decision. The choice to have sex or to not have sex is theirs alone. No one can make the decision for them.
- It is normal and natural to want to be loved, and it is normal and natural to have sexual feelings. They may choose to act on sexual feelings or to wait.
- Sexual intercourse has physical and emotional consequences and is not the only way to express love.
- There are good reasons to wait to have sex. For example, adolescents many want to finish school. They many want to avoid a pregnancy, they may want to avoid an

STI or they simply may not be ready to have sex right now.

- Young people should not feel pressured to repay someone with sex in return for an expensive date, present or meal.
- Others adults may be able to help them. They may want to talk with their parents, a teacher or a religious leader.
- They should realize that movies, television, radio or magazines do not always give a very realistic portrayal of sex. While programs or articles emphasize that sex is fun, they do not always explain the consequences of sexual activity.
- They should not make decisions about sex while using alcohol or drugs since these substances make it difficult to think clearly or rationally.

To help young people learn to say no to sex, you can encourage them to take these five steps if someone pressures them to have sex:

Step 1: Make a statement about your intentions.

Step 2: Say no and identify the problem or issue.

Step 3: Say no and identify the consequences.

Step 4: Suggest alternatives.

Step 5: Assert yourself.

For example, if someone suggests having sex because "everyone is doing it," here is how a young woman or man could respond:

Step 1:
"No, I do not want to have sex."

Step 2:
"No! Not everyone is having sex. Some people talk about sex, but that does not mean they are sexually active. Some people are not truthful about their experiences."

Step 3:
"No! If I have sex now, I could risk an unplanned pregnancy or an STI or HIV. An unplanned pregnancy could keep me from finishing school. An STI could lead to serious health problems. HIV could kill me."

Step 4:
"I am going to go home now."

Step 5:
"I am not ready for sex now."

Or, if someone suggests having sex to "prove you love me:"

Step 1:
"I love you, but I am not ready for sex."

Step 2:
"No, if you loved me, you would care about what is right for me."

Step 3:
"No, if we have sex now we could risk an unplanned pregnancy or an STI."

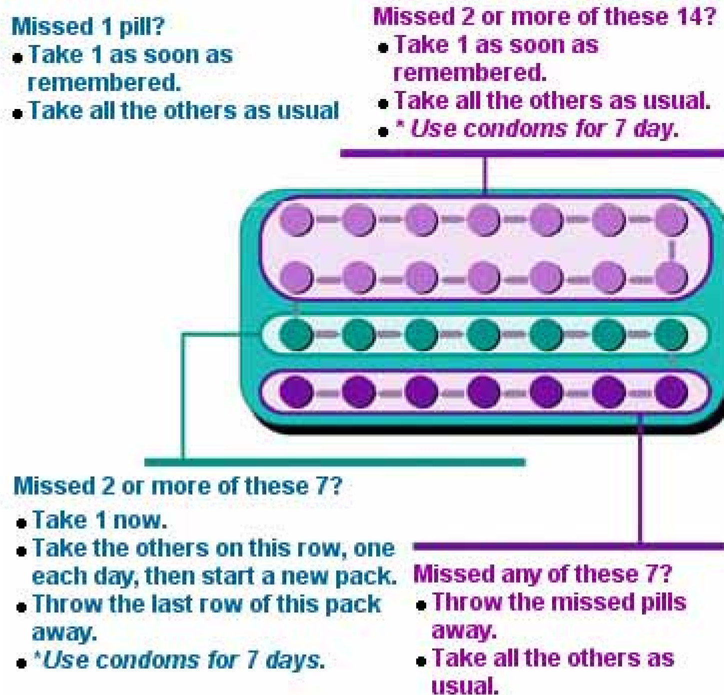
Step 4:
"There are other ways to show our love for each other. Let's talk about those."

Step 5:
"I care for you, but I also care for myself. I want to wait."

* Adapted from: CDConsults: Refusal Skills. July 21, 2000; Peer Pressure: Should I or Shouldn't I? July 21, 2000; Teen Sex? It's Okay to Say "No Way." July 21, 2000; Part 2: Making Your Own Decisions. Sex on the Brain. July 21, 2000.

What to Do about Missed Pills

If a young woman forgets to take combined oral contraceptives (COCs), you can explain that there are steps she can take to reduce her risk of pregnancy, outlined by the diagram below.*



* Adapted from Hatcher RA, Rinehart W, Blackburn R, et al. The Essentials of Contraceptive Technology. Baltimore: Johns Hopkins School of Public Health, Population Information Program, 1997.
** The last 7 pills are not included in some packs.

Dual Protection

Because many young people face the double risk of unplanned pregnancy and STIs, dual protection may be recommended.

Dual protection is defined as the simultaneous prevention of STIs and unwanted pregnancy. For example, a couple may use condoms to protect against STIs and oral contraceptives to protect against pregnancy. Or they may use condoms as their primary means of pregnancy and STI prevention, with emergency contraception as a backup against pregnancy if the condom breaks or slips. Practicing abstinence is also an option.

While dual protection offers obvious benefits, its use can be problematic for adolescents. This is because both abstinence and consistent use of condoms require high motivation, and members of this age group may have difficulty using two methods consistently and correctly.

Negotiating condom use

You can help adolescents learn to negotiate condom use by:

Encouraging young people to talk about contraception and STI protection before they have sex.

Encouraging young men to take responsibility for protecting themselves and their partners by preventing an unplanned pregnancy or STI.

Helping young women recognize that they can ask a young man to wear a condom.

Helping young people overcome embarrassment in talking about condoms.

One strategy that is effective in helping young people negotiate condom use is role-playing. The following role-play offers suggestions for responses when one partner is reluctant to use a condom. In a one-on-one counseling session, you and your young client can pretend to be a couple discussing condom use. In a larger group setting during an education session, for example you may ask two young people to volunteer to participate.

Role-plays: Talking about Condoms*	
If your partner says:	**You can say:**
"I don't like using condoms. It doesn't feel as good."	**"I'll feel more relaxed, and if I'm more relaxed, I can make it feel better for you."**
"We have never used a condom	**"I don't want to take any more**

before."	risks."
"Using condoms is not pleasant."	"Unplanned pregnancy is more unpleasant. Getting AIDS is more unpleasant."
"Putting it on interrupts everything."	"Not if I help put it on."
"Don't you trust me?"	"I trust you are telling the truth. But with some STIs, there are no symptoms. Let's be safe and use condoms."
"I know I do not have an STI."	"I want to use the condom to prevent pregnancy."
"Why should we use a condom? Do you think I have AIDS?"	"No, but I could have an STI. We need to protect both of us."
"I don't have a condom."	"I do."
"I will pull out in time. I will practice withdrawal."	"Women can still become pregnant or get STIs from pre-ejaculation fluid."
"I thought you said condoms were for casual partners."	"I decided to face facts. I like having sex with you, and I want to stay healthy and happy."
"Condoms are not romantic."	"What is more romantic than making love and protecting each other's health at the same time?"
"But I love you."	"Then you'll help me protect myself."
"I guess you don't really love me."	"I do, but I do not want to risk my life to prove it."
"We're not using a condom, and that's it."	"OK. Let's do something else."
"Just this once without it."	"It only takes once to get pregnant. It only takes once to get a sexually transmitted infection. It only takes once to get AIDS."

* Adapted from materials from the Planned Parenthood Federation of America and the California Office of AIDS.

Emergency Contraceptive Pills: A Special Consideration

Emergency contraceptive pills should be available to adolescents who have unprotected sex. The earlier ECPs are administered after unprotected sex, the greater the chances that they will be effective. You can provide ECPs in advance to young people. However, you should counsel clients that ECPs are for emergencies only. They should not be substituted for a regular contraceptive method.

What are ECPs?

ECPs are the use of oral contraceptives within 72 hours after sexual intercourse to prevent pregnancy. It is especially important that adolescents know this method is available for them, since they may not plan to have intercourse or may not use regular methods effectively. ECPs can also be used for victims of rape or other coercive sex acts.

W**hat types of ECPs are available?**

Certain types of combined oral contraceptive pills or progestin-only pills can be used as ECPs. In some places, pills packaged specifically for emergency contraceptive use are available. Where they are not, regular pills can be used, as long as the COCs contain ethinyl estradiol and levonorgestrel, and the POPs contain levonorgestrel.

How do ECPs work?

Depending on when they are taken during the menstrual cycle, ECPs can:

Delay or inhibit ovulation.

Have effects after ovulation.

ECPs do not interrupt or harm an established pregnancy, and do not cause abortion.

Who can use ECPs?

Any young woman can use ECPs, even those who cannot regularly use oral contraceptives because of migraine headaches, severe heart and blood vessel disease or acute liver disease. If a woman is already pregnant, ECPs will not be effective. ECPs will not harm the pregnancy.

Are there any side effects of ECPs?

Yes. They include:

- Nausea
- Vomiting
- Headaches

- Dizziness
- Fatigue
- Breast tenderness

Side effects can be unpleasant but typically do not last more than 24 hours after the second dose is taken. Nausea and vomiting are more common with COCs than with POPs. Antiemetic drugs can help minimize these side effects.

What should I tell clients about how to take ECPs?

Two ECP regimens have proven effective. One contains only levonorgestrel (POPs), and the other contains both levonorgestrel and ethinyl estradiol (COCs). The levonorgestrel regimen has been proven to be more effective. You should determine which pills are most readily available in your community and tell your clients about that particular regimen.

Progestin-only pills: One dose equals 0.75 mg of levonorgestrel. Tell clients to take one dose within 72 hours after unprotected sexual intercourse, then take another dose 12 hours later. This means that for pills packaged especially for use as emergency contraception, clients will take a total of two pills. For POPs that are not packaged for emergency contraception, the client may have to take as many as 20 pills for each dose.

Combined oral contraceptives (Yuzpe Method): One dose equals at least 0.1 mg ethinyl estradiol and 0.5 mg of levonorgestrel. Tell clients to take one dose within 72 hours after unprotected intercourse and another dose 12 hours later. The number of pills taken varies, depending upon the amount of hormones in the pills. You should advise clients on how many pills to take, depending on the formulation used.

What should I know about ECPs?

The correct dosage for clients and how to take them.

How ECPs work.

Their effectiveness.

Which pill brands to use.

Their side effects.

Where they are available in my area.

Also, you should know:

If vomiting occurs within two hours of taking pills, some experts recommend repeating that dose.

ECPs do not cause abortion.

ECPs can be provided in advance for use when needed.

It is not essential in some countries for a young woman to visit the doctor to obtain ECPs. She can obtain pills from the pharmacy, although a doctor's permission may be required.

What should I tell young people who want to use ECPs?

Explain the correct use of ECPs.

Explain their effectiveness. The sooner ECPs are taken after unprotected intercourse, the greater their effectiveness.

Discuss side effects.

Explain that ECPs will not cause menstrual bleeding to start immediately. Menses may start a few days earlier or later than usual.

Explain that ECPs will not be effective if the young woman is already pregnant. ECPs will not harm an existing pregnancy.

ECPs should not be used as a regular contraceptive method because long-term safety data on their frequent use are not yet available. Young women and men who are sexually active should use a regular contraceptive method.

The client should return to you if she has additional concerns, if her menstrual period is more than a week late or if she needs information about contraception.

Explain that ECPs provide no protection against STIs/HIV.

Questions to Ask Adolescents about the Use of ECPs

To make sure young people understand ECP use, you can ask the following questions.

When providing ECPs *in advance:*

What contraceptive method are you currently using?

Are you having problems using this method effectively? Why? What kinds of problems are you having?

How soon after unprotected intercourse will you start taking your ECPs?

How many pills will you take?

How often will you take ECPs?

What side effects can you expect?

What will you do if you experience side effects?

When should you come back to the clinic if your menstrual period does not start?

When providing ECPs *after unprotected intercourse:*

Why do you think you need emergency contraception?

If you take your first dose now, when will you take your second dose?

How many pills will you take?

How often will you take ECPs?

What side effects can you expect?

What will you do if you experience side effects?

What is your regular method of contraception? Do you want to continue to use this method? Would you like to try another method?

If you do not have a regular contraceptive method, would you like to choose a method?

When should you come back to the clinic if your menstrual period does not start?

Postpartum and Postabortion Contraception

Adolescents who are pregnant need information about how to have a healthy pregnancy and safe delivery. They also need information about contraception to prevent future unplanned pregnancies or to space births to improve infant and maternal health. Although they may have contact with a health provider during delivery or abortion, they may not be offered contraceptive methods as part of follow-up care.

A study in Brazil found that among 367 pregnant teens, 46 percent said their pregnancy was wanted.

While young postpartum clients need information about contraception, the needs of the postabortion woman are more immediate since fertility can return in as little as two weeks.

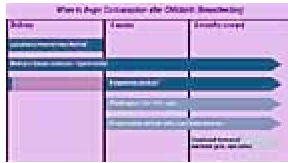
For the postpartum woman, ovulation can occur as early as four weeks after delivery if she is not breastfeeding or be delayed for as long as six months (and possibly longer) if she is breastfeeding. Methods that contain estrogen are not recommended for breastfeeding women, since estrogen can reduce breastmilk production.

The following charts outline guidelines for postpartum and postabortion contraception.*

* Sterilization is not included on the charts because it is not recommended for adolescents.

(Please click on thumbnails below to view detailed graphics)

When to Begin Contraception after Childbirth (Breastfeeding)

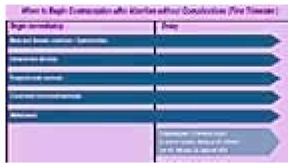


IUDs should be inserted within 48 hours or else delayed 4-6 weeks.

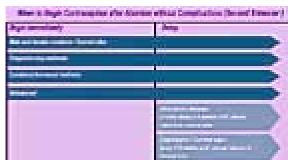
When to Begin Contraception after Childbirth (Not Breastfeeding)

IUDs should be inserted within 48 hours or else delayed 4-6 weeks.

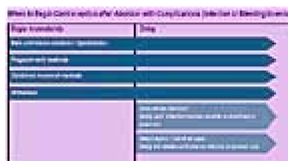
When to Begin Contraception after Abortion without Complications (First Trimester)



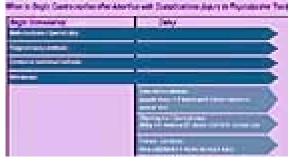
When to Begin Contraception after Abortion without Complications (Second Trimester)
n



When to Begin Contraception after Abortion with Complications (Infection or Bleeding/Anemia)



When to Begin Contraception after Abortion with Complications (Injury to Reproductive Tract)



Questions for Providers and Program Managers about Preventing Pregnancy

? Is adolescent pregnancy a concern in your community? Are data available on local adolescent pregnancy rates? If so, what are the pregnancy rates in your community?

? Which contraceptive methods does your clinic or program offer adolescents?

? Why are certain methods not offered? Can these methods be added?

? Do you discuss emergency contraceptive pills with young people? Are ECPs available at your clinic? If not, how can young clients obtain ECPs in your community?

? Are contraceptive services offered for both young women and men? What factors might encourage or discourage youth from seeking services?

? How do you educate boys about adolescent pregnancy?

? Does your clinic or program work with local schools and youth organizations to provide information about pregnancy prevention? If not, could this be arranged? What factors would encourage this? What types of barriers would you encounter?

? Is unsafe abortion a concern in your community? Can you work with local hospitals that provide care for abortion complications to offer contraceptive information to patients?

Space has been provided at the end of the handbook for your answers.

Chapter 4: Preventing Sexually Transmitted Infections

"For me, the first time you should always take precautions. Myself, I never have sex without a condom. It's better to prevent than to treat."

Young man in Senegal

Adolescents may think they are too young or too sexually inexperienced to acquire STIs. They may also think they are not at risk, because they incorrectly believe that STIs only occur among people who are promiscuous or who engage in "bad" behaviors. As a provider, you can play an important role not just in treating young people who contract STIs, but in helping them learn about prevention.

Young people are particularly vulnerable to STIs and consequent health problems because:

- They lack information about how to prevent STIs.
- They are less likely to seek proper information or treatment due to fear, ignorance, shyness or inexperience.
- The risk of acquiring trichomoniasis, chlamydia, genital herpes or human papilloma virus (HPV) is greater at first exposure to the STI.
- Adolescent females are more susceptible to infections than older women due to their immature cervices.
- Early sexual experience can result in trauma to vaginal tissue, increasing adolescent women's vulnerability to STIs.
- Adolescents who begin sexual activity early are more likely to have a greater number of lifetime sexual partners.

Other risk factors for adolescents are:

- Unprotected sex (without condoms).
- Sex with multiple partners.
- Having a partner with other sex partners.
- Having a partner with STI symptoms.
- Sex with a new partner or more than one partner in the last three months.
- Sex with strangers or sex in exchange for money.
- Vulnerability to sexual violence, coercion and abuse.
- Use of vaginal drying agents.
- A history of STIs or pelvic inflammatory disease (PID).

One of the most important facts you can help adolescents learn is that male latex condoms provide the best protection from STIs including HIV. Condoms must be used consistently and correctly with each act of intercourse.

Young people also need to know symptoms that may indicate they have an STI. These include:

- Urethral discharge or painful urination in young men.

- Genital sores or ulcers in young women or men.
- Lower abdominal pain or tenderness in young women.
- Unusual vaginal discharge or vaginal itching in young women.
- Painful urination or painful intercourse for young women.

Adolescents should be counseled to seek treatment as soon as possible if they have any of these symptoms.

Young people who contract STIs risk serious long-term health problems, including:

- Permanent infertility.
- Chronic pain.
- Cancer of the cervix.
- Heart and brain damage. (Without treatment, can develop 10 to 25 years after initial exposure to syphilis.)

Also, STIs are a risk factor for HIV transmission and acquisition.

STIs can be transmitted from mother to infant during pregnancy and birth. Infants of mothers with STIs may:

- Have lower birth weights.
- Be born prematurely.
- Be at increased risk of other disease, infection and blindness.

<table>
<tr><th colspan="2">Sexually Transmitted Infections: Key Issues to Discuss</th></tr>
<tr>
<td>Syphilis (bacterial)

• If untreated, long-term effects include damage to major organ systems, paralysis, deafness, blindness, insanity and death, spontaneous abortion, stillbirth, premature birth.
• Women can transmit to infants during birth. Health workers should test all women during the prenatal period.
• Can be cured with antibiotics.
• Important to take medications as directed and to finish all</td>
<td>Chancroid (bacterial)

• Men: can lead to urethral stricture, causing urination difficulty.
• Can be cured with antibiotics.
• Important to take medications as directed and to finish all medications.
• Clients should see provider 3-5 days after treatment begins, then return weekly until infection is gone.
• Can increase risk for HIV.

Chlamydia (bacterial)

• Bacteria can infect urethra, cervix or other pelvic organs.
• Women: scarring of fallopian tubes</td>
</tr>
</table>

medications. • Genital ulcers can increase the risk of HIV acquisition, so client should be tested for HIV. **Gonorrhea *(bacterial)*** • Women: scarring of fallopian tubes can lead to infertility. • Men: scarring can lead to sterility and urination difficulty. • Newborns' eyes can be infected during birth. • Can be cured with antibiotics. • Important to take all medicines as directed and to finish all medications. • Can increase risk for HIV.	can lead to infertility or ectopic pregnancy. • Newborns' eyes and lungs can be infected at birth. • Can be cured with antibiotics. • Important to take medications as directed and to finish all medications. • Can increase risk for HIV.
HIV/AIDS *(viral)* • No cure, so prevention is crucial. • Persons with HIV may live with minimal symptoms or be symptom-free for many • years. However, they may still infect others during this period. • Drug therapies may reduce HIV levels in blood and semen, reduce symptoms and • delay onset of AIDS. However, treatments are expensive, have severe side effects and are not widely available in developing countries. • Can be transmitted to	**Genital herpes *(viral)*** • Women: pregnancy loss and pre-term delivery. • Can be transmitted from mother to infant during vaginal delivery if symptoms are present. • No cure. • Medications can be given to relieve pain, reduce length of outbreak. • Abstain from sex while ulcers are present. • Can be transmitted even when symptoms are not present. • Can increase risk for HIV. **Hepatitis B *(viral)*** • Long-term problems can include chronic hepatitis, cirrhosis, liver cancer, liver failure. • Death possible.

infant during pregnancy, childbirth or breastfeeding.

HPV *(viral)*

- May increase risk of cervical cancer. Client should undergo Pap smears, if possible.
- No cure.
- Can cause genital warts, which can be removed by burning, freezing or using chemicals.
- Can be transmitted from mother to infant.
- No cure.
- Symptoms can be treated.
- Preventive vaccine available in many industrialized countries.

Trichomoniasis *(protozoan)*

- Women: premature childbirth, low-birth weight and risk of HIV acquisition.
- Can be treated.
- Important to take medications as directed and to finish all medications.
- Return if not cured or problem recurs.

STIs and Young Women

Generally, the long-term health consequences of an STI can be more numerous and severe for women than for men.

- A woman's risk of contracting an STI during a sexual encounter appears to be greater than a man's risk because women are biologically more susceptible to STIs.
- The surface of the vagina is larger and more vulnerable than the skin-covered penis.
- The amount of ejaculate deposited in the vagina during intercourse is greater than the amount of cervical and vaginal secretions to which a man is exposed.
- Young women often have a condition called cervical ectopy, in which the cells that line the inside of the cervix extend to the outer surface of the cervix. These cells are more vulnerable to infections such as chlamydia.
- Once they have an STI, young women are at greater risk of reproductive cancers and infertility. Other health problems can include pelvic inflammatory disease, ectopic pregnancy and spontaneous abortion.
- Young women are less likely than men to experience

symptoms, so some STIs go undiagnosed until a major health problem develops.

Because young women are especially vulnerable to STIs and their long-term consequences, one of the best ways to protect them is to protect young men. You can:

- Encourage abstinence.
- Encourage young men to use condoms.
- Help young men learn and identify the signs of STIs.
- Promptly treat STIs or refer young men to a treatment center.
- Encourage young men with STIs to notify their sexual partners immediately.
- Encourage young women to seek diagnosis and treatment promptly if their partners have an STI.

The "good" news about STIs is that they can be prevented, and many can be cured. Preventive measures include abstinence, mutual monogamy or using male latex condoms correctly during each act of intercourse. Female condoms offer protection against bacterial and possibly viral STIs. Other barrier methods, such as diaphragms or spermicides, may offer some protection from bacterial STIs for women whose partners do not use male condoms.

STIs caused by bacteria can usually be treated successfully with antibiotics. These include gonorrhea, syphilis, chlamydia and chancroid. Trichomoniasis, a protozoan infection, can also be treated. STIs caused by viruses cannot be cured, although the symptoms of some, including hepatitis B, genital herpes and HPV, can often be managed so that the client's quality of life is improved. Although there are drugs that can help to manage the symptoms and illnesses of HIV-positive patients, these drugs are prohibitively expensive and are not widely available in developing countries. And even with their use, HIV/AIDS results in death. We will discuss HIV more in Chapter 5.

The following chart outlines key STI counseling issues for providers working with young people. Additional information about counseling can be found in Chapter 6. It is important to remember:

- Anyone at risk of STIs should use male latex or female condoms for protection.
- Notifying sexual partners is an important element of STI treatment and prevention. Sexual partners should be evaluated and treated, if necessary. Adolescents may have an especially difficult time discussing STIs with sexual partners. You can help by volunteering to notify partners.
- Clients who are infected should abstain from sex until their infection is resolved or use condoms to protect their partners.

Questions for Providers and Program Managers about Preventing STIs
? Are STIs a concern in your community? **?** Are data available on STI prevalence in your community? If so, what are the most common STIs? **?** Does your clinic or program see adolescent STI clients? **?** Are you able to offer adolescent clients counseling? Partner referral? **?** What types of services does your clinic or program offer to educate adolescents about their STI risks and about prevention and treatment? **?** How can you improve adolescents' access to STI information? What steps can you take to encourage adolescents to protect themselves and their partners? Does your clinic or program provide STI treatment for adolescents? **?** If not, are there other clinics or organizations that you can link with that provide these services? What are the names and locations of these clinics? How will you make adolescents aware of them? What factors would encourage you to refer young people to these programs? What would discourage you?

Chapter 5: Preventing HIV/AIDS

Every minute, five people ages 15 to 24 are infected with HIV.

Of all the sexually transmitted infections, HIV/AIDS is perhaps the most frightening, because it has no cure.

- Of the 33 million people worldwide who have HIV, at least one-third are ages 10 to 24.
- Nearly 3 million new infections occur annually among young people, including 1.7 million in Africa and 700,000 in Asia and the Pacific.
- Some 10.4 million youth under age 15 have lost one or both parents to AIDS. Many of these AIDS orphans live on the streets and suffer abuse and exploitation.

People who are HIV-positive may face ostracism in their communities. Adolescents may be forced out of school or home. They are typically less aware of their legal rights, more vulnerable to financial hardships and less able to find and purchase care. They may be angry that they were infected so early in life and confused about their future and the risk of spreading the disease to others.

While AIDS has no cure, HIV infection can be prevented, and you as a service provider can play a major role in this area.

You can explain that:

- HIV is most commonly transmitted in one of three ways:
    - Through sexual intercourse (semen and vaginal fluids).
    - Through contact with infected blood (shared or reused needles, accidental sticks with needles, shared razors, body piercing, transfusions of infected blood).
    - From mother to infant during pregnancy or delivery (vaginal fluids) or through breastmilk.
- HIV is not transmitted:
    - Through the air, the way tuberculosis or colds are.
    - By insect bites.
    - Through saliva or kissing.*
    - Through touching or hugging.
    - Through food.
    - By sharing plates, cups or glasses with someone who is infected.
    - Through swimming.
    - On toilet seats.
    - Through condoms (as has been rumored in some countries).

  * "Wet" kissing is considered safe if no cuts in the mouth are present.

- Sexual activities that increase the risk of HIV include:
    - Vaginal sex without a condom.
    - Anal sex without a condom.
    - Taking semen in the mouth during oral-genital sex.

- Any sexual act that causes bleeding.

- The best way to tell if a person has HIV is through a blood test. This usually reveals the presence of HIV six to eight weeks after exposure.
- In working with young people to help them prevent HIV, you can:
  - Provide services for youth that offer education and information about HIV prevention.
  - Provide information to help young people make decisions about sexual behaviors.
  - Discuss safe forms of sexual expression.
  - Provide opportunities for youth to discuss sexuality and sexual responsibility.
  - Offer condoms to sexually active young men and women and encourage use with every act of intercourse.
  - Build networks with other organizations that work with young people.
  - Provide compassionate care, respect and support for adolescents who are HIV-positive or who have AIDS.
  - Treat youth with AIDS for opportunistic infections.

  - Help young people separate fact from fiction about what HIV is and how it is transmitted.
  - Provide young men with accurate information about the increased risk of HIV transmission from sex workers and the special need for condom use during these sexual contacts.
  - Inform young women of the special risks of HIV infection from older men (e.g., sugar daddies) in some communities.

"I go about telling people my status ... they accuse me of being promiscuous. But this sexual act that left me HIV-positive was only my second."

Young adult

Questions for Providers and Program Managers about Preventing HIV/AIDS

? Are there data on adolescence and HIV in your community? What percentage of the adolescent population in your community is HIV-positive?

? Does your clinic or program offer HIV testing and counseling for adolescents?

? If not, are there other clinics, agencies or organizations where you can refer clients? What are the names and locations of these clinics or organizations? How do you make adolescents aware of them? What factors would encourage you to set up linkages with these organizations? What barriers would you encounter? How could you overcome these barriers?

? What types of information and education does your clinic provide to prevent HIV transmission among young people? Can you link with other clinics or organizations, such as schools, women's groups or employers, to provide HIV information?

Chapter 6: Counseling Young People about Reproductive Health

"Nowadays there's more danger in not talking about sexuality than in talking about it."

Secondary school teacher in Cote d'Ivoire

Counseling is critical for all reproductive health clients, including adolescents. As with adults, adolescents should have:

- Adequate information about reproductive health issues.
- A choice of contraceptive methods to ensure that they can protect themselves against unplanned pregnancy and STIs.
- The opportunity to make decisions and take actions without pressure or coercion.
- The assurance of confidentiality.
- Services and information provided in a nonjudgmental manner.

The goal of counseling is to provide young people with facts that will enable them to make informed, voluntary decisions. You should offer information and guidance, but ultimately, the adolescent must decide whether to use contraception, which method to use, whether to continue or discontinue a method, whether he or she needs a contraceptive method that also offers STI protection, or whether to seek STI treatment.

You may be reluctant to discuss sexual health issues with young adults. You may believe that adolescents should not be sexually active, that only married youth should be sexually active or that sexual activity is acceptable for boys but not girls. You may be embarrassed or uncomfortable discussing sexual details with youth.

It is important, however, not to let personal feelings and biases get in the way of professional behavior. Ideally, you should:

- Be a *reliable*, factual source of information about reproductive health, including pregnancy and STI prevention.
- Create an atmosphere of *privacy, respect* and *trust*, so that young people will feel free to ask questions, voice concerns and discuss intimate sexual issues.
- Engage in a *dialogue* or open discussion with the young person.
- Offer choices and *do not judge* the young person's decisions. Accept his or her right to choose and the choices made.

Questions to ask adolescents

In talking with young people about reproductive health issues, you can begin by asking questions about:

- Sexual knowledge, attitudes and behaviors.
- Reproductive goals.

To help build rapport with young people, you can begin with general questions about the young person's life and interests.

- Do you go to school? What do you like or not like about your classes?
- Do you work? Tell me about your job.
- Tell me about your family.
- Tell me about your friends.
- Do you have a boyfriend/girlfriend?
- Why did you come here today?
- How can we help you?

As you and the client feel more comfortable talking together, you can ask more intimate questions about sexual knowledge and experience, such as:

- Have you had sexual relations before? (For some adolescents, the term "sexual intercourse" or "sexually active" may be unclear. Instead, providers may want to ask about specific sexual activities, such as touching genitals, vaginal intercourse, oral sex or anal intercourse.)
- Did you plan to have sex at those times?
- How did you feel about this experience? Was it pleasant? Was it unpleasant?
- Has anyone ever forced you to have sex?
- Do you plan to have sexual relations in the near future?
- Are you physically attracted to men? To women? To both? To neither? How do you feel about these attractions?
- Do you have one sexual partner, or have you had more than one partner in the past?
- Are your partners members of the opposite sex, the same sex or both?

What you can do

In a positive client- provider relationship, the provider listens as well as talks. You should explain and share knowledge about reproductive health, but you should also give young people plenty of time to talk, express their concerns and ask questions. You should listen carefully, respect their wishes and experiences and provide relevant information in language that is simple to understand.Your actions and attitudes are the key to successful client-provider relationships. At the beginning of any counseling session with young people, you can:

- *Explain* that:
    - Adolescence is a time when young people begin to change their bodies change, they are curious and they want to experiment.
    - Interest in sex is normal.
    - What happens to them as adolescents can affect their future reproductive health.
- *Assure* young people of confidentiality. (Explain that there may be exceptions if the client discusses suicide, homicide or sexual abuse.)
- *Explain* that it is necessary to ask sensitive questions when discussing pregnancy and STI prevention.

During counseling sessions on reproductive health, there are several things you can do to improve client-provider interactions:

- Use simple language and short sentences. Avoid technical terms.
- Use nonjudgmental language. For example, avoid saying, "You should " Instead say, "You can " or "You may want to think about this "
- Ask questions about young clients' fears and concerns.
- Correct erroneous information.
- Refrain from offering nonmedical advice.
- Encourage young people to ask questions.
- Be aware of language and slang adolescents use to discuss sexual issues. Ask them to clarify what they mean. For example, a young person may say they engage in oral sex. You may think they are talking about mouth-penis contact, when they may be talking about kissing.

The percentage of women who have given birth by age 18 ranges from 1 percent in Japan to 53 percent in Niger.

- Use "reflective listening." Paraphrase the young person's statements and repeat them back to him or her. This shows empathy and confirms that the young client understands what you are saying. If a young woman says she is concerned about preventing pregnancy, you can say, "So, you want to prevent pregnancy now. You want to wait to have children." If a young man says he wants to prevent STIs, you can say, "I understand that you want to learn how to prevent sexually transmitted infections. You have questions about protecting yourself and your partner."
- Ask open-ended questions that will lead to discussion rather than questions that require "yes" or "no" answers. For example, ask, "What do you know about contraception?" rather than "Do you know about contraception?" Or ask, "What do you know about sexually transmitted infections?" rather than "Do you have an STI?"
- Make sure young clients understand what you are saying to them. Do not simply ask, "Do you understand what I have said?" as clients may be embarrassed to admit they do not. Instead, ask questions that will help determine if the young person understands. For example, after you have explained condom use to a young man, you can say, "Tell me when you should use a condom and how you put it on." You can also ask, "What are the symptoms of an STI?" or, for young women, "What will you do if you miss more than one pill?"
- Learn to read "body language." Be conscious of what your own body language is communicating by the way you stand, sit or make eye contact.
- Let adolescents do the talking. Ask questions and let them tell you what they know. Correct misinformation.
- Do not stereotype or treat all adolescents the same; treat each young person as an individual.

Remember: *Good counseling takes time.* This is especially true with adolescents, who may need basic information about reproductive health, plus specific information about preventing pregnancy and STIs. Setting aside time to talk at length with young people may be difficult for service providers, many of whom are already overworked. But thorough counseling is important. It can reduce the number of return visits, help young women prepare for contraceptive side effects and reduce contraceptive discontinuation and help young adults learn how to use methods correctly and how to prevent STIs. In the long term, good counseling can improve reproductive health. It is worth the investment of time.

In Zambia, young people outlined what they want from health providers:

- Confidentiality.
- Information.
- Acceptance (no moralizing or judgment).
- Respect for opinions.
- Environment in which they can decide for themselves.
- Welcoming and comfortable environment.
- Services provided at times that are convenient for adolescents.*

* Bernstein S. *The State of the World Population: The New Generations.* Ed. Marshall A. New York: United Nations Population Fund, 1998.

Questions for Providers and Program Managers about Counseling Young People

? To counsel effectively about reproductive health, health workers must have technical expertise as well as communications skills. Has your clinic or program worked to train employees in these areas? What more can you do?

? What do you do to ensure adolescents that their privacy and confidentiality will be respected during counseling?

? Do you provide counseling for pregnancy prevention? STI prevention? If not, how could you incorporate this?

? Does your clinic or program offer HIV testing? Do you offer counseling before and after testing? Where do you refer HIV-positive youth for additional help?

? Do providers at your clinic have enough time to counsel clients adequately? If not, what kinds of changes would you have to make to ensure they have time for counseling?

Counseling about Contraception

Your goals in counseling young people about contraception are to help them:

- Identify their reproductive intentions (to begin, postpone or space childbearing) and assess their risk of pregnancy.
- Determine whether they will use contraception.
- Decide which method is best for them.

"We thought about using contraceptives, but we don't use them in the drugstore people will notice you and we don't like that."

Young man in Colombia

Questions to ask adolescents

In counseling youth about contraception, you can begin by asking these questions:

- For young women: Have you ever been pregnant? For young men: Have you ever impregnated anyone?
- How did/do you feel about the pregnancy? How did/will your partner feel? How did/will your parents react?
- For young women: Would you like to become pregnant in the near future? Why or why not? For young men: Would you like to have children right away? Why or why not?
- What do you know about contraception?
- How do you feel about using contraception?
- Have you ever used contraception before? What did you like or not like about that method?
- Which method would you like to use? Why would you like this method?
- What do you know about this method?
- Can you discuss contraception with your partner?
- If you choose to use contraception, how will your partner feel?
- What would prevent you from using your chosen method effectively?
- If you have a baby now, are you breastfeeding? If you are pregnant, do you plan to breastfeed?

What you can do: pregnancy prevention

- Explain that there are a variety of ways to prevent pregnancy.
- Explain that the best way to prevent pregnancy is to abstain from sexual intercourse.
- Explain that some contraceptive methods protect against STIs while others do not.
- Emphasize that while all methods are medically safe for young people, some are more appropriate than others.
- Ask the young person which method he or she wants to use and what he or she knows about that method.
- Explain how the chosen method works, correct usage, possible side effects and how to cope with them and problems that indicate a need to see a health worker.
- Refer the young person elsewhere if he or she chooses a method the clinic does not offer.
- Give young people a chance to practice putting condoms on models or to practice negotiating condom use. (See role-play activity in Chapter 3 on "Preventing Pregnancy.")
- Explain that the young person has a right to change his or her mind and stop using a method or to select another method.
- Ask the young person to repeat back to you instructions on the use of the chosen contraceptive.
- Explain how the young person can get a resupply of methods (more condoms, more pills, etc.) if needed.

Counseling about Sexually Transmitted Infections

Because of shame, fear, concerns about privacy and worries about costs, adolescents may not seek STI treatment. They may try to diagnose their illnesses themselves then seek treatment from pharmacies, traditional healers, friends or relatives. If and when they do come to a health clinic, they may do so after months of self-treatment.

In counseling young people about STIs, your goals are to help them:

- Assess their risks of contracting an STI.
- Consider their partner's risk of contracting an STI and determine how that risk affects them.
- Outline strategies they can use to prevent STIs (abstinence, condom use, monogamy with an uninfected partner).
- Identify symptoms that may indicate they have an STI.
- Identify resources or locations for STI treatment.

Questions to ask adolescents

In counseling clients about STIs, you can ask the following questions:

- What do you know about sexually transmitted infections?
- What do you do to prevent STIs?
- Have you had an STI before?
- For young men: Do you have difficulty urinating now? Do you have a burning feeling when you urinate? Do you have an unusual discharge from your penis? Do you have ulcers, sores or blisters on or near your penis? Do you have any painless, fleshy growths in your genital area?
- For young women: Do you have frequent urination? Is it painful when you urinate? Do you have an unusual discharge from your vagina? Does this discharge have a bad odor? Do you have blisters, sores or ulcers near your vagina? Do you have any soft, fleshy growths near your vagina? Do you have pain or tenderness in your lower abdomen? Do you have fever or chills?
- Do you think you might be at risk for an STI? Why or why not?
- Do you think your partner(s) is (are) at risk for STIs? Have they had any STI symptoms?
- Can you discuss STI protection with your partner? How will he or she react?
- Have you ever used a condom? Did you like using it? Was it easy or difficult to use?
- If you wanted to use protection against STIs, what obstacles would you encounter?

What you can do: STI prevention

In counseling sexually active clients about STI prevention, you can:

- Outline ways to prevent STIs:
    - Future abstinence.
    - Correct and consistent use of condoms.
    - Mutually monogamous relationships with uninfected partners.
- Explain symptoms. Explain that for women, STIs are often asymptomatic.
- Provide comprehensive information about treatment, including:
    - How to take medication.

  - The importance of finishing all medication.
  - The need for sexual abstinence or condom use while taking medication.
  - Reasons to stop taking medication and signs that indicate a need to return to the clinic.
  - The need for partners to be treated.
- Emphasize that the long-term consequences of STIs are serious. They include infertility, STI transmission to newborns, miscarriage, stillbirth and death.
- Emphasize that people who contract STIs are at greater risk for contracting HIV.
- Explain that STIs can be spread not only through vaginal intercourse, but also through oral sex, anal sex or genital-to-genital contact.
- Demonstrate condom use and give clients a chance to put condoms on models.
- Encourage young women and men to develop communication skills so they can discuss STI and HIV risks and negotiate condom use.
- Recommend female condoms, if available, for young women whose partners refuse to use male condoms.
- Help clients identify risky behaviors and encourage clients to modify their actions.
- Describe symptoms and advise clients to seek treatment when symptoms appear or if they think they may have been exposed to an STI.
- Diagnose STIs or refer clients to other health clinics for diagnosis and treatment.

For clients who have been diagnosed with STIs or who are treated presumptively for STI symptoms, you can offer treatment for partners as well.

When managing STIs, health clinics can offer services for:

- *Primary prevention* prevention among young people who do not yet have an STI. This includes information on how to reduce the risks of acquiring STIs, including abstinence, condom use and mutual monogamy.
- *Secondary prevention* diagnosis and treatment of clients who already have an STI and their partners, plus information on how clients can protect themselves against reinfection.

"I am not afraid to buy condoms because it is my life. ... As long as I believe that condoms could save my life, I will not be bothered about [what people think]."

Out-of-school youth in Ethiopia

Counseling about HIV/AIDS

When counseling about HIV, you should talk to young people about risks, prevention and treatment.

Questions to ask adolescents

Many of the questions you ask to help young people assess their STI risks can be modified to help them assess their HIV risks. For example:

- What do you know about HIV/AIDS?

- What do you do to prevent HIV/AIDS?
- Do you know someone who has/had AIDS? What was your relationship to this person?
- Do you think you might be at risk for HIV/AIDS? Why or why not?
- What are the symptoms of HIV/AIDS?
- Do you think your partner(s) is (are) at risk for HIV/AIDS? Has your partner had any STI symptoms?
- Can you discuss HIV protection with your partner? How will he or she react?
- Have you ever used a condom? Did you like using it? Was it easy or difficult to use?
- If you wanted to use protection against HIV, what obstacles would you encounter?

What you can do: HIV prevention

In counseling young adults, you can:

- Stress that young people who delay sexual activity reduce their HIV risks.
- Explain that decreasing the number of sexual partners reduces HIV risks.
- Explain that young people can reduce their risks if they are in a mutually monogamous relationship.
- Explain that STIs increase the chance of acquiring and transmitting HIV.
- Emphasize that the male latex condom provides the best protection against HIV for young people who are sexually active. The female condom also provides protection.
- Describe HIV/AIDS symptoms.
- Help youth learn how to communicate with partners about HIV prevention and treatment.
- Refer sexual partners for HIV testing.
- For young men, discuss the increased risk of contracting HIV during encounters with sex workers.
- For young women, explain the increased risk of contracting HIV during sexual encounters with older men (e.g., sugar daddies).
- For adolescents who are in the military, working as truck drivers or working in jobs that take them away from their regular partner or whose partners may be engaged in these activities explain that sex with casual partners may significantly increase their risk of HIV.

What you can do: HIV testing

For young people who are concerned about AIDS, you may want to recommend HIV testing. Special counseling is required for clients who decide to take this step.

Before testing:

- Explain how HIV is transmitted.
- Explain the test that it will determine the presence of HIV antibodies in the blood. These antibodies do not necessarily mean a person has yet developed AIDS.
- Explain the advantages of testing:
    - Early diagnosis can mean a longer, healthier life since it can provide clients with opportunities to better care for their health.
    - Testing can enable a couple to make decisions about future pregnancies.

  - Knowledge of HIV status can help adolescents prevent transmission to uninfected partners.
- Understand that clients may have reactions to HIV testing, such as:
  - Distress.
  - Anxiety.
  - Uncertainty.
  - Depression.
  - Fear that partners and families may suffer.
  - Fear of discrimination by the community, coworkers or relatives.
  - Concern they may not have access to treatment.
- Talk about the emotional, social and medical consequences of an HIV-positive or HIV-negative test result.
- Help the client make a plan for what he or she will do if the HIV test is positive.
- Discuss ways to prevent HIV transmission.

After testing:

- Counsel the client in person, in a private place, when possible.
- If test result is negative:
  - Explain that this could mean the client is not infected.
  - Explain that this could mean he or she is infected but it is too early for HIV antibodies to be present in the blood. If
  - the client thinks he or she has been exposed to HIV,
  - another test should be done in six months.
  - Counsel about prevention, emphasizing the use of condoms during each act of intercourse.
- If test result is positive, explain:
  - The importance of using condoms to prevent reinfection, which can hasten the progression of the virus.
  - How to maintain health.
  - How to avoid transmitting HIV to others.
- Ask questions:
  - What does this test result mean to you?
  - What are you worried about?
  - How can I help you?
  - Do you want to know more?
  - What questions do you have?
- Refer the young person to other agencies that work with HIV-positive individuals (mental health, economic assistance, transportation, etc.).
- Schedule a follow-up session to plan long-term health care and support.

Chapter 7: Counseling Victims of Sexual Violence or Coercion

Records at the Maternity Hospital of Lima, Peru, found that 90 percent of young mothers ages 12 to 16 were pregnant as the result of rape.

For some young people, sex is not voluntary.

- Some adolescents are forced to have sexual relations, are assaulted if they refuse to have sex or are forced to work as prostitutes in order to survive.
- Some victims of sexual abuse are assaulted by family members or acquaintances.
- The number of street children in the world is growing an estimated 40 million in Latin America, 10 million in Africa and 25 million in Asia. Many exchange sex for food, money or protection.
- In war or in refugee camps, sexual violence can be commonplace.

For girls and women, who typically have less power and less status in society, the short- and long-term health consequences of sexual violence can be physically and emotionally damaging.

- Physically battered females are more likely to experience repeat miscarriages and vaginal infections.
- Battered girls and women may be fearful of using contraception (or even discussing it with their partner), so they are more likely to experience unplanned pregnancies, seek unsafe abortions or acquire an STI.
- Violence does not stop during pregnancy. Complications can include preeclampsia, premature labor, miscarriage and low-birth-weight infants.
- Women and girls who are raped can suffer long-term health problems (chronic pelvic pain, headaches, asthma or irritable bowel syndrome), as well as psychological consequences (depression, fear, anxiety, low self-esteem or sexual dysfunction).
- Women and girls who are raped may be ostracized or blamed by their families and communities.
- Women who are sexually abused as children may be more likely to engage in risky sexual behavior and have an unplanned pregnancy.

Boys and young men can also be victims of sexual violence, abuse and rape, although less information is available about their long-term physical and psychological effects. You should be sensitive to their needs for counseling.

Questions to ask adolescents

Sexual violence and abuse carry stigma, shame and fear, so young people are not likely to volunteer information about their situation. You can be aware that coercion and violence occur and that these acts can have negative consequences on reproductive health. Through counseling, you can help identify young people who are victims or potential victims and provide services, either directly or through referral. It is important that you listen carefully to the young person when discussing violence. You can establish trust and rapport and create an atmosphere of respect and privacy elements that may be missing from the lives of young people who are victims of sexual violence.

"If you refuse, he's going to beat you, and you will give in to his desires by force."

Young woman in Senegal

In counseling, you can ask:

- Have you ever been touched sexually against your will?
- When did it first occur? Is it still going on?
- Do you feel you are in immediate danger? Are you afraid to go home?
- Does your partner abuse alcohol or drugs? Are you more likely to be abused during episodes of drinking or drug-taking?
- Do you use alcohol or drugs to help you cope with the violence?
- How has this violence affected your daily life?
- How has it affected your views of sexual relationships today?
- Have you ever thought of suicide?
- Is there someone you can talk to about this?

If the client talks about suicide, you should immediately refer him or her to a mental health worker and follow up to make sure the client receives help.

Some experts recommend that all young adults should be questioned about sexual violence, especially if:

- They have chronic, vague complaints with no obvious physical cause (such as sleep disturbance, persistent headaches or chronic pain).
- They are pregnant or have an STI.
- They have had an abortion or miscarriage.
- Injuries do not appear to be consistent with the young person's description of how they occurred.
- The young woman's partner is overly controlling or solicitous.
- The adolescent is suicidal or has a history of attempted or threatened suicide.*

* Sassetti M. Domestic violence. *Prim Care* 1993;20(2):289-305.

What you can do: sexual violence

In working with adolescents who have been victims of sexual violence or coercion, you can:

- Be sensitive and listen carefully to the client's needs.
- Treat any medical problems.
- Offer a pregnancy test, if available.
- Offer information about emergency contraceptive pills.
- Provide information about or services for STI/HIV screening and treatment.
- Offer information about routine contraceptive use.

- Refer young people to organizations that offer psychological counseling and legal advice, if available.

Questions for Providers and Program Managers about Counseling Victims of Sexual Violence

? Are counselors trained to identify victims of sexual violence or coercion? If not, how could counselors learn about this? Where are young people referred when they need legal, emotional or social support?

? Are there organizations in your community that work with young victims of sexual violence and coercion? What are the names and locations of these programs? How do you make adolescents aware of these programs?

? How can you work with these organizations so that you can refer clients to them and they can refer clients to you?

? What barriers or obstacles would you encounter? How could you overcome these obstacles?

Chapter 8: Youth-friendly Programs

"With someone your own age, you will be serious. You'll feel at ease. With someone older, you don't want to discuss some things, problems, what's in your heart."

Student peer educator in Haiti

To meet the needs of adolescents, you can consider ways to attract and better serve young people. There are strategies to make services more "youth-friendly."

Youth-friendly programs:

- Actively involve adolescents in program design and service delivery.
- Consider how adolescents' needs differ from those of adults and provide services that specifically meet the needs of young people.

Providing youth-friendly services does not necessarily mean building a new clinic. It can mean adding adolescent-only hours or offering services in places where adolescents congregate, such as youth centers, sporting events or work sites. For community-based workers, it can mean including young people in home visits. And for all health workers, it means establishing or working within a *referral network*. While family planning/reproductive health programs may not be able to offer all methods and services to young people, they can link with other organizations that offer services to young people, including educational and social service programs.

What you can do: youth-friendly programs

How far you can go to meet the needs of adolescents depends on your resources, interest and motivation.

1. At a minimum, you can and should do the following:

- Involve young people in planning and implementing health services.
- Make all staff receptionists, nurses, physicians aware that they should treat adolescents with respect and dignity.
- Revise clinic policies and procedures that prevent youth from getting services and information. For example, revise age requirements for contraceptive use or requirements that clients must be married.
- Ensure that young clients have privacy and that clinic policies emphasize confidentiality.
- Train staff in counseling techniques and make sure they have the most current information on contraceptives.
- Allow enough time for counseling.
- Develop referral systems. Find out about other services in your community for adolescents. Keep a list of these services readily available.

2. If you have some resources for improving adolescent services, you can also add these components:

- Offer separate services for adolescents and adults.
- Offer services at hours that are convenient for adolescents, such as after school or on weekends.
- Make the clinic attractive to adolescents (bright colors, posters, popular music).
- Offer information and education to young clients, both at the clinic and as part of community outreach. For example, hold education sessions at your clinic at times convenient for adolescents, such as after school, or meet with adolescents at local youth clubs to answer their questions about reproductive health.
- Reduce prices for young clients. Provide services free or based on a sliding scale.
- Involve young people by creating a youth advisory board.

3. Programs with more resources can do more. Possibilities include:

- Advocate to improve national policies and service delivery guidelines for adolescents.
- Develop community outreach programs and off-site clinics held at schools, in factories or on the streets.
- Reach adolescents through educational talks before they need reproductive health services. Target parents, too.
- Train peer educators to provide information, education and certain methods to youth.
- Work with mass media to communicate reproductive health messages. Use billboards, soap operas, videos, radio dramas, comic books, popular songs or plays.
- Create or work with "youth development programs" programs that improve socioeconomic status, such as literacy programs or job training.
- Evaluate your program. Examine quality, gender equity and respect for adolescent rights. Evaluations may include:
    - Simple observations.
    - Review of clinic statistics to determine if more young people are attending clinics and returning for follow-up visits.
    - Collection of data to compare services before and after
    - youth-friendly services are implemented.
    - Outcome evaluations to assess whether the project met its goals.

General guidelines for all adolescent programs

If you decide to offer services to adolescents, you can take several steps to ensure that programs are effective:

- Identify which specific target groups will be served. The group can be defined by age, school status, marital status or place of residence (urban versus rural).
- Establish specific objectives and indicators to measure whether these objectives were achieved. For example, an objective might be to increase awareness about STIs. An indicator might be that 10 peer educators were trained and then they reached 100 young people with safer sex messages.
- Involve young people in program planning, implementation and evaluation.
- Consider the potential effects of gender, culture and tradition on service delivery.
- Offer short waiting times and welcome drop-in clients.
- Welcome boys and develop programs targeting them.

To be successful, you also may need to consider approaches to service delivery that involve the community, such as:

- Peer motivators and educators.
- Contraceptive information at schools, sports events, youth clubs, concerts or other places where young people congregate.
- A parents' day at the clinic to provide information to adults about adolescents' reproductive health needs.
- A young people's day at the clinic to provide information about good health. Children of all ages, not just adolescents, could be invited.
- Community feedback sessions to solicit ideas from young people about the types of health services they want, their satisfaction with current services and their ideas for changes and improvements.

The key to providing quality services for adolescents is to treat clients with courtesy and dignity. Above all, young people who seek reproductive health information and services deserve respect.

Questions for Providers and Program Managers about Youth-friendly Programs

? What can you do to make reproductive health information and services more accessible, attractive or convenient to youth? How can you make your clinic or program more youth-friendly?

? Among the three levels of improvements outlined in this section, which can your clinic or program undertake now?

? Which specific activities in this section can you implement to improve adolescent services?

? What creative activities can you undertake to ensure that services and information reach more young people?

? How can you work with parents and other adults in your community to help them understand the unique reproductive health needs of adolescents?

? How will you evaluate your clinic or program to determine whether it is meeting the needs of adolescents?

Chapter 9: Creating a Referral Network

You can create a referral network for your clinic or program by taking the following steps:

- Create a referral book or a set of referral cards.
- List the names of other organizations in your community that work with adolescents.
- List their address, telephone number and the name of a person for young clients to contact.
- Make this list available to all staff in your clinic or program.
- Ensure clients that any referrals you make will be confidential.

Use the following references to help you create a referral network for your community.

References

The following publications and materials were useful in compiling this handbook, including the quotes from and about adolescents.

Adolescence Education: Physical Aspect. Module One. Bangkok: UNESCO Principal Regional Office for Asia and the Pacific, 1991.

Adolescent reproductive health. Network 1997;17(3).

Adolescent reproductive health: making a difference. Outlook 1998;16(3).

Adolescent Sexual Activity and Childbearing in Latin America and the Caribbean: Risks and Consequences. Washington: Population Reference Bureau, Macro International, Inc., Centers for Disease Control and Prevention, 1992.

Adolescent Women in Sub-Saharan Africa: A Chartbook on Marriage and Childbearing. Washington: Population Reference Bureau, 1992.

AIDS: The Second Decade. A Focus on Youth and Women. New York: United Nations Children's Fund, 1993.

Barnett B, Stein J. Women's Voices, Women's Lives: The Impact of Family Planning. A Synthesis of Findings from the Women's Studies Project. Research Triangle Park, NC: Family Health International, 1998.

BCC Experiences from the Field in Jamaica. Arlington, VA: Family Health International, 1997.

Belete F, Demissie H, Hogle J, et al. BCC Experiences from the Field in Ethiopia. Arlington, VA: Family Health International, 1997.

Bernstein S. The State of the World Population 1998. Ed. Marshall A. New York: United Nations Population Fund, 1998.

Bruno ZV, Bailey P. Brazil: Adolescent Longitudinal Study. Summary of a Final Report Prepared for the Women's Studies Project. Research Triangle Park, NC: Family Health International, 1998.

Cohen S, Flanagan D, Mahler H. Behavior Change through Mass Communication: Using Mass Media for AIDS Prevention. Arlington, VA: Family Health International, nd.

Curtis KM, Bright PL, eds. Recommendations for Updating Selected Practices in Contraceptive Use: Results of a Technical Meeting. Volume I. Washington: Technical Guidance Working Group, U.S. Agency for International Development, 1994.

Cyprian J, McLaughlin K, Quint G. Sexual Violence in Teenage Lives: A Prevention Curriculum. Burlington, VT: Planned Parenthood of Northern New England, 1995.

Descriptive Analysis of AIDSCAP/Haiti BCC Projects. Some Lessons from the Field. Arlington, VA: Family Health International, 1996.

Emergency Contraceptive Pills. Contraceptive Technology Update Series. Research Triangle Park, NC: Family Health International, 1998.

Field ML, Flanagan D, Dallabetta G, et al. Behavior Change Communication for the Prevention and Treatment of STDs: Community and Clinic-based Approaches for STD Programs. Arlington, VA: Family Health International, nd.

Flanagan D, Williams C, Mahler H. Peer Education in Projects Supported by AIDSCAP. A Study of 21 Project in Africa, Asia and Latin America. Arlington, VA: Family Health International, 1996.

Gaines M, ed. Recommendations for Updating Selected Practices in Contraceptive Use. Volume II. Washington: Technical Guidance/Competence Working Group, U.S. Agency for International Development, 1997.

Hatcher RA, Trussell J, Stewart F, et al. Contraceptive Technology. Seventeenth Revised Edition. New York: Ardent Media, Inc., 1998.

Helzner JF. Implementing ICPD+5 at the field level: A case study from IPPF/WHR. Presentation. 1999.

Hirsch JS, Barker G. Adolescents and Unsafe Abortion in Developing Countries: A Preventable Tragedy. Washington: Center for Population Options, 1992.

Improving Access to Quality Care in Family Planning: Medical Eligibility Criteria for Contraceptive Use. Geneva: World Health Organization, 1996.

Improving service quality. Network 1998;19(1).

McLain J. An Introduction to Human Sexuality. New York: Soros Foundation, nd.

Jackson J, Leith J, Lee A, et al. The Jamaica Adolescent Study. Final Report Prepared for the Women's Studies Project. Research Triangle Park, NC: Family Health International, 1998.

Kane TT, De Buysscher R, Taylor-Thomas T, et al. Sexual activity, family life education, and contraceptive practice among young adults in Banjul, The Gambia. Stud Fam Plann 1993;24(1):50-61.

Kodjogbe N, Mboup G, Tossou J. Benin Demographic and Health Survey 1996. Summary Report. Cotonou: Bureau Central du Recensement, 1997.

Kols AJ, Sherman JE. Family Planning Programs: Improving Quality. Popul Rep 1998; J(47).

Lema VM, Hassan MA. Knowledge of sexually transmitted diseases, HIV infection and AIDS among sexually active adolescents in Nairobi, Kenya and its relationship to their sexual behavior and contraception. East Afr Med J 1994;71(2):122-28.

Life Skills for Young Ugandans. Primary Teachers Training Manual. Kampala: Republic of Uganda, United Nations Children's Fund, Norwegian Agency for Development Cooperation, nd.

McCauley A, Slater S, Kiragu K, et al. Meeting the needs of young adults. Popul Rep 1995; J(41).

McDevitt TM, Adlakha A, Fowler TB, et al. Trends in Adolescents' Fertility and Contraceptive Use in the Developing World. Washington: U.S. Bureau of the Census, 1996.

Mahler H, Flanagan D. HIV/AIDS Care and Support Projects: Using Behavior Change Communication Techniques to Design and Implement Care and Support Projects. Arlington, VA: Family Health International, nd.

Mahler K, Rosoff JI. Into a New World: Young Women's Sexual and Reproductive Lives. Ed. Johnson J. New York: Alan Guttmacher Institute, William Gates Foundation, 1998.

Moore K, Helzner JF. What's Sex Got to Do with It? Challenges for Incorporating Sexuality into Family Planning Programs. New York: Population Council, 1996.

Murphy EM. Contraceptive Safety: Rumours and Realities. Washington: IMPACT Project, Population Reference Bureau, 1988.

Murphy E. A closer look at client-provider interaction. In Report from the Meeting on Changing Communication Strategies for Reproductive Health and Rights. New York: Population Council, 1998.

Morris L, Nu??L, de Velasco AM, et al. Sexual experience and contraceptive use among young adults in Mexico City. Int Fam Plann Perspect 1998;14(4):147-52.

Nar?, Katz K, Tolley E. Measuring Access to Family Planning Education and Services for Young Adults in Dakar, Senegal. Research Triangle Park, NC: Family Health International, 1996.

Nguer R, Niang CI, Katz K, et al. Identifying Ways to Improve Family Life Education Programs. Research Triangle Park, NC: Family Health International, 1999.

Pick de Weiss S, Vargas-Trujillo E. Conducta sexual y reproductiva de los adolescentes en America Latina. Av Psicol Clin Latinoam 1990;8:11-41.

Pillai VK, Benefo K. Teenagers in Zambia: sexual activity among school-going females. Int J Contemp Sociol 1995;32(1):125-32.

Population Council. Update. The Population Council Africa Operations Research and Technical Assistance Project II. New York: Population Council, 1996.

Postabortion Care Consortium. Postabortion Care: A Reference Manual for Improving Quality of Care. Eds. Winkler J, Oliveras E, McIntosh N. Np: Postabortion Care Consortium, 1995.

Radhakrishna A, Gringle RE, Greenslade FC. Identifying the Intersection: Adolescent Unwanted Pregnancy, HIV/AIDS and Unsafe Abortion. Issues in Abortion Care 4. Ed. Hord C. Carrboro, NC: IPAS, 1997.

Reproductive Health of Young Adults. Contraception, Pregnancy and Sexually Transmitted Diseases. Reproductive Health Series. Research Triangle Park, NC: Family Health International, 1998.

Sharma V, Sujay R, Sharma A. Can married women say no to sex?: Repercussions of the denial of the sexual act. J Fam Welfare 1998;44(1):1-8.

Sexually Transmitted Diseases (STDs). Reproductive Health Series. Research Triangle Park, NC: Family Health International, 1999.

The Condom. Online. Planned Parenthood Federation of America. Http://www.plannedparenthood.org/bc/condom/htm. June 2, 2000.

Tolley E, Dev A, Hyjazi Y, et al. Context of Abortion among Adolescents in Guinea and C??d'Ivoire. Final Report. Research Triangle Park, NC: Family Health International, 1998.

Violence against Girls and Women: A Public Health Priority. New York: United Nations Population Fund, 1999.

Voices of Young Women. Washington: Centre for Development and Population Activities, 1997.

Weiss E, Whelan D, Gupta GR. Vulnerability and Opportunity: Adolescents and HIV/AIDS in the Developing World. Findings from the Women and AIDS Research Project. Washington: International Center for Research on Women, 1996.

What Teens Know and Don't (But Should) about Sexually Transmitted Diseases: A National Survey of 15 to 17 Year-Olds. Menlo Park, CA: Henry J. Kaiser Family Foundation, MTV, Teen People, 1998.

When To Begin Family Planning Methods after Pregnancy. Poster. Research Triangle Park, NC: Family Health International, nd.

The World's Women 1995. Wall chart. Washington: Population Reference Bureau, nd.

Yinger N, deSherbinin A, Ochoa LH, et al. Adolescent Sexual Activity and Childbearing in Latin America and the Caribbean: Risks and Consequences. Washington: Population Reference Bureau, 1992.

Youssef M, Wallace B, Connolly M, et al. Working with Young People. A Guide to Preventing HIV/AIDS and STDs. Ed. Waddel T. London: Commonwealth Youth Programme, World Health Organization, United Nations Children's Fund, 1995.

Youth: Acting on Cairo and Beijing. Washington: Centre for Development and Population Activities, United Nations Population Fund, 1997.

Acknowledgments

This handbook was produced by Family Health International (FHI). Jane Schueller coordinated this project, and Barbara Barnett wrote the text. Nina Frankel was responsible for graphic design and production, and Karen Dickerson coordinated photographs and copyedited the handbook. FHI is especially grateful to Karen Katz and Hally Mahler for their contributions to the content, structure and review of this document. FHI wishes to also thank expert staff who reviewed the contents of this manual: Nina Frankel, David Grimes, Nash Herndon, JoAnn Lewis, Susan Palmore, Elizabeth Raymond, Roberto Rivera, Elizabeth Robinson, Cynthia Waszak and Irina Yacobson. In addition, FHI is grateful to the following health experts who provided comments and suggestions: Douglas Huber and Cathy Solter of Pathfinder International and Sharon Epstein and Tijuana James-Traore of the FOCUS on Young Adults Project of Pathfinder International. We also wish to thank Olivia McDonald and selected health providers from Kingston, Jamaica, for their contributions. Finally, FHI wishes to thank the U.S. Agency for International Development (USAID) for funding this project.

This publication was funded through Cooperative Agreement CCP-A-00-95-00022-02 to Family Health International from USAID. The information contained in the publication does not necessarily reflect FHI or USAID policies.

Meeting the Needs of Young Clients:

A Guide to Providing Reproductive Health Services to Adolescents

By Barbara Barnett with Jane Schueller

Library of Congress Card Number: 00-106541

ISBN: 0-939704-68-4

Â© 2000 by Family Health International
P.O. Box 13950
Research Triangle Park, NC 27709 USA

Telephone: 919.544.7040
Fax: 919.544.7261