Reproductive Health of Young Adults: Contraception, Pregnancy and Sexually Transmitted Infections/HIV

Suggested Narrative

Introductory note to the presenter: This presentation is divided into four sections. Depending on the background and needs of your audience, you may decide to use some or all of the sections of the module, or parts of the sections.

Section I: Reproductive Health Issues of Young Adults

Section I contains background information on the young adult population, including reproductive health risks and consequences. This section is particularly useful for policy-makers or program directors.

Section II: How to Reach Young Adults

Section II discusses what information and services young adults need, and how to make services more accessible. This section is appropriate for those involved in planning and designing programs for youth.

Section III: Contraceptive Options for Young Adults

Section III provides clinical information on contraceptive options for young adults. This section is useful for providers and others involved in reproductive health services and counseling.

Section IV: STI/HIV Prevention and Treatment: Priority for Young Adults

Section IV addresses STI and HIV prevention and treatment issues, focusing on STIs among the young adult population. This section is particularly useful for providers involved in reproductive health services and counseling.
Depending upon the background and needs of your audience, you may decide to use some or all of the slides or supplement them with information relevant to your local situation.

Items found in shaded boxes are suggestions for activities and discussion questions that you may wish to use with your audience. Including some or all of these elements can help your presentation become more interactive, enhancing the learning process. In some cases when activities are used, you may find that slides covering the same material may be omitted.

Regardless of whether or not you include the participatory activities, be sure to familiarize yourself with the contents prior to your presentation. Before the presentation begins, inform your audience about how your presentation is organized and how you would like to structure the discussion (i.e., taking questions during the presentation or waiting until the end). Depending on how much information you decide to use, you may want to consider breaking the presentation into two or more sessions.

**Slide 1**

**Introduction**

This presentation is designed to help policy-makers and providers better serve the reproductive health needs of young people. By understanding the unique needs of adolescents, providers can in turn counsel young people and help them make informed choices to maintain their health and well-being. While the presentation focuses on developing countries, information from developed countries is included when useful.

**Opening Activity**

- Ask participants to introduce themselves to the group stating:
  - name, position and title
  - medical or practical experience working with young adults, specifically regarding reproductive health (RH)
  - one goal that she or he hopes to achieve by attending today's session (list these goals on a flipchart)
- Review the list of goals, discussing which ones are feasible to attain during the session. Put check marks next to those items. Post the list in a visible place in the room.
Section I: Reproductive Health Issues of Young Adults

Reproductive Health Issues of Young Adults: Topics to Be Covered
This section first summarizes why it is important for reproductive health programs to focus on young adults. It then identifies the young adult population and discusses its characteristics. Next, the medical, psychological, and social risks and consequences of early sexual activity and marriage are discussed, focusing on pregnancy and sexually transmitted infections, or STIs. This section is particularly useful for policy-makers and others who need background information.

Slide 3 Activity: Defining Young Adults

- Ask the group to define “young adult” and answer the question “Why is it important to address this special group?”
- Have two volunteers from the group list the responses on a flipchart.

Slide 3

Why Focus on the Reproductive Health of Young Adults?
More than one of every four people worldwide is between ages 10 and 24. During these years, children develop into adults in physical, cognitive, emotional, moral, social and economic ways.

Slide 4

Youth Are Assets
Young people are a great potential resource for the future, with fresh energy, ideas and hopes. They are resilient, energetic, and eager to learn. To reach this potential, they need to acquire skills and knowledge. This
includes understanding and coping with reproductive health risks and consequences.

---

**Slide 5**

*Photo: R. Lord*

**Reproductive Health Risks and Consequences for Young Adults**

Reproductive health issues are critical for young adults. The term “reproductive health” in a broad sense refers to the health and well-being of women and men in terms of sexuality, pregnancy, birth, and related conditions, infections and illnesses. This presentation focuses on reproductive health issues related to pregnancy and STIs, including HIV.

Youth have high rates of unprotected sexual activity. This leads to unintended and too-early pregnancy, STIs, including HIV/AIDS, and unsafe abortion. Also, young people, particularly women, often face sexual violence or exploitation. These risks can result in serious medical, psychological, social and economic consequences.

---

**Slide 6**

**HIV/AIDS Risk for Youth**

About half of all HIV infections are among youth ages 15 to 24. Even so, the HIV/AIDS epidemic among youth remains largely invisible to many adults. Stopping HIV/AIDS requires working with youth in a comprehensive way. This includes working with schools, job generation activities, health systems, sports clubs, and reproductive health programs.

Young women are several more times more likely to get infected than young men, due to both physiological and cultural reasons. This presentation will address all of these issues in more detail.
Transition from Childhood to Adulthood

The transition from childhood to adulthood is a universal process that varies greatly by individual and by region, country and culture. The beginning point of this transition for both females and males is usually considered the onset of puberty, which occurs at various ages. There is no clearly defined ending point for the transition from childhood to adulthood.

Puberty is the physical process of sexual maturation that includes the development of secondary sexual characteristics, such as breasts for girls and increased pubic hair for boys and girls. Generally during puberty, males begin to produce sperm and have their first ejaculation; females have their first menstruation — called menarche — and begin ovulation. Puberty occurs gradually over several years.

In addition to becoming physiologically mature during this transitional stage, youth undergo psychological and cognitive changes. Young people become less dependent on parents and more involved with peers. They begin to form identities as individuals and develop further capacity for interpersonal relationships. During this time, young people often move from being socially and financially dependent to being relatively independent. In certain cultures, other events or processes also help to define this transition, such as formal initiation practices and traditions.

Defining Young Adults

Different words, definitions, age ranges and characteristics are used to describe the transition from childhood to adulthood. The World Health Organization uses the word “adolescents” for ages 10 to 19 and the term “young people” to cover ages 10 to 24. The U.S. Agency for International Development uses the term “young adults” to refer to individuals in transition from childhood to adulthood, without specifying an age span.
“Teenagers” generally refers to those ages 13 to 19. The term “youth” has no formal definition by age range and is used in many contexts.

This presentation includes information that may be pertinent to youth within the age range of 10 to 24, depending on culture, marriage, school status and other factors. Some information focuses on a more narrow age range. The slides on sexuality education, for example, apply to youth as young as 10, whereas the details on contraceptive methods generally apply to older youth. In general, this presentation uses such words as young adults, young people, youth, adolescents and teenagers interchangeably where exact distinctions are not critical.

---

**Slide 9**

**Factors Affecting the Reproductive Health Needs of Young Adults**

Although age is one way of defining the young adult population, it may not be the most important factor when considering the reproductive health needs of young adults. Other factors to consider are: marital status, gender norms, whether sexual relations have begun, whether young people are in or out of school, whether they have already had a child or an abortion, their economic status, whether they live in a rural or urban setting, peer pressure, and political and cultural climates.

---

**Slide 10**

*Photo: B. Goldberg, PAHO*

**Married and Unmarried Youth**

Married and unmarried youth have common biological characteristics that affect reproductive health. Regardless of marital status, young adults also have a common need for accurate information about their bodies, sexuality, communication in relationships, contraceptives, pregnancy and other issues.
Marital status does, however, affect the context in which youth seek and receive reproductive health information, as well as their access to services. Youth who are married generally have the same access to reproductive health services as do married adults. Unmarried youth, however, often face more obstacles than do those who are married. Also, the contraceptive needs of unmarried youth are frequently different from the needs of married youth. For example, unmarried youth may want to avoid pregnancy while married youth may want to begin childbearing.

Slide 11 Activity: Youth and Sexual Activity

- Divide the participants into a group of men and a group of women
- Ask each subgroup to list on newsprint some of the factors that affect youth when they are sexually active. Examples could include: advantages/disadvantages of becoming pregnant, and what society thinks about young females and young males having intercourse.
- Have each subgroup present its list to the larger group.

Slide 11

Gender Affects the Reproductive Health of Youth

The term “gender” refers to the different roles and relationships of males and females, as determined by the society and culture in which they live. Many societies place a higher value on males than females. Gender roles and norms have a major impact on the reproductive health of young adults.

Gender affects expectations regarding the sexual activity of boys and girls. For example, in a survey of factory workers in Thailand ages 15 to 24, a majority of men said premarital intercourse was expected of them and that boys who had not had intercourse were ridiculed by their peers. Women said premarital intercourse was unacceptable, and could damage the family’s reputation.
Regarding responsibility for contraception, young men viewed contraception as a woman’s responsibility, but young women would not consider seeking or requesting contraception for fear of being thought of as sexually active.

Differences in expectations create separate standards for males and females in terms of the social and economic consequences of pregnancy. For adolescent girls in many countries, an unplanned pregnancy usually means expulsion from school, while teenage fathers can remain in school.

Gender affects the interactions between clients and providers. Services tend to be focused on females, especially for contraception, so boys stay away. Girls are especially sensitive to discuss sensitive issues with a provider. A difference between the sexes can magnify a power differential between client and provider.

Gender Affects HIV/AIDS, Other Risks

The degree of risk for HIV/AIDS infection also varies because of gender. Males generally have more ability to use a condom than females. Males report knowing how to use a condom correctly, how to negotiate condom use, and being willing to buy a condom more often than do females, according to a Cameroon study. Girls saw using condoms as a sign of love and protection, whereas boys tended to use them with casual partners, according to peer group discussions in South Africa.

Gender also affects cultural acceptance of behaviors and practices that can jeopardize reproductive health. Females are at higher risk of sexual violence, including rape or domestic violence, than are boys. A recent Demographic and Health Survey in Egypt, for example, showed that nearly nine of every 10 women believed beatings by husbands are justified under some circumstances.
circumstances, and almost one-third reported being beaten during pregnancy. Female genital mutilation, practiced in some cultures, can also jeopardize reproductive health. The World Health Organization reports that some two million girls undergo the procedure annually. Girls have less economic autonomy than boys, so they may rely on “sugar daddies” or sex work for economic needs.

Note to presenter: If female genital mutilation or FGM is common in your region, you may want to add more detail about this procedure and how it affects childbirth and reproductive health. The impact on birth varies depending upon the type of FGM practiced.

Slide 13

Fertile Years Prior to Marriage Increasing
The length of time when women are fertile prior to marriage has been increasing, because the age of menarche is falling and the age of marriage is rising. Therefore, youth are at risk of premarital pregnancy for more years and may be more likely to change sexual partners, thus increasing their risk for STIs as well.

In North America, where the best data are available, the number of fertile years for women prior to marriage has increased from 7.2 years in 1890 to 11.8 years in 1988. This is due to a falling age of menarche, from 14.8 years to 12.5, and a rising age of marriage for women, from 22.0 to 24.3. Studies have found similar trends in other countries, including Kenya, Guatemala, South Africa, India and Morocco. Experts think menarche may be falling due to better health and nutrition. Changes in legal requirements and cultural norms have led to the rising age of marriage.
Average Age at First Intercourse for Unmarried, Sexually Active Youth

Among unmarried youth who are sexually active, the average age of first intercourse is well below the average age of marriage. In most countries, boys report having sexual activity at a much younger age than girls, according to surveys from the Centers for Disease Control and Prevention, the World Health Organization and others.

In Latin America, among sexually active youth ages 15 to 19, males begin sexual activity at age 14 to 16, while females report first intercourse at age 16 to 18, depending on the country. In comparison, the average age of first marriage for Latin American women is 19 to 22. In two Asian countries, the Philippines and Thailand, males begin sexual activity at age 16 to 17, compared to age 17 to 18 for females. The nationwide age of marriage for women in these countries is 21 to 22. In North America, for males, the average age of first intercourse is 16.6, compared to age 17.4 for females. The average age of marriage for women is 24.3.

In sub-Saharan African countries, data from the Demographic and Health Surveys indicate that the majority of unmarried adolescents have been sexually active. The figures vary widely by country.

Young Adults and Contraceptive Use

Few married youth use contraception before the birth of their first child. Among unmarried youth, a U.S. study found that young people typically delay using contraception until about a year after beginning sexual activity. In surveys in Latin America and in Kenya, unmarried youth say the main reason they did not use contraception was because they did not expect to have sex at that time. Sexual activity tends to be sporadic and unplanned among young adults.
Two other common reasons youth give in surveys is that they lack information about contraceptives and they lack access to contraceptives. For example, surveys in Nigeria and Guatemala showed that without accurate information, youth may have unnecessary fears about the effects of contraception on their health. Even if youth know about contraceptives, such as condoms or pills, they often do not know where to get them or how to use them correctly. Young men mention lack of knowledge more than young women. Also, men do not usually see contraception as their responsibility.

Limited Contraceptive Use: Characteristics of Youth

At this stage of life, most young people focus on the present and tend not to plan ahead or anticipate the long-term consequences of their choices. Many unmarried youth think of contraception or family planning as something married couples do — they do not think of themselves as “planning a family” and they may have difficulty discussing contraception.

Most youth also do not think they are at risk, seeing themselves as invulnerable to potentially dangerous consequences of sexual activity, such as pregnancy and STIs. They may lack the motivation or confidence to be successful users of contraceptive methods. They also may be embarrassed to seek out services or may not be assertive enough to get their needs met.

Many youth lack the power and skill to use contraceptives, especially young women who must negotiate the use of condoms with a male partner. Many young women are forced to have sex and have no control over contraceptive use. There may also be cultural expectations or beliefs that limit the use of contraception.
Limited Contraceptive Use: Barriers to Access
Young adults also lack access to contraceptive services or methods. Most clinics are not designed in a way that will be inviting to young clients. Providers are sometimes reluctant to give contraceptives to young people, especially to those who are unmarried. In some countries, laws or policies prohibit provision of contraceptive methods to unmarried youth.

Often, youth lack the transportation to clinics or money for transportation. They also may lack money for services and for contraceptives. Young people may be afraid of being judged by providers or adult clients, or they may be worried about being discovered by their parents. Young women may be concerned about having a pelvic exam. They may only be willing to seek out services anonymously or from someone they truly trust.

High Proportion of Births Are Unintended
Lack of contraceptive use is a major contributor to the high rates of unintended pregnancies and birth observed worldwide for young adults. An unintended birth or pregnancy is one that is either mistimed or not wanted. Every year, about 15 million women under age 20 give birth. This accounts for more than 10 percent of all births worldwide.

Among all women under age 20, the proportion of last births that were unintended was more than three of every six in many sub-Saharan Africa countries and about two of every six in Latin America. In Asia, the Near East and North Africa, data are available only for married women, who would be expected to have lower rates of unintended pregnancies. For this group, the proportion was about one of every six, reported for married women only. Unmarried women have a higher percentage of unintended pregnancies than do married women — as many as three out of four pregnancies in many countries.
Slide 19 Activity: Consequences of Pregnancy

- Divide the group into two subgroups.
- Give each subgroup newsprint and colored markers.
- Ask each subgroup to make a list of the “consequences of pregnancy for youth.” Examples could include: medical risks, maternal mortality, and psychological and social consequences.
- Have each subgroup present its list to the larger group.

Slide 19

Psychological and Social Consequences of Pregnancy for Unmarried Youth

In most cultures, young unmarried mothers face social stigmas that can have harmful psychological and social impact. Pregnancy usually means the end of formal education. In many sub-Saharan countries, girls are expelled from school if pregnant, according to a review of adolescent health rights. In Kenya, for example, some 10,000 girls leave school annually due to an unplanned pregnancy.

Becoming a mother at a young age alters basic life choices in terms of careers, opportunities and future marriage. It is a major economic burden. Those who are already poor are more likely to remain in poverty. For economic reasons, in some countries young unmarried mothers resort to prostitution to support their children. Any of these consequences can lead to depression, loss of self-confidence, lack of hope and other adverse psychological conditions. However, in a few cultures, women are expected to prove their fertility, and early childbearing, even outside of marriage, can improve a woman’s status.

The consequences of early pregnancy are much more severe for young women than for men. But some young men may also bear some social and psychological consequences, especially if they leave school to support a child, reducing their opportunities for education or economic advancement.
These consequences also affect the lives of the children. Many teenage parents lack the experience, skills and resources that they need to raise their children.

**Slide 20**

**Maternal Mortality Higher for Young Women**

Teenage women are much more likely to die in pregnancy or childbirth, compared to older women. In Nigeria, for example, for every 1000 live births, 27 women under age 16 die, compared to four women aged 20 to 24 and 16 women aged 30 to 34. For every 1000 live births in Bangladesh, 17 women under age 15 die, compared to four women ages 20 to 24 and six ages 30 to 34. Similar patterns exist in Ethiopia and other countries.

**Slide 21**

**Medical Risks of Pregnancy in Young Women**

Although medical risks exist during pregnancy at any age, the risks increase among women under age 16. This is because the pelvis of a younger woman often is not fully developed. A small pelvis is one condition that can result in obstructed or prolonged labor. This may in turn lead to complications such as infection, hemorrhage, or fistulas, which are openings in the wall between the vagina and the bladder or rectum. It may also lead to death for the infant or the mother.

In addition, first pregnancies at any age carry greater risks than second or third pregnancies, and many first pregnancies occur at a young age. This higher risk is due to the possibility of developing hypertensive disorders during pregnancy. These disorders include pregnancy-induced hypertension and preeclampsia, a condition in which a combination of increased blood pressure, edema, or swelling, and protein in the urine may be present. Preeclampsia and pregnancy-induced hypertension are conditions that can lead to uterine bleeding or hemorrhage. They can also lead to eclampsia, with
symptoms such as coma and convulsions. Without prompt treatment, bleeding and eclampsia can be fatal to the mother and infant.

Young mothers have a higher incidence of premature labor, miscarriage and stillbirth. Their infants weigh less at birth and experience higher rates of mortality and morbidity. A study of 20,000 births in Mali and Burkina Faso, for example, found that adolescents were 45 percent more likely than older women to have infants of low birthweight, and children of teenagers faced a 35 percent greater risk of dying in their first two years of life, even after socioeconomic and demographic factors were taken into account.

Maternity Care
If a young woman is pregnant, intended or unintended, she needs prenatal, delivery and postpartum care. Many young women, both married and unmarried, do not seek prenatal care. Prenatal care is important, because it is an opportunity to learn about proper pregnancy care, including good nutrition and signs of possible complications. It also gives a provider the chance to assess the woman for risk factors, such as anemia, hypertension or infections.

Young women under age 16 and in their first pregnancy need to be monitored closely during delivery because of their increased risk. Many maternal and child deaths result because a mother does not receive timely care for obstetric complications, including obstructed delivery and hemorrhage. Ideally, a young woman should either deliver at a health facility with good quality emergency obstetric care or have immediate access to such care. For all women, the immediate postpartum period is an important time to check for possible bleeding and infection. For young people and first-time parents, the prenatal and postpartum periods are good times to
provide information on contraception, breastfeeding, child-care skills and child health.

**Slide 23**

**Risk of Unsafe Abortion**

Unintended pregnancies among young women account for at least 2 million unsafe abortions each year worldwide. Abortions may be unsafe for a number of reasons. Safe services may not be accessible or affordable for many young women. Therefore, they may try to self-induce or have the procedure performed by an unskilled or nonmedical provider. Due to cost and other reasons, young women are also more likely to postpone abortion until after the first trimester, which makes the procedure more risky. Young women with abortion complications may delay getting treatment, which can worsen their condition. Greater access to family planning among young women can reduce the number of unintended pregnancies and reduce the number of unsafe abortions.

**Slide 24**

**Consequences of Unsafe Abortion**

Three out of five women hospitalized for abortion complications are under 20 years of age, according to data from Africa, Asia and Latin America. Complications from unsafe abortion include infection, hemorrhage, injury to reproductive organs, intestinal perforation, and toxic reactions to substances or drugs used to induce abortion. These complications may result in infertility or even death.

Whether there are medical complications or not, young women may face negative psychological and social consequences after abortion. They may feel remorse or guilt, or they may encounter negative reactions from peers, family, providers or society.
Youth at High Risk of STIs/HIV

Note to presenter: STIs, including HIV, are discussed in detail in Section IV. If you are not using that section, you may want to use some of those slides with the brief discussion here.

Young adults are at high risk for STIs, including HIV, due primarily to their behaviors. Even if sexually active youth do plan ahead to prevent pregnancy, they still may be vulnerable to sexually transmitted infections if they do not use condoms consistently and correctly. Most youth have little knowledge of STIs and their symptoms. Many do not seek treatment, or they attempt to treat themselves first and only later seek treatment at a clinic.

The risk for STIs is greatly increased for anyone who has multiple sexual partners or if their partner has multiple partners. Young people who start sexual activity at earlier ages are more likely to have more than one partner, thus increasing chance of exposure to STIs.

Young women are more susceptible to STIs than young men because of biological factors, especially cervical ectopy. This is a normal condition that is present in most female adolescents. Also, females are more often asymptomatic than males. In some countries, young people are at high risk because economic or family problems force them to seek work in the sex industry. Other young adults are at risk because they may be coerced into sexual relations. Young women may be targeted by older men because these women are believed to be free of STIs.

Consequences of STIs, Including HIV

STIs can be divided into two general categories, those than can be cured and those that cannot. The curable STIs are mostly bacterial. If not treated, some can lead to pelvic inflammatory disease, or PID, in women. Untreated PID can cause chronic pain, damage the fallopian tubes and result in infertility. Untreated
bacterial STIs also can cause infertility among men. Infertility can be a problem for young women in cultures where social status depends heavily upon childbearing.

Even more tragic are viral STIs, especially HIV, which leads to AIDS and is almost always fatal without expensive drug regimens, which are largely unavailable in developing countries. Globally, at least half of those currently infected with HIV are younger than 25. The incidence of AIDS is increasing rapidly among young females. Learning that one is infected with an incurable STI can have serious physical and psychological consequences in individuals. The rate of HIV infection among young people is harmful to the larger society as well, weakening the work force and reducing the number of future leaders in the social fabric of a country.

### Slide 27

**Risks and Consequences of Sexual Abuse**

In some countries, young people, particularly women, face sexual abuse. Rape is the most obvious form, but abuse also includes sexual assault, incest, involuntary prostitution, and other harmful practices.

These types of abuse can result in physical injury, unintended pregnancy, STIs and psychological trauma. Those who have suffered from sexual abuse are more prone to low self-esteem, earlier consequential sexual activity, and high-risk sexual behaviors, such as multiple partners. However, many young women also have strong resilience, and with help, can heal and be a valued asset for future generations.

### Slide 28

**Summary and Next Steps**

Young adults face high risks of pregnancy and STIs. Moreover, the fertile years prior to marriage are increasing, thus heightening these risks. To help young adults reduce these risks and consequences, they need information, skills and access to services.
Policy-makers, planners and providers need to understand how to make reproductive health services more available to young adults — what kinds of services they need, who can provide services, and where to reach youth. Also, providers need to know how contraceptive methods and approaches to STI prevention and treatment apply specifically to youth. Other sections of this training packet address these issues.
Section II: How to Reach Young Adults

How to Reach Young Adults: Topics to Be Covered

This section of the presentation discusses how to make reproductive health services more accessible to young adults. This information will be particularly useful for those involved in planning and designing programs for youth. The section is divided into three parts.

We first summarize who can provide services for youth, including what types of skills and attitudes providers need in order to serve youth most effectively. Then, we discuss what reproductive health information and education young people need and what research has shown about the impact of sexuality education. The last section discusses where information and services can be provided, beginning with a summary of research on the most important elements in these programs.

Youth Involvement Is Critical

Young people are capable of positive reproductive health behavior when they have good problem-solving and decision-making skills. When young people are full partners in reproductive health and HIV/AIDS-prevention programs, those programs have the potential to have more impact. Substantial youth involvement incorporates the perspective of the target audience of program interventions for youth. These programs tend to have more credibility when working with youth rather than for youth – that is, when youth are involved in the conceptualization, planning, implementation and evaluation of a project. Such an approach draws on the energy, hope, eagerness to learn and resilience of youth. The World Health Organization recently said that youth,
“should be involved from the start as full and active partners in all stages” of a project. Throughout this section, keep in mind the value of involving youth.

**Slide 31 Activity: Provision of Information**

- Ask participants who they think provides general information (any kind) to youth. List responses on a flipchart.
- Ask participants who they think provides health services to youth. List responses on a flipchart.

---

**Who Provides Information and Services to Youth?**

Young people benefit from having access to various types of providers, depending on their circumstances and the types of services, information and counseling needed. These can include doctors, nurses, other health care providers, social workers, counselors, teachers and youth workers, such as peer counselors. Family members can also be important sources of information.

In some cases, adolescents will approach only their peers for information and services. In others, they will visit a doctor. Program planners need to think about the right kind of provider for the circumstance, in order to increase a young person’s receptiveness to counseling and information. These issues are particularly important for unmarried youth but may also be true for young married adults.

Different types of providers are best suited to meet specific needs. Teachers, for example, are good sources of information but rarely provide contraceptives. Peers, when trained adequately, can be very good at providing basic information and condoms, as well as referrals to other services. Most youth do not, however, have the skills and training required to be counselors. In order to
offer a range of reproductive health services for youth, various types of providers working from more than one location need to be involved.

**Slide 32**

**Provider Attitudes Often Negative Towards Young Adults**

Adults generally do not approve of sexual activity among unmarried youth. Providers may have personal or religious views about sexuality that influence how they assist youth. Most providers have difficulty seeing the situation from the point of view of the young person. Hence, adolescents often hesitate to tell adult providers that they are sexually active and to seek information about contraception or disease prevention.

Providers are often judgmental about unmarried women who are pregnant, regardless of the circumstances of the pregnancy. Also, providers may not be helpful to young people seeking services. A study in South Africa, for example, found that even though clinics were supposed to serve youth, personnel resisted young people’s requests for condoms and provided no instructions on condom use.

**Slide 33**

**Sexuality: Open Discussions Are Important**

Sexuality is a difficult topic to discuss openly for most youth and adults, including family planning providers, family members, teachers, counselors and religious leaders. The more those working with youth can understand and be comfortable with their own sexuality, the better they can discuss this topic.

Youth are just beginning to learn about sexuality and may be embarrassed or hesitant to talk about it. They may be dealing with a wide range of issues related to their sexuality, some of which can be very sensitive, such as peer pressure, sexual identity, sexual orientation, sexual capability or sexual coercion. By using good
communication skills, providers can offer youth the opportunity to express and understand their feelings about this complex subject. This in turn can result in healthy sexuality and more responsible sexual behavior, which can prevent unintended pregnancy and STIs.

■ Communication Skills Needed by Providers

Young people vary widely in their needs, even within the same age group in the same country. Good communication skills can help providers assess and meet the particular needs of a young adult. While communication skills are helpful for serving all clients, they are particularly important when dealing with young people. Providers need to listen carefully to understand the needs of each youth and to assess the level of the person’s cognitive and emotional maturity.

Good communication skills include “reflective listening,” where the provider paraphrases a statement or question and repeats it back to the youth. This can show understanding of the words, as well as concerns and feelings. Also, open-ended questions, which allow youth to talk freely, should be used. Positive body language, such as nodding to indicate that the provider is paying attention, is also important.

Providers can better communicate with youth by being sincere, honest, open-minded and nonjudgmental. It is helpful to show respect, use a sense of humor, and show they really care about the young person’s situation.

Confidentiality is very important in serving youth. Where possible, a young person needs to be assured that information discussed will not be revealed to others. If regulations limit total confidentiality, providers need to tell youth about this limitation. Good communication skills will help to build trust and make young people more likely to continue seeking the services they need.
Provider Training Needed

Providers for adolescents need to have good technical skills, whether they are doctors, nurses, youth leaders, teachers or peer counselors. Technically competent providers of information and services inspire confidence, which is particularly important for young adults.

Providers also need information on the broad range of issues facing young adults. Young people’s problems are often interrelated. For example, youth seeking reproductive health services may ask about alcohol, drugs, school problems, or relationships with peers or parents. Providers need to know how to respond to these questions, or if necessary, to refer the client to another provider.

Providers need to reflect on their own views about how they may treat males and females differently. As with sexuality in general, their personal values regarding gender roles and expectations can affect the way they interact with clients and the services they provide.

Ideally, providers who work with youth should receive training in the communication skills necessary for counseling young people. Unfortunately, most providers for youth have no formal training in this area.

Also, it is helpful to be familiar with role playing and other techniques that are useful in strengthening young people’s communication skills. Such techniques can help young people negotiate difficult situations, such as requesting condom use or refusing unwanted sexual activity. For example, a study in Thailand among 240 unmarried female factory workers, ages 14 to 24, found that discussion groups helped them to communicate about STI risk and condom use. The portion of women who said they felt confident talking to a partner about STI risk increased from 60 percent to 90 percent, and the portion who said they would not be embarrassed to give a partner a condom jumped from 36 percent to 82 percent.
Slide 36 Activity: What Information Is Needed

- Divide participants into two subgroups.
- Ask each subgroup to list on newsprint their answers to the question, “What reproductive health information do youth need?” Examples could include risks and consequences of sexual activity, contraceptive choices and STI prevention.
- Have each subgroup present its list to the larger group.

Slide 36

What Reproductive Health Information and Education Do Youth Need?

In every region of the world, adults debate what kind of reproductive health information and education youth need. Young people need information and skills to be able to take responsibility for their sexuality.

Youth need to understand the risks and consequences of sexual activity, which are described in the first section of this presentation. Basic information on contraceptive options and ways to prevent and treat STIs, including HIV, also essential for youth, are addressed in the final two sections of this presentation. The slides that follow discuss sex education, sexuality, the range of sexual expression, fertility of men and women, and gender roles. In all of these areas, information needs to be age-specific. Youth ages 10 to 13 need different types of presentations, compared to those ages 18 to 24.

Slide 37

Research Shows Sex Education Helps

Research has shown the value of sex education for youth. However, providing information and education about sex to youth is controversial. Critics claim that such education will encourage youth to initiate sex at earlier ages and be promiscuous. However, a World Health Organization review of 52 scientific articles on sex education programs found that such programs do not lead
to earlier sexual activity and, in some cases, delay first intercourse. Studies have also shown that in some cases, sex education programs result in the increased use of contraceptives, especially if the programs reach youth before they began sexual activity. Also, beginning sex education before youth initiate sexual activity can help them develop healthy approaches to sexual behavior before they establish unhealthy practices.

**Elements of Effective Sex Education Programs**

Programs that lead to safer sexual behaviors address both attitudes and skills that youth need, and provide accurate information. A review of 49 studies designed to reduce sexual risk-taking among youth found that young people need more than knowledge about contraception and the risks of STIs to practice safer sexual behavior. The analysis found that the programs that did result in safer sexual practices among their participants had certain elements in common. Other research has confirmed these findings. These elements are grouped on the slide according to content and to teaching methods and program design.

**Content:**

- provides basic, accurate information
- focuses on reducing sexual risk-taking
- addresses peer pressures to be sexually active
- strengthens individual and group values against unprotected intercourse.

**Teaching method/program design:**

- provides modeling and opportunities for students to practice communication and negotiation skills
- trains the instructors and involves the students in the teaching methods
• lasts at least 14 hours or includes intense small-group exercises.

**Slide 39**

**Sexuality: What Youth Need to Know**

As young people’s bodies change, they naturally develop an interest in sex. The combination of biological changes with exposure to sexual messages in everyday life, especially through the media, can lead youth to focus only on physical aspects of sexuality. However, sexuality includes issues of identity, societal roles, and human relationships, as well as biological development.

Young adults, both married and unmarried, need a basic knowledge of both male and female reproductive systems and how their bodies, minds and feelings are changing. They need to learn how to communicate about sexuality and how to handle societal and peer pressures about sexual behavior. They need to know that many of the common images of sexuality, especially in the media, are misleading. They need to know how to make their own decisions about sexual activity, including abstinence. And, if they decide to begin sexual activity, they need to know how to negotiate contraceptive use. Learning about sexuality is the first step toward responsible sexual decision-making and behavior.

**Slide 40**

**Ways of Expressing Sexuality**

Unmarried young people need to know that they should not be in a hurry to begin sexual activity — that intercourse is just one of many ways of expressing love, affection and acceptance. They need to decide for themselves when to begin, and not be talked into having sexual intercourse before they are ready. They also need to know alternatives to high-risk sexual behaviors.

Abstinence from sexual intercourse is the most effective way to prevent pregnancy and STIs. While abstinent, there are ways to express sexual feelings that are safe in
terms of preventing pregnancy and STIs. These behaviors include holding hands, hugging, dry kissing, massage, body rubbing, masturbation and mutual masturbation. Contrary to popular myths, there are no health risks from masturbation. Wet kissing is usually safe as well, although it has been associated with HIV transmission in people with exposed sores in their mouths.

When unmarried and married youth choose to have intercourse, they need to be able to make an informed choice about contraceptive options that can prevent unintended pregnancy and STIs. They also need access to these services. While there are various methods that youth can use safely and effectively to prevent pregnancy, the male condom is the most effective method for prevention of all STIs, including HIV. When the male partner will not use a condom, the female condom is recommended as an alternative.

### Fertility Awareness

All young adults need to learn about women’s and men’s reproductive systems, their fertility, the menstrual cycle and its relationship to pregnancy, and how pregnancy occurs. Awareness of fertility also includes, in a broader sense, an understanding of attitudes and cultural norms about fertility, contraception and childbearing. Knowing how the process of reproduction works is important for both young men and women. By understanding the relationship of the menstrual cycle to fertility, males and females may be better able to communicate about pregnancy prevention.

### Fertility of Men and Women

Young people need to understand when they are fertile and when sexual activity can lead to pregnancy. In men, sperm production starts during puberty. Once this begins,
men’s bodies produce sperm continuously. Thus men are fertile all the time, typically for the rest of their lives.

Women are fertile for a short period of time during each menstrual cycle, from menarche until menopause when menstrual bleeding ends. This occurs at about age 45 to 50. The menstrual cycle is governed by a series of hormonal changes and generally varies in length from 21 to 36 days. The cycle begins with the first day of menstrual bleeding, which is the shedding of the uterine lining. Hormonal changes then lead to ovulation, when the egg is released from the ovary.

The number of days from the beginning of the cycle until ovulation varies. For most women, ovulation usually occurs 14 days before the initiation of the next menstrual bleeding. This means for a 28-day cycle, which is about average and is shown in the slide, ovulation occurs around day 14. In a 24-day cycle, ovulation would occur at about day 10, and in a 34-day cycle, at about day 20. For women with irregular cycles, it is particularly difficult to predict the day of ovulation.

After ovulation occurs, the egg can survive up to 24 hours. However, sperm can survive in the woman’s reproductive tract for up to five days, so sperm deposited before ovulation can fertilize the egg. Thus, the fertile time for a couple — when it is unsafe to have unprotected intercourse — could begin six days before ovulation and last for 24 hours after ovulation. If fertilization occurs, the lining of the uterus is not shed and there is no menstrual bleeding. A missed menstrual period is often the first sign of pregnancy. If the egg is not fertilized, the cycle begins again about two weeks later, with another shedding of the uterine lining.
Gender Awareness for Youth

Note to presenter: For more on gender issues, use slide number 11 from the first section.

The term gender refers to the different roles and relationships of males and females, as determined by the particular society and culture in which they live. Gender affects expectations the society has regarding the sexual behavior of boys and girls, as well as their responsibility for contraception and unplanned pregnancy. Gender also affects the cultural acceptance of practices that can jeopardize the reproductive health of girls, such as sexual abuse or female genital mutilation.

Incorporating gender into reproductive health programs for youth can be an opportunity to emphasize communication and shared responsibility between young men and women. Providers can also build into counseling the importance of male responsibilities in reproductive health. Often, young men do not consider reproductive health issues until they have to go to an STI treatment facility. Including young men in a broad range of discussions and education can lead to a lifelong involvement in reproductive health issues.

Where Can Information and Services for Youth Be Provided?

The following slides discuss what types of programs for youth are most effective and where youth can be reached. The home, clinics, school-based programs, community-based youth organizations and the mass media can all be used to reach youth. These programs can serve both married and unmarried youth in many cases but may also be targeted to unmarried youth only. It is also helpful to keep in mind the need to incorporate a gender perspective into all of these programs.
Effective Programs for Young Adults

Reaching young adults requires different techniques than those used to reach older adults. Most youth do not seek out services on their own. Thus, programs need to increase adolescents’ awareness of reproductive health issues in order to encourage them to seek services. When designing programs, policy-makers and providers need to acknowledge the importance of culture and tradition and, at the same time, be bold in advocating and providing what young people want and need.

Research from the World Health Organization, the United Nations Population Fund and other groups has identified the most important program elements that are effective in reaching youth. First, programs need to identify clearly a target group by age, school status, and other factors, and then analyze the group’s specific assets and needs, developing appropriate strategies to meet those needs. Second, many agencies have stressed the importance of involving youth in various ways. These may include needs assessments, planning, peer...
promotion, focus groups, evaluation and board membership. Third, working with community leaders, teachers, school principals, religious leaders, and family members can help reduce fears or misconceptions about programs for youth.

Fourth, using materials that are designed, or at least field tested among youth, is crucial. This will help to ensure that the materials are relevant and can be understood by young people. Fifth, services need to go where youth are, and be accessible in terms of cost, location, hours of operation, waiting time and other practical factors, which youth can help identify. Health services also need to be linked with other services to provide a holistic approach to the care of each individual. Sixth, it is important to use good evaluation tools to create projects that can be sustained and replicated. Private donors and government programs should provide sufficient funds to permit successful, small-scale projects to expand.

Youth-Adult Partnerships

Effective programs for young adults involve substantive youth-adult partnerships. Elements of good partnerships include a clear organizational commitment and capacity, including clear goals, expectations and responsibilities for youth and adults. It requires a commitment from all levels of the organization. An attitude shift among both adults and youth is often needed. This means addressing misconceptions and biases that youth and adults have about each other, an awareness of different styles of communication, and using training to diminish stereotypes and facilitate collaboration.

Careful attention needs to be given to selection, recruitment, and retention of youth. This involves recognizing the differences among youth in terms of age, gender, education and other factors. Youth may need support to balance school, work and family
commitments. Youth age out of programs, and a system for ongoing recruitment is needed.

Substantial levels of participation are important, not just token involvement. Projects need to work to determine ways that youth can be involved meaningfully.

Family Involvement
In many cultures, youth may want to talk to their family members about sexuality. Where culturally appropriate, family members should begin communication about sexuality as early in their child’s life as possible. Crucial elements in family involvement include: parental availability and approachability, attitudes and knowledge, and communication skills.

Programs are needed to help train parents to discuss with their children their strongly held family values, as well as information about sexuality and contraception. One technique that youth projects have used effectively involves having a young person discuss sexuality with an adult who is not his or her parent. This encourages more frank discussions, and both youth and parents gain skills in communication. Also, if culturally appropriate, teachers can give assignments that involve communication with parents about sexuality. It is often very difficult to involve parents, however, because of work demands, cultural norms and emotional biases about their own children’s sexuality.

Family members can also support youth in seeking counseling and services. It is important that parents do not block their children from receiving the services that they need. Parents also may be in a position to advocate for the availability of good information and services. Parents and other family members can serve as positive role models, teaching values and attitudes through their own behavior.
Health Clinics Designed for Youth

Health clinics in general have not been successful in reaching young adults with the kinds of services they need. Services for youth need to be where youth are and be well-designed. Long waiting times, impersonal staff, or judgmental providers may easily discourage youth.

In an attempt to serve youth better, some clinics are opening either separate units or outreach clinics designed for youth with specially trained staff. Small outreach clinics in structures separate from the major health facility have been shown to attract young people and win community support when they are part of a broader social services network. Mobile clinics have also been successful in some places. Services with special hours of operation when youth can come are important for attracting youth. Clinics need to be located where youth will find them convenient and safe, such as in youth centers. Youth-to-youth promotion can encourage use of these clinics as can specially designed informational materials. The cost of services can be a constraint for many young people. To be successful, youth programs may need to provide free or low-cost services.

Traditional Health Clinics: An Opportunity to Reach Youth

Traditional health care services can also help reach youth. Those providing prenatal, delivery, postpartum and abortion services have a valuable opportunity to reach young adults. In outpatient clinics, for example, providers have an opportunity to provide basic reproductive health information to youth and to talk to them about their reproductive health needs. This might be one of the few times a teenager gets such information or has a chance to talk to a provider. In a confidential setting, a provider could at least ask one question: “If you are sexually active, what are you doing to prevent pregnancy and sexually transmitted infections?”
Referrals to other service providers are very important. It is not critical that all services be housed under one roof. A nurse at a health post, for example, can take advantage of supplementary resources available in the community.

Elements of School-Based Programs

Large numbers of youth can be reached efficiently at schools. These programs should begin as early as possible for a number of reasons. Since many youth drop out of school, and in many places girls do not attend school as long as boys, appropriate sex education in the early school years reaches more young people. Keep in mind that these programs can be used in all types of schools, including vocational, technical training and specialized schools.

Reproductive health education curricula should ideally cover sexuality, relationships, general health, self-esteem, communication and negotiation skills. Reproductive health education has been done through general health curricula, often called family life education or FLE programs. This has advantages and disadvantages. FLE programs can place reproductive health in the larger and proper context of developmental issues. On the other hand, this broader focus can result in diminished emphasis or a total deletion of material on sexuality, fertility awareness and contraception.

In addition to sex education programs, some schools have on-site or linked health clinics that provide such reproductive health services as counseling and contraceptives. Linking sex education programs to community services can be important. Other school-based services include health screenings, public education campaigns, and referrals to community-based youth programs and emergency services. Training instructors and administrators in the curricula and services makes these efforts more effective, as does involving families and community leaders.
Community-Based Youth Organizations
Community-based youth organizations have faced opposition due to fears — which research has shown are unfounded — that contraceptive services will lead to increased sexual activity. Consequently, programs have often incorporated reproductive health services for youth into broader service offerings, including recreation, sports teams, drama groups, vocational training and tutoring. Youth-oriented activities such as scout programs have begun to focus on reproductive health services. Religious organizations can also be effective with education, recreation and other youth programs. Community programs can also target out-of-school youth through street programs and the workplace.

Programs such as these can help provide adult role models for youth. Youth themselves — called peer promoters or educators — often provide information, counseling and in some cases condoms to other youth. A study in Mexico showed that peers and adults can be used effectively in varying circumstances.

Some community-based programs have focused specifically on serving pregnant and parenting teens. While these programs generally serve small numbers of young women, some have helped change national policies, allowing young women to remain in school. These projects have helped pregnant and parenting youth finish school. They have also offered tutoring, skills training and vocational training. Research has shown that there are fewer second pregnancies among program graduates compared to other adolescent mothers.

Mass Media and Other Creative Outreach
Throughout the world, young people love radio, television, videos, film and comic books, and they can be effective ways to reach youth. Successful prevention programs have used these media to disseminate messages directed at youth. Soap operas on television depict typical
situations that youth often face. Telephone hotlines have been successful in various countries as a means for youth to get information from adults and peers that is anonymous and nonjudgmental.

Drama groups, puppet shows, rock concerts and other entertainment forms are effective at reaching youth. Youth drama groups, for example, provide youth an outlet for creating and conveying messages that have more legitimacy with youth than does advice from adults.

Groups have also begun to use computer technology to provide information to youth. Among the electronic tools used are: distance learning training modules, CD ROMs, web sites and listservs. These can be used in health clinics, school-based programs and community-based programs.

Social marketing is another successful way to reach youth with information and some contraceptives, especially condoms. These campaigns use advertising and creative promotion techniques to saturate a particular market segment. This builds product recognition, breaks down barriers to discussions about use, and provides a convenient distribution system — ranging from concerts and mobile information booths to more traditional outlets such as pharmacies.

**Summary**

Policy-makers and program planners in the reproductive health field have not traditionally focused on young people and have not paid enough attention to their needs. Nor have youth organizations normally included reproductive health as part of their services. These patterns are slowly changing, and more reproductive health programs designed for youth are being established.

Research has shown that sex education does not increase sexual activity and can delay initiation of intercourse when programs focus on attitudes and skill building, as
well as knowledge. Designing programs with youth involvement is essential in attracting youth to the services they need. Given the potential value of such programs, it is important to think carefully about the many types of providers who can serve youth, about the types of information and education they should provide, and about where these services can be provided. Projects that incorporate youth-adult partnerships can help influence attitude shifts among adults and youth.
Section III: Contraceptive Options for Young Adults

Slide 54

Contraceptive Options for Young Adults: Topics to Be Covered
This section first discusses contraceptive methods in terms of preventing pregnancy and STIs. A short description of each contraceptive method is included, covering issues most pertinent to young adults. Emergency contraception and dual method use are also explained. Discussion is included on postpartum and postabortion contraceptive options. This section is particularly valuable to those actually providing services to youth.

Slide 55 Activity: Contraceptive Issues for Youth

• Ask participants to answer the question, “What are some contraceptive issues for young adults?” Examples could include: lack of accurate information, and lack of access to methods.
• Write the group’s responses on a flipchart.

Slide 55

Contraceptive Issues for Young Adults
There is no medical reason for denying a young person any contraceptive method based on age alone. However, nonmedical issues are important when considering young adults’ use of methods to prevent pregnancy or the transmission of STIs. For example, sterilization is not appropriate for youth because they may regret the decision later.

Many youth engage in high-risk behaviors, such as having multiple partners or a series of partners. Youth often lack accurate or complete information about contraceptives and tend to rely on secondhand
knowledge, including myths and misconceptions. Also, they may not use methods consistently and correctly and tend to have unplanned and sporadic sexual activity, which is more likely to be unprotected. Many lack knowledge about and access to emergency contraception, which must be used shortly after unprotected intercourse to prevent pregnancy. Since many youth are vulnerable to STIs, counseling about contraception should include STI prevention messages.

---

**Slide 56-72 Activity: Contraceptive Methods**

- Ask participants to name the family planning methods that are available in their areas/clinics.
- Write their responses on a flipchart.
- Divide the group into as many subgroups as there are methods listed.
- Ask each subgroup to consider, and list on newsprint, the following characteristics for the method they have been assigned:
  - advantages this method offers young adults
  - disadvantages this method presents to young adults
  - important counseling points to discuss with clients about this method
- As the subgroups are working on their lists, rearrange slides 56-72 so the methods that they are working on are shown first.
- Ask the subgroups to present their lists to the larger group.
- Show slides 56-72, referring to the lists to compare the information.
- Ask members of each subgroup how they would ensure that this information reaches the young adults in their clinics (or in the model clinics they designed earlier).

---

**Complete Abstinence**

Complete abstinence is the most effective way to prevent pregnancy and STIs. It is usually defined as abstaining from penetrative and oral sex. Abstinence has no ill-effect on the health of young women or men. A range of sexual expressions are possible during abstinence,
including hugging, holding hands, massage, body rubbing, kissing, masturbation and mutual masturbation.

Abstinence should be discussed as an option both for young adults who have not initiated sexual intercourse and for those who have already begun sexual activity. In discussing abstinence, providers should help youth gain the skills to cope with peer and partner pressure. Abstinence requires high motivation and self-control. Partner communication and cooperation are also essential. Social support for delaying sexual activity can help young adults practice abstinence. Nonetheless, abstinence can be difficult for a sizable proportion of young adults. For this reason, policy-makers and service providers must ensure that all youth have information about, and access to, reliable contraceptive options.

**Slide 57**

**Barrier Methods**

Barrier methods include male condoms, female condoms, spermicides, diaphragms and cervical caps. These methods can be used alone, in combinations, or with non-barrier contraceptives, such as pills.

Barrier methods are most effective at preventing pregnancy when used consistently and correctly. If these methods are used correctly with every act of intercourse, called “perfect use,” pregnancy rates range from about 3 percent for male condoms to 7 percent for spermicides. A 3 percent pregnancy rate means that three out of every 100 women using this method for a year would get pregnant. Normal use in everyday life, which is not always consistent or correct, is called “typical use.” In these circumstances, pregnancy rates range from about 12 percent for condoms to 21 percent for spermicides, but in some settings the rates may be substantially higher.

Barrier methods are safe and have no systemic effects, although in rare cases some people may be allergic to latex condoms or spermicides.
The most widely used spermicide, Nonoxynol-9, does not protect against transmission of HIV or other STIs, nor does it add protection when used with condoms. Moreover, when used alone during anal sex or frequent vaginal sex, it can cause genital irritation and may increase the risk of HIV transmission. Nonoxynol-9 is still an appropriate method of contraception for women at low risk of STI/HIV, but is most effective when used with another barrier method.

Slide 58

Barrier Methods: Advantages

Barrier methods are particularly appropriate for young people for these reasons:

- Many are at high risk for STIs. The male condom is the most effective method for STI/HIV prevention. The female condom offers an alternative which some men may be more willing to use. The female condom has been shown to prevent transmission of STIs, including HIV, in laboratories, and research in human use is promising. However, the female condom is not readily available in most developing countries. Diaphragms and cervical caps may provide some protection against cervical gonorrhea and chlamydial infection.

- Many youth have easier access to barrier methods, especially male condoms, than other methods. Youth can provide condoms to other youth. Condoms are generally available at low cost without a prescription. However, young people may be embarrassed to ask for condoms in certain settings. Only diaphragms and cervical caps, which are not widely available in developing countries, require a clinic visit for proper fitting.

- Many young people have sex infrequently and without advance planning. Barrier methods are well suited for these situations, provided they are available at the time.
• Barrier methods are user-controlled and can be easily initiated and discontinued.

Slide 59

**Barrier Methods: Counseling**

Successful use of barrier methods requires overcoming disadvantages of these methods. Because barrier methods must be used correctly for every act of intercourse in order to be effective, appropriate counseling is essential to help young adults use them successfully. This is true for young people in particular because most barrier methods, especially condoms, require partner participation and negotiation skills. Counseling needs to emphasize that a high level of motivation, self-confidence and self-control are necessary for youth to be successful users of barrier methods. In addition, many youth are inexperienced sexually, are embarrassed to use condoms or are concerned that barrier methods will interrupt their sexual activity, making it awkward or less pleasurable. Counseling also needs to address these concerns.

Even though barrier methods are often not obtained from providers, youth need clear, practical information about how to use these methods correctly and how to avoid common mistakes in use. They also need to know where to get more supplies and how to store them properly. Key messages for youth include:

• Be prepared: always carrying barrier methods so they are readily available when sex occurs;

• Communicate with your partner about shared sexual responsibility, a process that can establish positive patterns that last into adulthood;

• Use barrier methods consistently and correctly for them to be effective.
Male Condom
Key messages regarding condom use include:
- Condoms can be used for both pregnancy and STI prevention.
- If at risk for STIs, use a condom, even if you or your partner is using another contraceptive method.
- Use of the condom can be incorporated into sexual activity in order to avoid awkwardness.
- The tight fit of the condom can result in delayed ejaculation, which can help young men who have premature ejaculation.

Male Condom Use
When using a male condom:
- Open the package carefully to avoid tearing the condom.
- Do not unroll the condom prior to putting it on; unroll directly onto the erect penis.
- Hold onto the rim of the condom while withdrawing the penis from the vagina to help prevent the condom from slipping.
- Use only water-based lubricants such as KY-Jelly, spermicidal gels or creams, or saliva. Do not use any oil-based lubricants such as petroleum jelly, hand lotion or mineral, cooking or vegetable oils. These can weaken the latex in the condom and increase the likelihood of the condom breaking.

Oral Contraceptives
There are two types of oral contraceptive pills. Combined oral contraceptives, or COCs, contain both estrogen and progestin. The other type of pills is progestin-only pills, or POPs. COCs are by far the most commonly used worldwide, and most information available regarding oral
contraceptives and youth pertain to the combined pills. COCs are the best type of pill for young women, except for those who are breastfeeding, when estrogen might affect lactation.

Oral contraceptives are very safe for young women. They have no long-term effect on ovarian function or growth, and no age-related complications or side effects have been recorded. They are very effective at preventing pregnancy when used consistently and correctly. In perfect use, COCs have a pregnancy rate of less than 1 percent, but in typical use, the rate is about 8 percent. Oral contraceptives also provide non-contraceptive health benefits, such as improving acne, regulating menstrual cycles, decreasing menstrual cramps, and protecting against ectopic pregnancy, benign breast disease, ovarian and endometrial cancer, and some forms of pelvic inflammatory disease. Once a woman stops taking the pill, fertility returns quickly, which could be important to young women who want to become pregnant.

With the pill, young women gain more control over their fertility, since taking the pill is independent of sexual intercourse, and it can be used without a male partner’s knowledge or cooperation. However, young women using this method without parental knowledge or support may worry that their parents or other household members will discover the pill packs.

In many countries oral contraceptives are only available through a clinic visit. In other countries they may be distributed by trained providers through community-based programs or sold in pharmacies without a prescription. Oral contraceptives do not offer any protection against the transmission of STIs.
Oral Contraceptives: Counseling
Counseling about correct pill taking is particularly important for young women. The contraceptive effect of the pill wears off quickly once it has been discontinued. Pills must be taken daily. If a young woman is not having sex regularly, it may be easy to forget to take the pill. Also, a young woman may stop taking the pill when she breaks up with a boyfriend. If she resumes that relationship or starts another one and has intercourse before restarting regular pill use, she may be at risk for pregnancy.

Counseling can help young women prepare for possible side effects such as nausea or breakthrough bleeding. Knowing what to expect may reduce the likelihood that a young woman will discontinue use if side effects occur.

Providers should encourage young women to link pill-taking to a daily routine, such as teeth cleaning, to ensure correct use. To maintain its contraceptive effect, the pill must be taken daily except for a seven-day period between pill cycles, when no active pill is needed. However, some pill packs are designed for 28 days, with seven hormone-free or placebo pills at the end of the cycle. This encourages an uninterrupted daily routine of pill taking.

Providers should give condoms and explain when they need to be used as a backup method of contraception. If pill use is not begun during the first seven days of the cycle, condoms should be used for the first seven days. Condoms should also be used as a backup if two or more pills are missed. Providers should also discuss the use of condoms for STI protection with youth who are at risk.

Injectables and Implants
Young adults can safely use injectables and implants, which are hormonal contraceptives. There are two main progestin-only injectables. Depo-Provera, or DMPA
(depot-medroxyprogesterone acetate), is given every three months, and NET-EN, or Noristerat (norethisterone enanthate), is given every two months. Combined estrogen-progestin injectables, which include Cyclofem and Mesigyna, must be taken monthly and are not yet widely available.

The most common implant, Norplant, contains six thin, flexible, rod-like capsules containing the progestin levonorgestrel. Inserted under the skin in a woman’s arm in a simple surgical procedure, it is effective for up to five years. Norplant II, or Jadelle, which consists of two rods that release levonorgestrel, is effective for at least three years. Implanon, consisting of one capsule that releases the progestin 3-ketodesogestrel, is also recommended for three years of use.

Both injectables and implants are very effective, with pregnancy rates of less than 1 percent after one year of use. Like oral contraceptives, they have long-term, non-contraceptive benefits. These include decreased risk of pelvic inflammatory disease, ectopic pregnancy and endometrial cancer. Injectables and implants do not require daily action, and no supplies are needed at home. Their use is independent of sexual intercourse, and they can be used without partner knowledge.

Injectables require a periodic trip to a provider. For implants, the clinic visit for insertion or the high initial cost may be a barrier for many youth.

Like the pill, injectables and implants do not protect against STIs. A theoretical concern exists regarding use of implants and progestin-only injectables by women under age 16. Using these methods reduces a woman’s level of estrogen and may have an impact on developing bone mass, which could potentially predispose young women to osteoporosis in later life. However, definitive studies on this question have not been completed.
Injectables and Implants: Counseling
For these methods, counseling about bleeding irregularities and return to fertility is important. Users of progestin-only injectables and implants often experience irregular bleeding, spotting or amenorrhea, which may be of concern to young adults. Young women need to know that bleeding irregularities may happen and that this doesn't mean anything is wrong. Bleeding irregularities are less of a problem with the monthly injectables that contain both estrogen and progestin. Unlike the pill, progestin-only injectables often cause a delay in return to fertility. About 50 percent of women conceive within 10 months after the last injection, and more than 90 percent are fertile again by 24 months. With implants, fertility returns immediately upon removal. If at risk for STIs, a woman should also use condoms.

Implants are more appropriate for those wanting a long-term method and where access to removal is easily available. Early discontinuation of implants has been associated with young age and low parity.

Intrauterine Devices (IUDs)
Intrauterine devices (IUDs) are very effective for preventing pregnancy. The widely used copper IUD is effective for up to 10 years. The levonorgestrel intrauterine system, or Mirena IUS, releases the progestin levonorgestrel through an IUD and is effective for up to five years. Both methods have a pregnancy rate of less than 1 percent.

IUD use is independent of sexual intercourse, and fertility returns quickly upon removal. An IUD must be inserted and removed by a trained provider, requiring a clinic visit and a pelvic examination. This may be a barrier to some young women. IUDs do not offer any protection against STIs, including HIV.
Intrauterine Devices (IUDs): Counseling

According to the World Health Organization, IUDs are not recommended for young women at increased risk of STIs/HIV unless other methods are unavailable or unacceptable. IUDs should never be inserted in a woman who has a current infection or has had an STI in the last three months. IUD use may increase the risk of pelvic inflammatory disease and infertility among women who have an untreated STI at the time of insertion or if the procedure is not performed under sterile conditions. Women under age 20 can generally use IUDs, although concern exists about an increased risk of expulsions among those in this age group who have never borne children.

With careful screening and counseling, IUDs may be used safely by young women in stable, mutually monogamous relationships. It is very important to emphasize that IUDs should not be used by young women at high risk of STIs, including those with multiple partners or whose partners have multiple partners. It is also important to counsel young women to look for signs of expulsion of the IUD by feeling for the IUD string in the cervical opening.

Lactational Amenorrhea Method (LAM)

The lactational amenorrhea method, or LAM, is a temporary contraceptive option available for the first six months after giving birth for women who are breastfeeding. To use LAM, a woman must be fully or nearly fully breastfeeding and remain amenorrheic during the first six months postpartum. LAM is highly effective when used under these conditions. If any of these conditions change, however, the woman must immediately initiate the use of another method if she wants protection against pregnancy. Providers can help prepare women by discussing other contraceptive options and providing the chosen method before LAM conditions expire.
LAM offers no protection against STIs. If a woman is at risk of HIV or other STIs, she should also use a condom.

Traditional Methods

The traditional contraceptive methods of periodic abstinence and withdrawal, or coitus interruptus, are always available to youth and, unlike modern methods, do not cost anything. Withdrawal is the practice of removing the penis from the vagina before ejaculation. Periodic abstinence means abstaining from sexual intercourse during the woman's fertile time. Some adolescents use these traditional methods, especially as they begin sexual activity, because they lack knowledge of or access to other methods.

Use of these methods can promote reproductive health awareness and skills. However, traditional methods have high pregnancy rates in typical use compared to other methods of contraception. Also, neither method protects against STIs. Both withdrawal and periodic abstinence require couples to be highly motivated and knowledgeable about their bodies and to use great self-control. Practicing these methods successfully can be difficult for adults and youths alike. Correct use of withdrawal requires that a man remove his penis from his partner’s vagina before ejaculation and ensure that ejaculation occurs away from his partner’s genitalia. Even when withdrawal is used successfully, pregnancy is still possible because pre-ejaculatory fluid may contain semen.

In the months immediately after menarche, the menstrual cycle tends to be irregular, making periodic abstinence difficult to practice using the calendar method. This point should be emphasized in counseling. The modern approach to periodic abstinence, called natural family planning (NFP), provides ways for women to track their fertile period more accurately than the previously used
calendar method. It requires knowledge of reproductive physiology, including fertility. Tracking fertility can be done with thorough training and practice by measuring basal body temperature, checking cervical mucus patterns and other signs to determine the time of ovulation, or using a device called “Cycle Beads,” which is similar to a necklace with different colored beads. NFP can be effective when used consistently and correctly.

Slide 70

Sterilization
Sterilization is generally not an appropriate method of contraception for young adults because they are at the beginning of their reproductive years. Many young adults, especially those without children, may later desire to have children. Studies show that regret about sterilization is often associated with undergoing the procedure at a young age. Hence, it is extremely important for any young adult contemplating sterilization to know that the procedure is permanent. Although reversal may be possible, it is not always successful, it is expensive, and it is not available in many locations. Sterilization needs to be clearly understood as a permanent method, not a temporary, reversible one. Having received all of this information in counseling, a client also has the right to know that there is no medical reason to deny sterilization to a young adult simply because of his or her age. It is a very effective contraceptive method, but it does not provide any STI protection. Many youth may not realize that men as well as women can be sterilized.

Slide 71 Activity: Emergency Contraception

- Ask participants if they provide emergency contraception in their clinics.
- Ask participants what they have heard about emergency contraception.
Emergency Contraception

Emergency contraception refers to the use of contraceptives to prevent pregnancy after unprotected intercourse has occurred. Few young adults know about it, although it is particularly important for them. Young adults may have unprotected sex for a number of reasons: neglecting to use a barrier method with each act of intercourse, having unplanned sex with no contraceptives available, using a contraceptive method incorrectly, or having a condom break or slip. Another reason for unprotected sex are cases of sexual coercion and rape, which is common among young women in many countries.

Emergency contraception is not meant to be a regular method of contraception. After use, a regular method should be started or resumed if pregnancy is not desired. Emergency contraceptive pills can be used at any time during the menstrual cycle and more than once during a cycle if necessary. It does not protect against STIs. It is most effective when used early after unprotected intercourse.

The primary types of emergency contraception are high doses of combined oral contraceptives or progestin-only contraceptives.

Emergency Contraceptive Pills: Combined Oral Contraceptives

The most commonly used method for emergency contraception is a special regimen of combined oral contraceptives. This regimen has been studied extensively and shown to be safe and effective. When used correctly, emergency contraceptive pills prevent about 75 percent of expected pregnancies.

Two doses of pills should be taken: the first within 72 hours after unprotected intercourse and the second 12 hours later. Each of the two doses of pills should contain...
at least 100 micrograms of ethinyl estradiol and 500 micrograms of levonorgestrel (LNG), which can be obtained either by taking four “low-dose” pills or two “high-dose” pills in each dose.

The mechanism of action is not well understood and may be related to the time it is used in a woman’s cycle. It is believed that the main effect is the inhibition or delay of ovulation. It may also interfere with fertilization and/or implantation. Once implantation has occurred, emergency contraceptive pills are not effective.

Counseling young women about the possible side effects of emergency contraceptive pills is important. The main side effects are nausea, which about one-half of women experience, and vomiting, experienced by up to one-fifth of women after the first or second dose.

Note to presenter: The common low-dose pills contain 30 micrograms of ethinyl estradiol and 150 micrograms of levonorgestrel. The common high-dose pills contain 50 micrograms of ethinyl estradiol and 250 micrograms of levonorgestrel.

Emergency Contraceptive Pills: Progestin-Only Oral Contraceptives

Another option for emergency contraception is a special dosage of progestin-only pills. Research indicates that POPs are a more effective form of emergency contraception than the special regimens of combined oral contraceptives, reducing the risk of pregnancy by up to 85 percent.

Two doses of pills should be taken: the first within 72 hours after unprotected intercourse and the second 12 hours later. Each of the two doses of pills should contain at least 750 micrograms of levonorgestrel. In some countries, progestin-only emergency contraception is available prepackaged, containing each required dose in one tablet.
Women using POPs for emergency contraception have a much lower incidence of nausea and vomiting compared to those using COCs.

**Slide 74**

**Dual Protection Against Pregnancy and STIs**

Youth at increased risk for STIs need to think about preventing both pregnancy and STI transmission. In such situations, some providers are beginning to recommend two methods, or “dual method” use — one for pregnancy prevention and the second for STI prevention. Young adults who are at risk for STIs should be advised to use condoms even if they are using another contraceptive method.

The male condom is the most effective method for the prevention of all STIs, including HIV. However, in typical use, condoms are not as effective at pregnancy prevention as some other methods. Given this dilemma, young adults need to make an informed choice about which method or methods to use. Providers should counsel youth clearly about approaches to dual method use and encourage youth to take responsibility for making their own choice.

One approach to dual method use is to use a contraceptive method highly effective at pregnancy prevention, such as the pill or injectables, and to use a condom for STI prevention. Some research among young adults shows, however, that the more effective the contraceptive method used, the less likely youth are to use condoms for disease prevention.

Another approach for dual protection is to use condoms as the primary method. Condoms are highly effective at both pregnancy and disease prevention when used consistently and correctly. Even with good counseling, however, youth often do not use condoms consistently. With this approach, youth need be counseled about using emergency contraception when condoms are not used, or
when they break or slip. Oral contraceptives for emergency contraception could be provided along with the condoms.

**Slide 75**

**Postpartum Contraceptive Options**

Providers need to know which contraceptives can be safely used by breastfeeding mothers and non-breastfeeding mothers. It is crucial to counsel a woman to weigh her options carefully for any method that would be used immediately after delivery. The best time for this counseling is during the prenatal period. During labor or immediately after delivery is not an appropriate time for contraceptive counseling.

All young women, breastfeeding or not, can begin to use condoms or spermicides immediately postpartum. Due to risk of expulsion, IUDs should be inserted within 48 hours by an appropriately trained provider. Otherwise, insertion should be delayed for six weeks until the uterus has returned to its normal shape. Diaphragm or cervical cap use should be delayed until six weeks postpartum because these devices cannot be fitted properly until that time.

Breastfeeding women can begin to use LAM immediately postpartum. They should wait six weeks before using progestin-only methods (Norplant, DMPA, NET-EN, or POPs) or natural family planning. They should wait six months before beginning combined hormonal contraceptives (-pills or injectables).

Non-breastfeeding mothers can begin using progestin-only methods immediately but should wait three weeks before beginning combined hormonal contraceptives or natural family planning. As discussed above, sterilization is not recommended for young mothers.
Postabortion Contraceptive Options
After a young woman has an abortion, she is at risk of another pregnancy immediately. Thus, it is important for her to begin using contraception right away. Women who have an abortion in the first trimester can begin using any method immediately postabortion. Women who have an abortion in the second trimester can use most methods immediately. However, they should wait six weeks before using the diaphragm or cervical cap. They should also wait four to six weeks before having an IUD inserted unless the provider is appropriately trained for immediate postabortion insertion and there is no infection. Women should use condoms while waiting to use another method.

Slide 77 Activity: Contraception Choices for Youth
• Place pieces of flipchart paper around the room, each with one of the following titles written on it:
  – abstinence
  – barrier methods
  – oral contraceptives
  – injectables and implants
  – IUDs
  – lactational amenorrhea method
  – traditional methods of family planning
  – female and male sterilization
  – dual protection
  – emergency contraception
  – postpartum contraceptive options
  – postabortion contraceptive options
• Ask participants to circulate around the room, adding a “key message” about each topic to each piece of paper. Make sure each participant circulates to each piece of paper.

Summary of Contraceptive Options for Youth
A World Health Organization technical working group reviewed the scientific literature and determined that there are no medical reasons to deny a young person any contraceptive method based on age alone. The group
created international guidelines for medical eligibility criteria, classifying specific known conditions into one of four categories:

1. The method can be used without restrictions
2. The method can generally be used
3. The method is not usually recommended
4. The method should not be used.

As the slide shows, when considering young age and parity, all modern contraceptives can be used without restriction or can generally be used. The category 2 applies to progestin-only injectables for young women under age 18 and to the IUD when used by women who are under 20 and nulliparous. No methods fall into category 3 (usually not recommended) or category 4 (presents an unacceptable risk) based on young age alone. There are no medical restrictions based on age for traditional methods or LAM. Of course, the category of nulliparous is not relevant for LAM, since a woman has to have given birth to use this method.

As mentioned earlier, sterilization is generally not an appropriate method for youth.
Section IV: STI/HIV Prevention and Treatment: Priority for Young Adults

The incidence of STIs in youth has increased dramatically in the last 20 years. Due to the high incidence of STIs, and the increasing spread of HIV infection, prevention and treatment of STIs are health priorities for young people. The slides that follow discuss STI risks and consequences, STIs common in young adults, STI prevention issues, STI counseling and risk assessment including voluntary counseling and testing, and STI management and treatment. Providers who are serving youth need to learn about STIs and how they affect young people.

---

**Slide 79-80 Activity: STI Risk and Young Adults**

- Ask participants to answer the question, “What are some of the reasons why young adults may be at risk for STIs?” Examples could include: they may have multiple partners, and they may not be able to negotiate condom use.
- Write the responses on a flipchart.
- Ask participants to answer the question, “What are some of the consequences of STIs for young adults?” Examples could include: they may be painful, and they are dangerous to one's health.
- Write the responses on a flipchart.

---

**Slide 78**

**STI/HIV Prevention and Treatment: Priority for Young Adults**

The incidence of STIs in youth has increased dramatically in the last 20 years. Due to the high incidence of STIs, and the increasing spread of HIV infection, prevention and treatment of STIs are health priorities for young people. The slides that follow discuss STI risks and consequences, STIs common in young adults, STI prevention issues, STI counseling and risk assessment including voluntary counseling and testing, and STI management and treatment. Providers who are serving youth need to learn about STIs and how they affect young people.
negotiation skills, making condom use difficult. When youth are coerced into having sexual relations, they cannot negotiate condom use.

Other high-risk behaviors include having multiple partners or a partner with multiple partners. This can include either having multiple partners at the same time, or having a series of monogamous relationships. Those who are married may be knowingly or unknowingly at increased risk for STIs due to extramarital sexual activities of either partner. Other factors that appear to increase the incidence of high-risk behavior include drug and alcohol use.

Women appear to be more susceptible to STIs than men, due to biological factors. Young women may be even more susceptible because of cervical ectopy. This is a normal condition that is present in most female adolescents and becomes less common with age. Cervical ectopy develops when the cells that line the inside of the cervical canal extend onto the outer surface of the cervix. These cells are more vulnerable to infections, such as chlamydia and gonorrhea. Also, theoretically, the cervical mucus in young women is less thick, possibly making them more susceptible to infection.

STI Consequences for Young Adults

STIs may result in such symptoms as vaginal or penile discharge, painful urination, abdominal pain or genital sores. STIs can be transmitted from mother to infant during pregnancy, delivery, or breastfeeding, and can result in miscarriages, stillbirths, premature delivery, low infant birthweight or infection. If left untreated, STIs can result in chronic disease, infertility or even death. Young adults and their children may also have severe psychological and social consequences. Economically, years of productive life are often lost, especially
with HIV/AIDS, affecting one’s family, children, and the larger society.

Slide 81-85 Activity: Local Prevalence of STIs

*Ask participants to identify the STIs most prevalent in their areas/clinics.*

**Slide 81**

**Most Common STIs**
The number of new cases of STIs is rising globally, but prevalence varies significantly by region. Hence, providers need to learn which STIs are most prevalent in their areas. STIs can be divided into those that can be cured and those that cannot be cured. The most common curable STIs are mostly bacterial, and include trichomoniasis, chlamydia, gonorrhea and syphilis. The incurable STIs are viral. The most devastating of these is HIV/AIDS. AIDS develops from infection by HIV, the “human immunodeficiency virus,” and is almost always fatal without expensive, and often unavailable, anti-retroviral medication. Other major viral STIs are human papilloma virus or HPV, hepatitis B and herpes.

**Slide 82**

*Photo: Photo Disc*

**Curable STIs**
Most curable STIs are caused by bacteria and can be treated effectively with antibiotics. With access to services, young people can get the treatment they need to prevent these infections from getting worse. In addition, treatment is an opportunity for youth to learn more about preventive measures.

However, some bacteria infections tend to be asymptomatic and, hence, difficult to diagnose. If left untreated, these infections can lead to pelvic inflammatory disease, or PID, which can lead to infertility. Some can be transmitted from mother to infant during pregnancy or childbirth, or can cause adverse
pregnancy outcomes. The presence of some STIs also increases the likelihood of HIV transmission.

**Slide 83**

**Most Common Curable STIs**

The most common STI that can be cured with antibiotics is trichomoniasis, a protozoan infection. Globally, trichomoniasis is estimated to account for more than half of all STI infections. If untreated, trichomoniasis has been associated with adverse outcomes of pregnancy and facilitating HIV transmission.

Two bacterial STIs that are particularly common among young adults are chlamydia and gonorrhea. In 1995, it was estimated that more than 30 million new cases of chlamydia and 20 million new cases of gonorrhea occurred among young adults — about one-third of the total cases worldwide. Chlamydia and gonorrhea may lead to PID, and they can be transmitted from mother to infant during delivery.

In many countries, syphilis is a problem for young adults. Although syphilis can be diagnosed and treated, young adults do not generally go to clinics where this can be done. Pregnant women with syphilis have a high risk of transmitting the disease to the child during pregnancy. A simple test that does not require expensive laboratory equipment can determine if a woman or man has syphilis. All pregnant women should be tested for syphilis since treatment prevents transmission to the unborn child.

**Slide 84**

**HIV: High Risk for Young Adults**

Approximately half of all HIV infections worldwide occur among youth under 25 years of age. In some countries, as many as 60 percent of all new HIV infections are among young adults, with twice as many in young women as in young men.
HIV is transmitted by an infected person through semen, vaginal fluids, blood, breastmilk or in utero. Between one-fourth and one-third of infants born to women infected with HIV become infected. Called vertical or perinatal transmission, this can occur in utero, during birth or through breastmilk. The percentage of infected infants is substantially lower when HIV-infected pregnant women take the drug nevirapine, which is relatively simple to use and inexpensive.

HIV infection leads to AIDS, or “acquired immunodeficiency syndrome,” a severe depression of the immune system resulting in various opportunistic infections. AIDS typically occurs several years after infection and is almost always fatal. Several new drug treatments show promise in delaying the onset of AIDS, but they are expensive and are generally not available in developing countries. No vaccine against AIDS is available at present.

The most potent weapon against HIV/AIDS is prevention. Anyone who works with youth must remember the urgent need for effective HIV prevention strategies.

**Other Viral STIs**

Other viral STIs widespread among young adults are HPV, hepatitis B and herpes. HPV causes genital warts and asymptomatic cervical infections. Certain strains of HPV are highly associated with cervical cancer, which is the leading type of cancer among women in many developing countries. In some populations, HPV has been found to be the most prevalent STI.

Hepatitis B causes liver damage and can lead to liver cancer. It can be transmitted sexually or at birth. A vaccine is available, and its use should be strongly encouraged. Herpes can be either symptomatic with painful blisters or asymptomatic. Widespread among the
adolescent population, it can enhance the transmission of HIV.

Addressing the HIV Epidemic: Youth Central to Strategies

There is still hope for the HIV epidemic, fueled by declines in HIV/AIDS in a few countries. Young people are taking fewer risks as well. To preserve their health and their lives, youth must be at the center of any strategy to control HIV/AIDS. A comprehensive approach must be undertaken to address youth and HIV. This involves:

- **Building support for AIDS prevention**
  Until more leaders speak out about the AIDS crisis among youth and give it top priority for funding and action, there is little hope of a solution.

- **Offering education and communication**
  Young people need help to become aware of risks for HIV/AIDS and how to avoid them. Education and communication programs must go beyond merely offering information to fostering risk-avoidance skills as well, such as delay of sexual debut, abstinence and negotiation with sex partners. HIV/AIDS education should begin early, even before children become sexually active.

- **Addressing cultural and social norms**
  Many traditions and cultural practices increase risks for young people more than adults and for young women even more than young men. Efforts to involve communities and to change social and gender norms are as crucial as efforts to reduce individual risk-taking.

- **Promoting condoms for dual protection**
  Condoms – the only contraceptive method that can protect against HIV as well as against pregnancy – are
vital to controlling HIV/AIDS among youth. Condoms should be widely accessible, and their use promoted among sexually active people of all ages.

- **Making services youth-friendly**
  To serve young people better, health care providers must do more to make young people feel welcome and comfortable. Services, including treatment of STIs and voluntary HIV counseling, testing, and referral, should be provided confidentially and sensitively.

- **Reaching out to vulnerable youth**
  Programs need to reach out to street children, sex workers and other vulnerable youth, including millions of young people orphaned by AIDS. Most programs for youth work better when young people help plan and run them. Programs must also find more effective ways to reach parents and other adults who can influence young people’s lives.

**Slide 87**

**Orphans and Vulnerable Children (OVC)**
The safety, health and survival of all children in many countries, especially in Africa, are increasingly jeopardized due to the effects of AIDS on families and communities. Increasing numbers of children are living in households with sick or dying parents or in households that have taken in orphans. The impact of AIDS on children is complex. Children suffer psychosocial distress and increasing material hardship due to AIDS. They may be required to care for ill or dying parents. Many are forced to drop out of school to work at home or to make up for the economic loss suffered when a parent is too ill to work. They experience declining access to food and medical care. They are at risk of exclusion, abuse, discrimination, and stigma.
There are other issues to consider regarding OVC as well. For example, if a parent is sick or has died from AIDS, should their children be tested for HIV as well? In order to best address the care and support needs of children as they relate to knowledge of one’s serostatus, the following critical areas must be considered:

- Motivation for testing
- Obtaining consent
- Disclosure between parent and child
- Counseling for OVC and parents

Orphans and other vulnerable children are at an increased risk for sexual exploitation because of economic and social factors. Some may engage in sex work out of economic necessity. Others are at risk of sexual abuse. Particular attention should be given to OVC to ensure that their reproductive health needs are met and that they are protected.

---

**Slide 88 Activity: STI Transmission**

**Before the presentation:** Prepare enough blank cards so that each participant can have one.
- On the back of one card, write an “X” so that it is not very noticeable.
- On the back of another card, write a “C” so that it is not very noticeable.
- On the back of a third card, write an “A” so that it is not very noticeable.
- On the front of this card write “Do not sign anyone else’s card and do not let anyone sign your card!”

- Ask participants to stand. Give each participant a card.
- Tell participants that they have 10 minutes to greet three other participants individually (one at a time). Each participant, when in conversation with the other three, should:
  - find out where the other person currently works
  - find out if she or he is married
  - tell the other person one thing that they like about them
  - have the other person sign their card.
- At the end of the 10 minutes have everyone sit down. Each person (except one) should have three signatures on their card.
**STI Prevention**

All reproductive health programs for youth need to include basic STI/HIV prevention services. This includes providing information on STIs, counseling clients about safer sexual behaviors, assessing client's risk for STIs, and the promotion and distribution of condoms. If a client might be at risk for infection, he or she should be
referred to a clinic that can diagnose and, if necessary, treat an infection. ■

**Slide 89**

**STI Counseling**
Counseling for STI prevention is essential. Youth need to understand that sexual activity, both heterosexual and homosexual, puts them at risk for STI/HIV transmission and that they are particularly vulnerable. They need to understand that the safest sexual behavior is abstinence. For those who choose to be sexually active, safer behaviors include assessing if their partner is infected, mutual monogamy, reducing the number of partners, engaging in low-risk sexual practices such as mutual masturbation, and using condoms. Condoms need to be made readily available to young adults, even those who are not yet sexually active, so that they are prepared for future sexual activity. Young adults need to understand the importance of consistent condom use and be shown how to use condoms correctly. ■

**Slide 90**

**Voluntary Counseling and Testing: (VCT)**
Many young people in countries where HIV prevalence is high have indicated they want to know their HIV status. VCT services can address young people’s HIV prevention and care needs. Program planners for VCT services face numerous challenges: they need to establish policies and bolster support services, develop adequate training for counselors for working with young people, make existing services youth-friendly, and address the problem of stigma. But the impact on behavior is great. VCT can help young adults use safer sexual practices and even reduce their rates of STIs.

**Slide 91**

**The VCT Model**
The VCT model begins with a young adult’s decision to seek testing. This is followed by pretest counseling, in which the counselor discusses with the youth the test
process, the implications of testing, risk assessment and risk prevention, and coping strategies for whatever the test result may be. After this counseling session, the youth then decides whether or not to proceed with an HIV/AIDS test.

If the youth decides not to be tested, the counselor advises the youth of ways to protect him or herself and his or her future partners.

If the youth decides to be tested, the test is followed up with posttest counseling based on the result of the test. Regardless if the test is positive or negative for HIV infection, the test result is given, a risk-reduction plan is made, and the youth and counselor discuss a risk-reduction plan. This is followed up with appropriate medical care and emotion and social support. It is important to remember that both positive and negative test results warrant counseling. A youth who tests negative for HIV may be relieved, but also needs to understand how to preserve their negative serostatus. A youth who tests positive for HIV needs to be informed of the best ways to preserve his or her own health, and how to protect the health of others. Youth who test positive for HIV also require emotional counseling. It is important for the counselor to be nonjudgmental, to establish rapport, and to instill hope in young people, especially those who test positive.

**Assessment of STI Risk**

Many youth do not know if they are at risk for STIs. Various techniques have been developed to help youth and others determine if they are at increased risk. Especially helpful are individual or group counseling sessions. Young men and women may feel more comfortable when they are in groups of the same sex. Counselors can discuss the symptoms of STIs, which include vaginal or penile discharge, painful urination, abdominal pain or genital sores. Many women regard
most vaginal discharge to be normal and do not realize that some discharge may be a sign of infection that needs treatment. Hence, women need to be educated on the differences in normal and abnormal vaginal discharge.

Counselors can also point out factors that put young people at high risk for STIs. These risk factors include the number of sexual partners, age, whether he or she has had a new partner in recent months, history of previous STI infection, whether their partner has other sexual partners, or whether their partner has STI symptoms. It is difficult for many women to know if they are at risk because they do not know whether their husband or boyfriend has multiple partners. The behavior of male partners may be the greatest risk factor for women. Current research is exploring whether such risk factors can be formalized into a checklist of questions on demographic, behavioral and related factors, called a risk assessment tool, and whether use of this tool can help to manage contraceptive choices and STI diagnosis and treatment.

---

**Slide 93**

**STI Management: Diagnosis and Treatment**

The only way to be certain if someone has an STI is to identify the disease-causing microbe with laboratory tests. Laboratory tests are expensive and require a client to return for results and treatment. Hence, WHO has developed an approach for diagnosing and treating STIs called syndromic management, which is based on a person’s symptoms and signs in the context of the local epidemiology of STI infection.

This syndromic management approach works well in some situations — for example, when treating men with genital ulcers or urethral discharge for gonorrhea and chlamydial infection. However, the syndromic approach has not worked well in diagnosing vaginal discharge. In addition, about three of every four women with gonorrhea or chlamydia infection have no symptoms in
the early stages, so syndromic management is not helpful in these cases. In fact, the main causes of vaginal discharge globally are trichomoniasis and bacterial vaginosis.

Research is under way to determine if various types of risk assessment tools can be used to make STI diagnosis and treatment of cervical infections more effective. Findings thus far are inconclusive, indicating that any risk assessment tool must be modified to individual countries and regions within countries. These tools must take into account prevalence rates for various STIs and cultural factors such as whether women are willing to report having multiple partners or are likely to know if their husbands have had multiple partners.

A full STI management program involves training providers, diagnosing STIs, treating STIs with antibiotics and tracing of partners for treatment. During treatment, counseling should emphasize the importance of partner notification and treatment in order to prevent reinfection. If programs decide they cannot afford to offer all of these services, they can at least offer STI/HIV preventive services and develop a referral system for diagnosis and treatment with another clinic. They can then counsel youth about the need for treatment and refer them to the other clinic.

Summary of STI/HIV
STI prevention and treatment are a priority for those working with youth. Young adults are at high risk of STIs, which can result in chronic illness, infertility or even death. Bacterial STIs such as chlamydia and gonorrhea, both common among youth, can be cured. But viral STIs, including HIV, cannot be cured. Given the STI/HIV epidemic among youth, anyone who works with youth, including family planning providers, must remember the urgent need for effective STI/HIV prevention strategies.
Special attention needs to be paid to young women, since HIV rates are increasing most rapidly among this group. Counseling about prevention can help all youth avoid infection. Good counseling includes discussions of symptoms of STIs, risk factors for infection, safe sexual behaviors and condom use. Where HIV infection rates are high, voluntary counseling and testing is important to educate youth and reduce the risk of infection in the community. Diagnosing and treating STIs may require referral to a clinic specializing in STIs.

Youth Are Our Future
Youth hold the future in their hands, and the entire society needs to be invested in their progress. With opportunities to learn and explore their curiosity, young people have much to offer. However, they face many challenges as well.

The HIV pandemic has become a youth epidemic, which poses huge barriers for many youth. In the face of AIDS, many young people have learned to change their behavior. Adults can support youth in these efforts by encouraging more open conversations about sexuality, working to reduce stigma regarding those infected with HIV, and supporting youth involvement in programs that affect their lives.

As children become adults, all youth need to learn about their sexuality and reproductive health issues. This includes a wide range of issues, including delayed sexual debut, limited number of sexual partners, and condom use for those who are sexually active.
Concluding Activity

**Before the presentation:** Find the question grid in the Presenter Tools section of this module. Copy the grid onto a flipchart. The questions in each block refer to information from particular slides. If any of the questions come from slides you did not use, make sure you substitute appropriate questions based on slides that you did present.

Give the questions in the top row a value of 10 points each. The second row should be worth 20 points, the third row 30 points, the fourth row 40 points, and the bottom row 50 points.

- Explain to the participants that they are now going to play a game as a way of summarizing the material covered in the session.
- Divide the group into two teams. Have each team organize themselves into a line.
- Determine which team will go first. Have the first person on the first team select a grid question to answer.
  - If she or he answers the question correctly, that team receives the designated number of points and the next person on that team selects a question to answer.
  - If she or he does NOT answer the question correctly, give the other team the opportunity to answer it.
  - If the second team answers the question correctly, the first person on that team can select a question to answer.
  - If the second team does NOT answer the question correctly, ask if anybody can answer the question. If somebody does, give the points to that team.
- Keep playing the game until all of the questions are answered or until the available time has expired.
- The team with the most points at the end of the game wins.
- To vary the game, cover the grid so that participants do NOT see the questions in advance. Instead, participants would have to state “section II for 30 points,” for example, to select a question.

Conclusion: Return to Opening Activity

- Return to the flipchart containing the goals listed by the group at the beginning of the training.
- Review the list, discussing whether the goals were achieved, and, if any were not, why not.