Orientation Programme

for

ANMs/LHVs

to provide

Adolescent-Friendly

Reproductive & Sexual

Health Services

HANDOUTS

ORIENTATION PROGRAMME

for ANMs/LHVs

to provide

Adolescent-Friendly Reproductive

and Sexual Health Services

HANDOUTS

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Introductory Module

Handout I

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Handout I

Schedule of the Orientation Programme

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Day 2

Module III	Communicating with the Adolescent Client
Module IV	Adolescent-Friendly Reproductive and Sexual Health Services

Day 3

Module V	Sexual and Reproductive Health Concerns of Boys & Girls
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Module VII	Adolescent Pregnancy and Unsafe Abortions
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Module IX	RTIs, STIs and HIV/AIDS in Adolescents
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Handout I

Background and Overall Aim of the Orientation Programme

India's population today is over one billion. Adolescents in the age group 10-19 years make up one fifth of the population.

It is increasingly being felt that investing in this group is going to have rich dividend for the future health. In the RCH-2 programme of the Government of India specific focus has been given to adolescents.

Overall RCH-II focuses on integrated package of services, addressing access and quality issues, reaching vulnerable groups and community involvement. Each state is accountable for implementation and management of RCH-II.

This programme is to introduce and orient health-care providers to the special characteristics of adolescence and the appropriate approaches to address selected priority health needs and problems of adolescents. This aim will be achieved through a series of modules.

The overall aim of the Orientation Programme is:

- To better equip ANMs/LHVs with the knowledge, and problems associated with adolescence in an earlier workshop.
- To better equip ANMs/LHVs with the knowledge and problems associated with adolescence.
- To make them more sensitive to the needs of adolescents.
- To enable health care providers (MOs at PHC and ANMs/LHVs at PHC and Sub-centres) to provide adolescent-friendly health services.

The Programme will help the participants to answer two questions:

- What do I, as a ANMs/LHVs, need to know and do differently if the person who walks into my clinic is aged 10-19 years, rather than 6 or 36?
- How could I help? In the health centre? during field visits. Are there other influential people in my community who understand and respond better to the needs and problems of adolescents?

Specific Objectives of the Orientation Programme

Specific objectives of the Orientation Programme are to make the participants:

- More knowledgeable about the characteristics of adolescent development
- More sensitive to their needs
- Better equipped with information and resources, thereby be able to provide adolescent-friendly health services
- Able to make a plan to indicate the changes in their work to deliver adolescent-friendly health services.

Annexure 1: Pre-test
Session 3, Activity 1

Handout I

Orientation Workshop for ANMs/LHVs on Adolescent-Friendly Reproductive and Sexual Health Services

Pre/Post-Test

Name of State _____ Name of District _____

Name of Block _____ Designation _____

Name of Participant _____

Dates of Programme _____ Date of Test _____

Note: Answer all questions. Multiple choice questions have only one correct answer. Please read each question and the multiple choices carefully and put a ' ◂ ' mark on correct answer.

1. Adolescents come under which age group?
   a) 8 -10 years
   b) 8 -15 years
   c) 10 -19 years
   d) 19 -35 years
2. What are the important changes that take place in the individual as he/she goes through adolescence?
   a) Physical
   b) Mental
   c) Emotional
   d) All of the above
3. What are health related concerns of adolescents?
   a) Menstrual problems in girls and night fall in boys
   b) RTIs/STIs - Hygiene
   c) Teenage pregnancy
   d) Anaemia
   e) Unsafe abortions
   f) Drug/substance abuse/smoking
   g) All of the above
4. We should invest in adolescents health because:
   a) a healthy adolescent grows into a healthy adult.
   b) health benefits for the adolescent's present and future.
   c) economic benefits to avert future health cost.
   d) Good health is adolescents' right
   e) all of the above
   f) none of the above
5. How do you think an adolescent feels when he/she walks into your health centre?
   a) shy, embarrassed, worried, confused
   b) happy and confident

Handout I

6. How would you strike a rapport with an adolescent client?
    a) By not asking too many questions and not making eye contact
    b) By friendly, warm and non-judgmental behaviour with positive non-verbal cues.
    c) Frowning and stern behaviour.
    d) None of the above.
7. Adolescents do not utilise available health services because:
    a) they fear the health providers will inform their parents.
    b) they are not interested.
    c) they do not recognise illness.
    d) they do not know where to go.
    e) All of the above.
    f) None of the above.
8. What are the barriers to good communication?
    a) Service provider use simple words and language
    b) Client feels comfortable
    c) Lack of privacy
    d) Adolescents are unable to talk because of fear
    e) Insufficient time to explain
    f) (a) and (b)
    g) (c, d and e)
9. What problems are caused by lack of menstrual hygiene?
    a) Anaemia, weakness, diarrhoea
    b) Malaria, worm infestation
    c) Vaginal discharge, burning during urination and genital itching
10. According to you, how will you rate masturbation for adolescent boys and girls.
    a) Normal behaviour
    b) Abnormal behaviour
    c) Shameful behaviour
11. Lack of nutrition in adolescence can cause-
    a) Protein - energy malnutrition
    b) Stunting of growth
    c) Anaemia
    d) All of the above
    e) None of the above
12. Night fall in boys is
    a) Abnormal
    b) Normal
    c) Sign of serious illness

13. What is the risk of maternal death among women aged 15-19 years as compared to women aged 20-35 years?
    a) Lower
    b) Higher
    c) Equal
14. What can an ANM/LHV do to prevent unsafe abortions in pregnant adolescents?
    a) Counsel and refer to appropriate facility for termination of pregnancy
    b) Conduct termination of pregnancy yourself
    c) Scold her for getting pregnant and tell her to continue her pregnancy now and take some contraception after delivery
15. Which contraceptive methods are appropriate for adolescents?
    a) Abstinence, condoms and oral pills
    b) Sterilisation, Fertility-awareness based methods and IUCDs
16. What can ANMs/LHVs do to prevent STIs among adolescents?
    a) Cannot do anything
    b) Counsel them that abstinence, being faithful to one's partner and use of condoms protect from STIs
    c) Criticise unmarried sexually active and inform the parents of sexually activer unmarried adolescents of their shameful behaviour
17. After unprotected sex, emergency contraceptive pills can be given to:
    a) Married adolescents
    b) Unmarried adolescents
    c) Both
    d) None of the above
18. Which services can you as ANM provide to adolescents?
    a) _____
    b) _____
    c) _____
    d) _____
19. What are the most important characteristics of adolescent-friendly health facilities?
    a) _____
    b) _____
    c) _____
    d) _____
20. Which contraceptive methods are protective against pregnancy and STIs/HIV (dual protection)?
    a) _____
    b) _____

Adolescent Growth and Development

Handout II

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Handout II

What is adolescence?

Adolescence (10-19 years) is a phase of life which has recently gained recognition as a distinct phase of life with its own special needs. This phase is characterized by acceleration of physical growth and, psychological and behavioural changes thus bringing about transformation from childhood to adulthood.

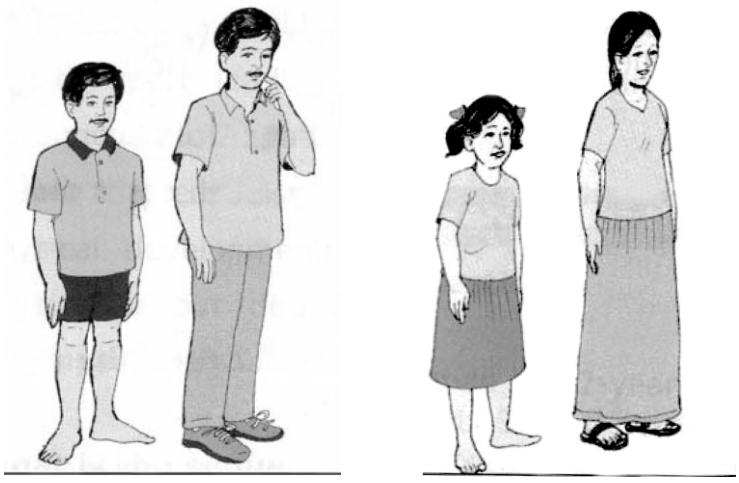
Adolescence has been described as the transition period in life when an individual is no longer a child, but not yet an adult. It is a period in which an individual undergoes enormous physical and psychological changes. In addition, the adolescent experiences changes in social expectations and perceptions. Physical growth and development are accompanied by sexual maturation, often leading to intimate relationships. The individual's capacity for abstract and critical thought also develops, along with a sense of self-awareness when social expectations require emotional maturity.

Age Groups

Adolescents are defined as individuals in the 10-19 year age group, "youth" as the 15-24 year age group. The Government of India, however, in the National Youth Policy defines youth as the 15-35 age group and adolescents as 13-19 years.

"Adolescence" is recognised as a phase rather than a fixed time period in an individual's life.

It is important to note that adolescents are not a homogenous group. Their needs vary with their sex, stage of development, life circumstances and the socio-economic conditions of their environment.



Adolescence in Boys and Girls

Developmental Characteristics of Adolescents

Adolescence, the transition between childhood and adulthood, is a stressful period of life characterised by discernible physical, mental, emotional, social and behavioural changes.

Physical development: Rapid and dramatic physical development and growth mark adolescence, including development of sexual characteristics. Marked morphological changes in almost all organs and systems of the body are responsible for the accelerated growth and the changes in contours and sexual organs. In case of boys, active acceleration in growth of coarse pubic hair and facial hair usually precede other signs of puberty such as voice changes. In girls, development of breasts, broadening of hips and rapid growth in height usually begins about two and a half years before menarche.

Emotional development: Adolescents have to cope, not only with changes in their physical appearance, but also with associated emotional changes and emerging and compelling sex urges. Bodily changes cause emotional stress and strain as well as abrupt and rapid mood swings. Getting emotionally disturbed by seemingly small and inconsequential matters is a common characteristic of this age group.

Hormonal changes are likely to result in thoughts pertaining to sex, irritability, restlessness, anger and tension. Attraction to the opposite sex leads to a desire to mix freely and interact with each other. However, in reality, this may not always be possible, partly due to societal restrains on pre-marital sexual expressions and also because of other priority needs in this period, viz. education, employment, etc. Hence, it becomes almost necessary for adolescents to learn how to face and deal patiently with the turbulence they face. It requires development of a sense of balance and self-imposition of limits on expression of one's needs and desires. An inability to express their needs often leads adolescents to fantasize and daydream that helps them to at least partially fulfil their desires.

Adolescence is also marked by development of the faculty of abstract thinking that enables them to think and evaluate systematically and detect and question inconsistencies between rules and behaviour. Parents as well as service providers often overlook this development, one of the basic reasons for the popularly known 'generation gap'.

Socially, adolescence consists in shifts from dependency to autonomy, social responses to physical maturity, the management of sexuality, the acquisition of skills and changes in peer groupings. The need to be a part of a gang or a large group is replaced by a preference for maintaining fewer, more steady and binding relationships. The main changes that occur during adolescence are listed below

Handout II

Physical events/changes during Adolescence

BOYS

- Growth spurt occurs
- Muscles develop
- Skin becomes oily
- Shoulders broaden
- Voice cracks
- Underarm and chest hair appears
- Pubic hair appears
- Facial hair appears
- Penis and testes enlarge

GIRLS

- Growth spurt occurs
- Breasts develop
- Skin becomes oily
- Hips widen
- Waistline narrows
- Underarm hair appears
- Pubic hair appears
- External genitals enlarge
- Uterus and ovaries enlarge

Emotional and Social changes in adolescent boys and girls:

- Preoccupied with body image
- Want to establish own identity
- Fantasy / daydreaming
- Rapid mood changes, Emotinal instability
- Attention seeking behaviour
- Sexual attraction
- Curious, Inquisitive
- Full of energy, Restless
- Concrete thinking
- Self exploration and evaluation
- Conflicts with family over control
- Seek affiliation to counter instability
- Peer group defines behavioural code
- Formation of new relationships

Sexual Development

- Sexual organs enlarge and mature
- Erections in boys
- Sexual desire
- Sexual attraction
- Menarche, Ovulation
- Sperm Production, Ejaculation
- Initiation of sexual behaviours
- Capability to reproduce

Pubertal development starts 1-2 years earlier in girls as compared to boys. There is a wide variation in age and velocity with which growth and development proceeds. In a group of adolescents who are growing together this wide variation leads to development of anxiety – "Am I normal?" and needs a lot of reassurance. Appearance of secondary sexual characters before the age of 8 years in girls and 9 years in boys, and non-appearance of secondary sexual characters by the age of 13 years in girls and 14 years in boys is considered abnormal. Such cases should be referred to higher center for management. A girl who does not start menstruation by 16 years age should also be referred.

Problems during adolescence

Adolescents today are more vulnerable to health implications due to their nature of experimenting and exposure to limited information regarding issues affecting their health and development. Problems in this age are related to their physical and emotional development and search for identity and risky behaviour.

Handout II

Profile of Adolescents in India

- **Adolescents comprise a sizeable population** – there are 225 million adolescents comprising nearly one-fifth of the total population (21.8 percent) (Census 2001).
- **Composition varies by age and sex** – Of the total population, 12.1 percent belong to 10-14 age group and 9.7 percent are in the 15-19 age group. Female adolescents comprise 46.9 percent and male adolescents 53.1 percent of the total population (Census 2001). The present adverse sex ratio in 0-6 years (927 girls for 1000 boys), will affect the adolescent population in the coming years.
- **Early marriage is common** – Fifty percent of Indian women were married before they attained the age of 18 years (NFHS 2). While the average age at marriage for educationally disadvantaged female is 15 years, for women who have completed school it is 22 years. It indicates that continuation of education results in delayed marriage.
- **Female mortality rates are higher than males** – A high risk of pregnancy and childbirth results in a high level of female mortality in the reproductive age group. Maternal mortality of teenage mothers is a grave cause for concern.
- **Adolescents from rural areas and girls are disadvantaged** – Twenty five percent of the 15-19 years age group in rural areas and ten percent in urban areas are illiterate. The male-female differences grow with each level of education (NSS 55th Round, 2001). Rural girls are most disadvantaged. Enrolment figures in schools have improved, but gender disparities persist. The challenge is to keep students in schools.
- **Economic compulsions force many to work** – Nearly one out of three adolescents in 15-19 years is working – 20.6 percent as main workers and 11.7 percent as marginal workers (2001 census). Economic compulsions force adolescents to participate in the workforce. Despite adult unemployment, employers like to engage children and adolescents because of cheap labour.
- **Malnutrition affects development** – More than half of the adolescent girls suffer from anaemia. Two thirds suffer from Chronic Energy Deficiency of the third degree with Body Mass Index (BMI) below 16. Married women aged 15-49 are also reported to have BMI below 18.5 (NFHS 2). Iodine Deficiency Disorders can lead to growth retardation and retard mental development. Anaemic adolescents mothers are at a higher risk of miscarriages, maternal mortality and giving birth to stillborn and underweight babies.
- **Drug abuse is emerging as a problem –** A major section of drug users are below 20 years. Forty percent of them started taking drugs when they were between 15 to 20 years of age (UNDOC, 2002). Social factors such as illiteracy, economic background, unemployment, rural residence and family disharmony increase vulnerability to drug abuse.
- **Crimes against adolescents are prevalent** – Sexual abuse of both boys and girls cuts across economic and social classes. According to a survey, in 84 percent cases, the victims knew the offenders and 32 percent of the offenders were neighbours (NCRB, 2001). Crimes against girls range from eve teasing to abduction, rape, prostitution and violence to sexual harassment. Unfortunately, social taboos prevent these crimes from being registered. Even when registered, prosecution rarely takes place.

Handout II

- **Unmet need for contraceptives** – While knowledge of family planning is being promoted, the availability and use of contraceptives is not publicized. Even amongst currently married women there is an unmet need of contraception, being the highest in the age group 15-19 years. Nearly 27 percent of adolescents have reported unmet need for contraception. 19% of TFR is contributed by adolescent mothers in the age group of 15-19 years (NFHS-I and 2).
- **Trafficking and Prostitution has increased –** Extreme poverty, low status of women, lax border checks and the collision of law enforcement officials has lead to increase in prostitution. Expansion of trafficking and clandestine movement of young girls has also increased across national and international borders.
- **Premarital sexual relations are increasing –** Most sexually active adolescents are in their late adolescence. Lack of contraceptives or condom use characterises the vast majority of sexual encounter among youth (Jeejeebhoy, 2003). Incidences of unintended teenage pregnancies and abortions have shown a steady increase. Unsafe abortions are a major source of reproductive mortality and morbidity.
- **Misconceptions about HIV/AIDS are widespread** – There is a high level of awareness about HIV among young people especially among those who are more literate. However, misconceptions on certain modes of transmission are widespread. 73 percent of young people were unaware that a healthy looking person could transmit infection. Many are unaware of the correct way of using a condom. Negative attitudes exist towards HIV positive individuals – only 40.7 percent of young people were willing to share food with infected persons (National Behavioural Surveillance Survey, 2001). A large percentage of HIV infected persons are between 20-40 years and had contacted the virus early in life indicating the importance of educating during adolescence.

Handout II

Why Invest in Adolescent Health and Development?

Reasons for investing in adolescent health and development are many -

- These are formative years, where physical, emotional and behavioural patterns are set. A healthy adolescent becomes a healthy adult

  The behaviours and lifestyles learned or adopted during adolescence will influence health of an individual both in the present and in the future. Tobacco use is a good example of how a behaviour, almost always adopted during adolescence, leads to disease and death later in life. Further, the benefits of adolescent health and development accrue not only to the adults that emerge from the process, but also to future generations.
- To build self-esteem in adolescents resulting in confident adults in a society
- To develop their capacity to cope up with the situations and deal with them responsibly
- To reduce morbidity and mortality among adolescents. It will maximize their opportunity to develop full potential and to contribute the best they can to society.There will be many other economic benefits eg improved productivity.
- To prepare them for adult/married life
- Investing in adolescents' health will reduce the burden of disease during this stage and in later life **and avert future health cost.**
- In the context of the RCH programme goals that refer to reduction in IMR, MMR & TFR, paying attention to adolescents will yield dividends in terms of delaying age of marriage, reducing incidence of teenage pregnancy, prevention and management of obstetric complications. Adolescents in the age group of 15-19 years contribute to 19% of the TFR and unmet need for contraception among them is 27%.
- It is adolescent's right (like other age groups) to have a right to achieve the highest attainable level of health.Promoting and safeguarding adolescent health should not only be regarded as an investment, but also as a basic human right. Young people have the right to preventive health care and require specific protection for those living in exceptionally difficult conditions or with disabilities. This means that governments have the responsibility to ensure that health and other basic services essential for good health are provided.

Annexure 1: Group Exercise
Session 2, Activity 3

Characteristics of Adolescents	Health Implications														

Communicating with the Adolescent Client

Handout III

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Handout III

Introduction

Communication plays a vital role in everybody's life. Communication is a process through which we convey our thoughts and feelings to other people. One of the major components of communication is to listen and to understand others' points of view and feelings. Communication is more effective if it is two-way rather than one-way. The exercises in this module involve discussion, behavior change and positive and negative role-plays. It will help Service Providers to understand the realities and the mindset of their adolescent client and will foster better communication and responsiveness to their needs.

What is Communication?

Communication is the art of expressing and exchanging ideas, feelings and thoughts through gestures,speech or writing.

Feelings of the Adolescent

Understanding the realities and mind-set of the adolescent client will foster better communication and responsiveness to her/his needs.

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

- Shy about being in a clinic (especially for RH) and about needing to discuss personal matters.
- Embarrassed that s/he is seeking RH care.
- Worried that someone s/he knows might see her/him and tell the parents.
- Inadequate to describe what is concerning her/him and ill-informed about RH matters in general.
- Anxious that s/he has a serious condition that has significant consequences (e.g. STI, pregnancy).
- Intimidated by the medical facility and/or the many "authority figures" in the facility.
- Defensive about being the subject of the discussion or because s/he was referred against her/his will.
- Resistant to receiving help because of overall rebelliousness or other reasons fostering discomfort or fear.

Handout III

Establishing Trust with Adolescent Client

The adolescent is going through dramatic biological and psychological changes in general. Seeking health care may be challenging and difficult for her/him.

Each staff person who may interact with adolescents must understand these circumstances and feelings and must be prepared to assist in a helpful, non-judgmental way.

Winning an adolescent's trust and establishing rapport with the adolescent client will facilitate discussion and enhance the likelihood that needs will be revealed and addressed.

The following are **tips for good communication:**

- Allow sufficient time for the adolescent client to become comfortable enough to ask questions and express concerns.
- Express non-judgmental views about the client's needs and concerns.
- Show an understanding of and empathy with the client's situation and concerns.
- Exhibit confidence and professional competence in addressing ARH issues
- Be genuinely open to an adolescent's question or need for information (ranging from "where is the toilet?" to "Should I use birth control?")
- Do not be judgmental in words or in body language that suggest disapproval of her/him being at the clinic, of her/his behavior, or of her/his questions or needs.
- Understand that the young person has various feelings of discomfort and uncertainty.
- Be reassuring in responding to the adolescent, making him or her feel more comfortable and confident.
- If sensitive issues are being discussed, help ensure that conversations are not overheard.

Barriers to communication

Even if the adolescent client and the service provider want to communicate there can be some situations which prevent an easy communication prcess.

Barriers to communication are:

- Too much noise and distraction
- Lack of privacy
- Inability to make the adolescent feel comfortable
- Use of medical terms-complicated, unfamiliar words for the adolescent
- Too much information given
- Own perception, beliefs and values clash with the adolescent's needs
- Not enough time devoted with the adolescent client to elicit complete history and provide services
- No follow up services

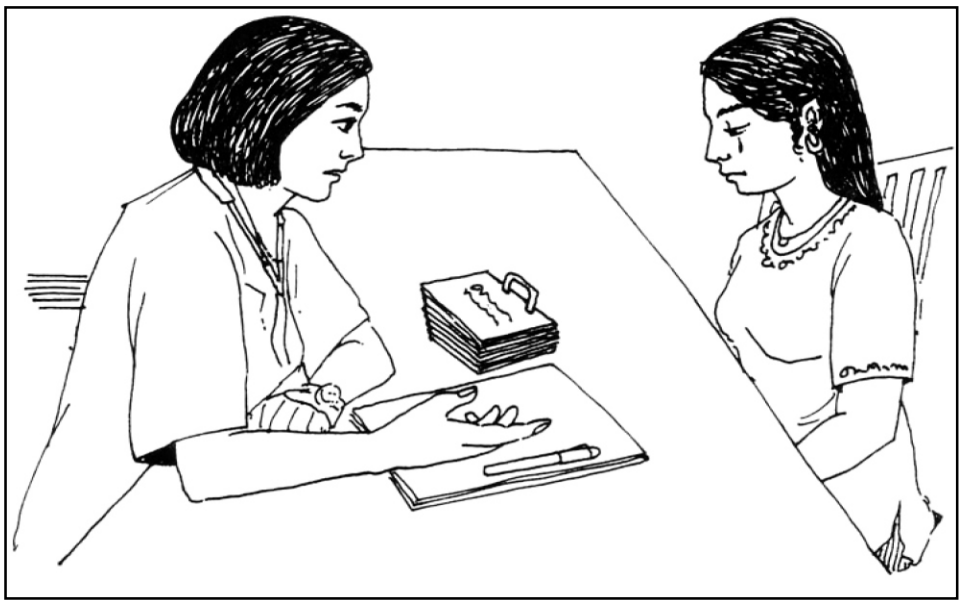
Handout III

How to deal with difficult situations when communicating with the Adolescent Client

The following are some situations that require appropriate handling:

- **If the adolescent is silent:** Silence can be a sign of shyness or may signify anger or anxiety.
  - "*If it occurs at the beginning of a session*, the provider can say, "I realize it's hard for you to talk. This often happens to people who come for the first time."
  - "*If s/he seems angry*, the counsellor can say, "Sometimes when someone comes to see me against her/his will and doesn't want to be here, it is difficult to speak.

    Is that what is going on?"
  - "*If the client is shy*, the provider can legitimize the feeling by saying, "I'd feel the same way in your place. I understand that it's not easy to talk to a person you've just met."
  - "*If the adolescent has difficulty expressing her/his feelings or ideas*, the counsellor can use some brochures or posters to encourage discussion or refer to a story or anecdote so the adolescent can talk about others rather than her/himself.
  - "*If the adolescent cannot or will not talk*, the counsellor should propose another meeting.
- **Crying**: The counsellor should try to evaluate what provoked the tears and assess if it makes sense in the given situation.
  - "*If the client is crying to relieve tension*, the counsellor can give the adolescent permission to express her/his feelings by saying, "It's okay to cry since it's the normal thing to do when you're sad."
  - "*If the client is using crying as manipulation*, the counsellor can say, "Although I'm sorry you feel sad, it's good to express your feelings."



Communicating with Adolescent

- "*If the crying is consistent with the situation*, the counsellor should allow her/him to freely express emotions and not try to stop the feeling or belittle its importance.

- **Threat of suicide**: All suicide threats or attempts must be taken seriously. It is essential to determine if attempts were made in the past, if s/he is really considering suicide, and the reasons for doing so-or it it's something said without thinking.
  - "It is best to refer the adolescent to a psychiatrist or psychologist and accompany her/him to the appointment.
- **Refusal of help**: The counsellor should discreetly try to find out why the adolescent feels this way.
  - "*If the client has been sent against her/his will*, the counsellor can say, "I understand how you feel. I'm not sure I can help you, but maybe we could talk for a minute and see what happens."
- **Need to talk**: Challenges in counselling may also include a situation where the client is very vocal and wants an outlet to express other concerns that may not be directly related to the immediate counselling need as perceived by the service provider.
  - Give the client the opportunity to express her/his needs and concerns. If you cannot help the client, show that you are listening to the concerns that s/he is trying to express. When possible, direct the client to someone who can help with the problem.
  - "The counsellor may say, "I can see that you are very concerned about this problem. I wish that I could do something to help you. Have you discussed this with . . ."
  - "If you cannot help the client or direct her/him to someone who can provide assistance, then demonstrate care and concern about the client's problem.

    However, be clear when you cannot help with the problem.

Handout III

Verbal/Non-verbal Communication

Health care **providers need to explore the many different nonverbal and verbal behaviours** they use when communicating with adolescents.

Sometimes, without realizing it, providers communicate one message **verbally**, while communicating the opposite message **nonverbally.**

Nonverbal communication is a complex and often unconscious mixture of actions, behaviours, and feelings, which **reveal the way we really feel** about something.

Nonverbal communication is especially **important because it communicates to clients the level of interest, attention, warmth, and understanding** we feel towards them.

Positive nonverbal cues include:

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

Negative nonverbal cues include:

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

What is Counselling?

It is face to face communication between two or more people in which one person helps the other to make a decision and then act upon it. :

- It is two way communication and the counsellor listens patiently to the clients' thoughts/fears/misconceptions/problems without being judmental.
- Takes into account psycho-social, emotional and spiritual needs of the client
- Is strictly confidential
- Information given to the client is full and accurate
- Helps the client to make decisions for himself or herself

The purpose of counselling the adolescent on Sexual and Reproductive Health issues is to help the adolescent to:

- Exercise control over her/his life.
- Make decisions using a rational model for decision-making.
- Cope with her/his existing situation.

Achieving control over behaviour, understanding oneself, anticipating consequences of actions, and making long-term plans are characteristics of maturity-one of the goals of adolescent counselling.

Handout III

The GATHER approach for counselling

Greet the adolescents

- put them at ease, show respect and trust
- emphasize the confidential nature of the discussion

Ask how can I help you?

- ask how can I help you?
- encourage them to bring out their anxieties, worries and needs, determine their access to support and help in their family and community;
- find out what steps they have already taken to deal with the situation
- encourage the person to express his/her feelings in own words
- show respect and tolerance to what they say and do not pass judgement
- actively listen and show that you are paying attention through your looking
- encourage them through helpful questions

Tell them any relevant information they need

- provide accurate and specific information in reply to their questions
- give information on what they can do to reamain healthy. Explain any background information they need to know about the particular health issue
- keep your language simple, repeat important points and ask questions to check if the important points are understood
- provide the important information in the form of a leaflet if possible that they can take away

Help them to make decisions

- explore the various alternatives
- raise issues they may not have thought of
- be careful of letting your own views, values and prejudices influence the advice you give
- ensure that it is their own decision and not one that you have imposed
- help them make a plan of action

Explain any misunderstandings

- ask questions to check understanding of important points
- ask the person to repeat back in their own words and key points

Return for follow-up or Referral

- make arrangements for a follow-up visit or referral to other agencies
- if a follow-up visit is not necessary, give the name of someone they can contact if they need help

Handout III

Tips for Effective Communication with the Adolescents

Several **techniques** help assure good communication with adolescents:

Create a good, friendly first impression

- Start on time; don't make the client wait.
- Smile and warmly greet the adolescent client.
- Introduce yourself and what you do.
- Ask her/his name and what s/he likes to be called.

Establish rapport during the first session

- Face the adolescent, sitting in similar chairs.
- Use the adolescent's name during the session.
- Demonstrate a frank and honest willingness to understand and help.
- Begin the session by allowing the adolescent to talk freely before asking directive questions.
- Congratulate the adolescent for seeking help.

Eliminate barriers to good communication

- Avoid judgmental responses of body or spoken language.
- Respond with impartiality, respecting the adolescent's beliefs, opinions, and diversity or expression regarding her/his sexuality.

Use "active listening" with the client

- Show your sincere interest and understanding and give your full attention to the client.
- Sit comfortably; avoid movements that might distract the adolescent.
- Put yourself in the place of the adolescent while s/he speaks.
- Assist the client to be more aware of the problem without being intrusive or taking away her/his control over the issue.
- Observe the tone of voice, words used, and body language expressed and reflect verbally to underscore and confirm observed feelings.
- Give the adolescent some time to think, ask questions, and speak. Be silent when necessary and follow the rhythm of the conversation.
- Periodically repeat what you've heard, confirming that both you and the adolescent have understood.
- Clarify terms that are not clear or need more interpretation.
- Summarize the most relevant information communicated by the adolescent, usually at the end of a topic.

Provide information simply

- Use an appropriate tone of voice.
- Speak in an understandable way, avoiding technical terms or difficult words.
- Understand and use where appropriate the terms/expressions adolescents use to talk about their bodies, dating, and sex.
- Use short sentences.
- Do not overload the adolescent with information
- Provide information based on what the adolescent knows or has heard.
- Gently correct misconceptions.
- Use audiovisual materials to help the adolescent understand the information and to demonstrate information in more concrete terms.

Ask appropriate and effective questions

- Use a tone that shows interest, attention, and friendliness.
- Begin sessions with easy questions, gradually moving up to more difficult questions.
- Try not to take notes except in a structured interview that has an established order for special cases.
- Ask a single question and wait for the response.
- Ask open-ended questions that permit varied responses and require thought. Allow for explanations of feelings or concerns.

  Examples: “How can I help you?”, “What’s your family like?”
- Ask in-depth questions in response to a previous question and to solicit more information.

  Example: “Can you explain that better?”
- Ask the same question in different ways if you think the adolescent has not understood.

Handout III

How to Counsel on Sexuality?

Sexuality means different things to different people. Many people equate mating, being able to reproduce and common sexual behaviour (romance, kissing, physical relations, provocative behaviour, marriage) with sexuality.

Sexuality is a very broad term, which includes the sum total of a person's personality, thinking and behaviour towards sex. It includes the identity, emotions, thoughts, actions, relationships, affection, feelings that a person has and displays. The negative aspects of sexuality also exist and include sexual coersion, eve teasing, sexual harassment, rape and prostitution.

Communicating and counselling with adolescents about sexuality can be challenging because it is a sensitive topic about which adolescents often feel emotional, defensive, and insecure.

Good communication and counselling about sexuality requires:

- Considering the adolescent's age and sexual experience.
- Demonstrating patience and understanding of the difficulty adolescents have in talking about sex.
- Assuring privacy and confidentiality.
- Respecting the adolescent and her/his feelings, choices, and decisions.
- Ensuring a comfort level for the adolescent to ask questions and communicate concerns and needs.
- Responding to expressed needs for information in understandable and honest ways.
- Exploring feelings as well as facts.
- Encouraging the adolescent to identify possible alternatives.
- Leading an analytical discussion of consequences, advantages, and disadvantages of options.
- Assisting the client to make an informed decision.
- Helping the adolescent plan how to implement her/his choice.

Adolescents must often make significant decisions on the following sexual and/or reproductive health matters:

- How to discourage and prevent unwanted sexual advances?
- Whether to engage in sexual relations or not. If yes, when?
- How to prevent pregnancy and STI/HIV.
- Whether to conceive a child or not? If yes, when?
- Whether to continue or terminate a pregnancy?
- What kind of antenatal care to seek and where to go?
- How to deal with sexual abuse and/or violence?

Most of these decisions can be worked through during counselling sessions that follow the described approaches. Sexual abuse and violence are more difficult and require additional help.

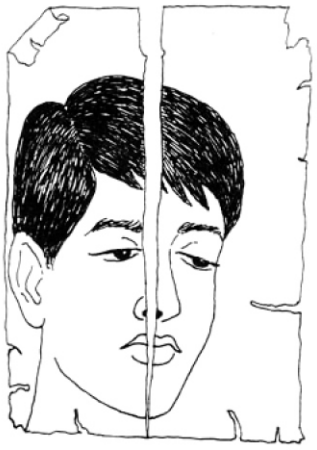
Counselling in Cases of Sexual Abuse and/or Violence

Sexual abuse is any sexual activity carried out against a person's will.

Often, sexual abuse is perpetrated by an adult, whether by deceit, black mail, or force, against a child or someone not mentally or physically mature enough to understand or prevent what is happening. Sexual abuse has a significant impact on an adolescent's health, mental state and life in general. It can cause serious future sexual and reproductive health problems.

If violence is associated with the abuse, even more severe physical and emotional problems can result. Refer such cases to PHC/CHC.

The **objectives of the counselling session** addressing sexual abuse are:



- Provide psychological and emotional support.
  - "Be understanding but not pitying.
- Help the adolescent to not feel guilty.
  - "Explore feelings of guilt.
  - "Tell the adolescent s/he is not responsible for what happened.
- Help the adolescent recover her/his sense of self-esteem.
  - "To regain self-confidence.
  - "To trust others.
- Counteract anxiety or depression.
- Refer her/him to a doctor.
  - "Explain why it is necessary to do so.
  - "If possible, accompany the adolescent to the referral appointment.

Handout III

Annexure 1: Role Play Scenarios
Session 2, Activity 3

Scenario 1

A 13-year-old girl comes to your health centre with her mother because she feels some white discharge come out of her private parts which stains her salwar. She also has a lot of pain during her periods.

How will you counsel the client?

Scenario 2

A 16-year-old married adolescent girl, with a three month-old baby wants to postpone her next pregnancy. Her sister uses oral contraceptive pills and likes that method very much. She says she wants to use it.

How will you counsel the client?

Scenario 3

A young couple accompanied by the husband's mother, comes to see you. They have been married for 3 months. The wife is 17 years old. The mother-in-law insists that they should have a child as soon as possible as she wants a grandson. The couple wants to postpone pregnancy for at least 2 years.

How will you counsel the client?

Scenario 4

A 16-year-old adolescent boy comes to the clinic because sometimes he has felt and seen some thick fluid come out of his penis at night while sleeping.

How will you counsel the client?

Annexure 2: Observer Roleplay Checklist Session 2, Activity 4

TASK	PERFORMED	
	YES	NO
Nonverbal Communication		
Friendly/ welcoming/ smiling?		
Non-judgemental/ empathetic?		
Listens/attentive/ nods head to encourage and acknowledge client's responses?		
Allows client enough time to talk?		
Verbal Communication		
Greats client		
Asks clients about themselves • Obtaining history - name, age, address, married/unmarried - basic medical information - family history - menstrual history (for girls) - social habits (smoking, alcohol, tabacco, gutka) - number of children, if married - contraceptive use (now and/or in the past) - asks client about her/his problem		
Tells clients about their choices/options.		
Helps clients choose		
Explains what to do		
Counsels to return for follow-up		
Language was simple and brief		

What did you learn from observing this role play?

_____

_____

_____

Please record your comments/observations for feedback to participants (both positive and negative):

_____

_____

Adolescent-Friendly Reproductive and Sexual Health Services

Handout IV

CONTENTS

Handout IV

What health services do adolescents need?

Adolescents have in many surveys expressed their views about what they want from health services. They want a welcoming facility, where they can "drop in" and be attended to quickly. They insist on privacy and confidentiality, and do not want to have to seek parental permission to attend. They want a service in a convenient place at a convenient time that is free or at least affordable. They want staff to treat them with respect, not judge them. They want a range of services, and not to be asked to come back or referred elsewhere. Of course, those who plan and provide services cannot only think about the wishes of adolescents – services must be appropriate and effective, and they must be affordable and acceptable for the community.

However, services for this age group must demonstrate relevance to the needs and wishes of young people. Health services play a critical role in the development of adolescents when they:

- Treat conditions that give rise to ill health or cause adolescents concern;
- Prevent and respond to health problems that can end young lives or result in chronic ill health or disability;
- Support young people who are looking for a route to good health, by monitoring progress and addressing concerns;
- Interact with adolescents at times of concern or crisis, when they are looking for a way out of their problems;
- Make links with other services, such as counselling services, which can support adolescents.

Young people in crisis need counselling and community support beyond what health services alone can offer. This support comes from parents, families, teachers, trained counsellors, religious or youth leaders and other adults and from their own peers. However, if these links break down, early signs of crisis may become apparent during contact with health services.

Health-care staff needs to be sensitive to signs of anxiety, and know how to deal with young people in crisis, or where to refer them. Services also need to include information and education to help adolescents to become active participants in their own health.

Programmes monitoring growth and development should provide a golden opportunity for adolescents to request help and for health-care staff to give them information. However, such programmes are rarely provided at school and even when health checks do take place, they seldom give young people this kind of opening.

Handout IV

1. Health services can help to meet adolescent needs, only if they are part of a comprehensive programme. Adolescents need:
   - A safe and supportive environment that offers protection and opportunities for development;
   - Information and skills to understand and interact with the world;
   - Health services and counselling - to address the health problems and deal with personal difficulties.
2. Health service providers cannot meet all these needs alone. They can join or create networks that act together and maximise resources.
3. There is no single "fixed menu" suitable for every region. Each district/ state must develop its own package, according to economic, epidemiological and social circumstances.
   - A package of basic health services must be tailored to local needs.
   - Reproductive health services and counselling are a high priority in most places.
   - Information and counselling are important elements to support adolescents.

Handout IV

Characteristics of adolescent-friendly reproductive and sexual health services

Adolescent-friendly programmes/policies

- Adolescents are involved in programme design.
- Both boys and girls are welcomed and served.
- Married/unmarried clients are welcomed and served.
- Parental involvement is encouraged.
- Services are well promoted in areas where adolescents gather.
- Linkages are made with schools, youth clubs and other adolescent-friendly institutions.
- Alternative ways to access information, counselling and services are provided.

Adolescent-Friendly Reproductive and Sexual Health Services Providers(s)

- Trained staff on adolescent issues.
- Respectful and empathetic staff.
- Maintains privacy and confidentiality.
- Non-judgemental, considerate, easy to relate and trustworthy staff.
- Good interpersonal and communication skills.
- Provides information and support to enable each adolescent to make free choices for his or her needs.
- Adequate time is given for client-provider interaction.

Adolescent-friendly health centre

- Easy and confidential registration of clients.
- Convenient hours.
- Convenient location.
- Adequate space.
- Sufficient privacy.
- Short waiting time.
- Comfortable surroundings.
- Affordable fees are available.
- Wide range of services is offered or necessary referrals are available.
- Adequate supply of medicines, equipment are available for basic services and necessary procedures.
- Drop-in clients are welcome and appointments are arranged rapidly.
- Waiting time is short.
- Educational material is available on site.

How are services best delivered to adolescents?

Adolescent-friendly health services can be delivered in hospitals, at health centres, in schools, or in community settings. They may be planned from above or started by groups of dedicated healthcare professionals who see that the needs of adolescents are not being met, and who believe that services can be more effective. This section gives examples in a range of different settings. This will also help ANMs/LHVs know the kind of services that can be provided by other providers or people away from her PHC or Sub-centre.

Services at health centres or hospitals

Basic health services are usually delivered at ordinary health centers and there is no reason why this should not also meet the needs for many adolescents. One important task is to train and support staff in this setting, to improve skills and to develop an empathetic approach, so that young people are willing to attend. These skills can be sustained through regular post-qualification training, and through a system of clinical protocols and guidelines, together with peer assessment and good quality supervision and management. Privacy may be improved by holding special sessions outside normal opening hours, by creating a separate entrance for young people or by improving confidentiality once inside. A number of hospitals have developed specialist adolescent services or clinics in outhouses or as part of the main building. Hospital based services have skilled specialists on site and can offer a full range of medical services. However, they are limited to centres of population, and may be constrained by competing demands for funds.

Services located at other kinds of centre

Because some adolescents are reluctant to visit health facilities, services can also be taken to places where young people already go. In youth or community centres, a nurse or doctor may hold special clinics, and peer educators can put young people in touch with relevant health or social support services. One advantage is that such centres are already used by adolescents so that they do not have to make a special effort to go there. One drawback is that a particular centre may only attract part of the adolescent population, being used mainly by boys or by girls or by one age group.

Outreach services

In both urban and rural areas there is a need to provide services away from hospitals and health centres, to reach out to young people who are unlikely to attend. Increasingly in towns and cities services are being provided in shopping malls, as well as in community or youth centres.

Some countries have promoted services on the Internet to catch the attention of young people who have access to computers. Adolescents in remote rural areas are often excluded from routine health services. Health-care workers from local centres can take mobile services to visit villages to reach adolescents over a wide area. Services provided in village halls can include screening and immunization with a discrete follow-up appointment service for those who need further treatment or counselling. Visiting health-care providers can also provide health education talks and materials aimed at young people.

Outreach services are also needed for adolescents who slip through the net although they may be geographically close to an existing health facility. Young people living on the streets find it difficult to access mainstream services but will respond to services targeted on this vulnerable client group. Such outreach services may be run from health clinics or provided by NGOs. Once contact is made with young people who are outside the system it is important to find a way to create links between the outreach team and mainstream services.

Handout IV

Health services linked to schools

Schools provide a natural entry point for reaching young people with health education and services. Schools are ideal places to screen for or treat a range of common illnesses, to provide vaccines such as booster tetanus shots, and for health and hygiene education. However, in practice this potential is seldom realized. Schools are short of resources and teachers have neither the training nor the equipment to deliver health education on top of their existing workload. To turn this around requires effective training to build the motivation and skills of staff, and may require outside support for sex education lessons. Some successful schemes train young people as peer educators in schools. As with outreach work, it is important to link school health services to local health services, so that students who need follow-up care receive it, and so that efforts are not duplicated.

It is also important to ensure that services provided at school have community support. Many head teachers are concerned that they will open themselves to criticism if they provide services for young people. Efforts among the school and community are required to ensure that such moves are supported. There is much evidence that parents welcome other responsible adults talking to their children about sensitive issues, as they often feel unable to deal with these issues at home.

SUMMARY

- Adolescent-Friendly Reproductive and Sexual Health Services can be delivered in health centres, in the community, through outreach services or at school;
- Hospital or clinic based services can become more adolescent-friendly;
- Community settings include services provided at community or youth centres, in shopping malls or even over the Internet;
- Outreach services are needed in cities to contact adolescents who do not attend clinics and those, like street children, who are marginalized;
- Outreach services in rural areas can be devised to reach young people living in isolated communities
- Schools offer a critical entry point to bring services to young people who are in school;
- Young workers, including adolescents, can be reached with health education or screening services targeted on the workplace;
- Services can be located anywhere where young people go – no single setting should become the only model.

Sexual and Reproductive Health Concerns of Adolescent Boys & Girls

Handout V

CONTENTS

Handout V

Introduction

This module on Sexual and Reproductive Health concerns of adolescent boys and girls. It provides an introduction to the growing up process of adolescents and addresses issues that concern adolescents on the road to adulthood, which is marked by the onset of puberty. Menstruation and initiation of sperm production are important milestones that result in development of sexual and reproductive capacity of girls and boys respectively.

This module addresses the socio-cultural issues related to menstruation and masturbation while dealing with the myths and misconceptions related to them. It also explores the barriers that diminish the access of adolescents to sexual and reproductive health care information and services. This module is the backdrop in which adolescent-friendly health services in the next module are to be contextualized.

Handout V

What is the meaning of of Sexual and Reproductive Health?

Sexual health

The term sexual health is used to describe the absence of illness and injury associated with sexual behaviour, and a sense of sexual well-being.

Sexuality influences thoughts, feelings, interactions and actions among individuals, and motivates people to find love, contact, warmth and intimacy. It can be expressed in many different ways and is closely linked to the environment in which people live.

Reproductive health

Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

Therefore Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right to access appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Handout V

Promoting the Sexual and Reproductive Health of Adolescents

Adolescent concerns tend to revolve around the immediate future, while the concerns of adults are for the longer term.

- The concerns of different groups of adolescents may not be the same. For instance, boys and girls, married and unmarried adolescents, urban and rural adolescents may have different issues of interest and concern.
- Understanding what their interests and concerns are, and the underlying reasons for this, may help adults deal with them more effectively.
- Information helps adolescents understand how their bodies work and what the consequences of their actions are likely to be. It dispels myths and correct inaccuracies.
- Adolescents need social skills that will enable them to say no to sex with confidence and to negotiate safer sex, if they wish to. If they are sexually active, they also need physical skills such as how to use condoms.
- Counselling can help adolescents make informed choices, giving them more confidence and helping them feel in more control of their lives.
- Health services can help healthy adolescents stay healthy, and ill adolescents get back to good health.
- As adolescents undergo physical, psychological and social change and development, a safe and supportive environment in their families and communities can enable them to undergo these changes in safety, with confidence and with the best prospects for health and productive adulthood.

It is worth stressing that adolescents are a diverse group. For example, a boy of 12 is at a very different stage of personal development than a boy of 18. Similarly, he is different in psychological and social terms from a girl of 12, in addition to obvious physical differences. Social circumstances can influence personal development; for example, the health and development of a boy of 12 who is part of a caring family is likely to be very different from those of a boy of the same age who is working and earning or himself and his family. Finally, even two boys of the same age, growing up in very similar circumstances, may proceed through adolescence in different ways, and at different "speeds". The sexual and reproductive health service needs of adolescents are correspondingly heterogeneous. Adolescents who are not yet sexually active have different needs from those who are; sexually active adolescents in stable, monogamous relationships may have different needs from those in more casual relationships. Quite different needs characterise those faced with unwanted pregnancies or infection, or those who have been coerced into sex. It is important therefore to be aware of the diversity of sexual and reproductive health needs of adolescents, and to tailor our responses to their specific needs.

What is Menstruation?

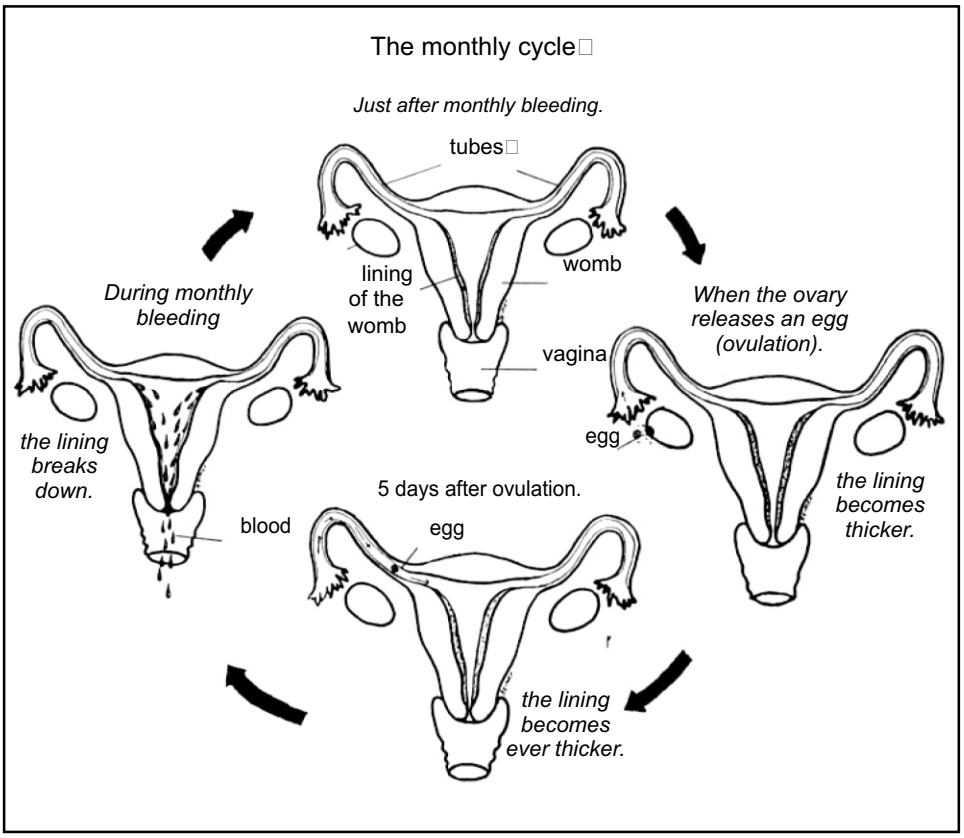
Menstruation is a natural body function. This is one of the processes, which prepares a girl's body to conceive a baby in the future. Menstruation is a sign that her reproductive system is functioning healthy and well.

The periods usually last 4- 5 days ± 2 days but may be longer or shorter in exceptional cases. A girl loses 50-80 ml blood on an average during a period. If she soaks more than 3-4 pads/day in the initial 2-3 days passes lots of blood or if periods last more than 7 days it may be considered excessive bleeding.

It is usual that during the first few years after initiation of menstruation, the girl may skip a few cycles. This should not be of much concern unless the girl is sexually active when she may be at risk of pregnancy.

It is important to talk about this normal body function since a significant number of adolescent girls have concerns related to the menstrual cycle, most of which require only reassurance or counselling. Also a number of myths and misconceptions in the society have led to it being perceived as something, which is unclean or polluted. Many traditional cultural beliefs and practices, which are followed even today, are not very helpful or sometimes harmful for the growing girl.

Menstrual Cycle



Handout V

Process of Menstruation

Menstruation (also called periods or monthly cycle because they occur every month), marks the onset of sexual maturity in girls. Menstruation is a normal body function. It usually begins (menarche) in the pubertal process, when the physical growth spurt is at its peak and breasts are fairly developed. This is one of the processes, which prepares a girl's body to conceive a baby in the future.

Menstruation is the periodic shedding of blood and tissue from the female reproductive organ called the uterus. Each month an egg (ovum) matures in one of the ovaries under the influence of hormones. This travels through the fallopian tubes to the uterus. The uterine lining becomes thick as a preparation of the uterus for receiving the fertilised egg (which grows into a baby). This can happen if the egg meets a sperm. If the egg does not get fertilised by sperms, the inner lining of the uterus begins to break away. It is this lining which flows out like menstrual blood. This cycle is repeated every month and has a duration of about 28 days. Average duration of bleeding is 4 to 5 days and estimated blood loss is between 50-80 ml in each cycle.

Excessive or scanty bleeding

It is possible that during adolescence, sometimes a girl may only bleed every few months, or have very little bleeding or too much bleeding. Their cycle usually becomes more regular with time.

What can the service provider do?

- Reassure the girls or/and their mothers that menstrual pattern will normalise after initial few years..
- If the problem continues after the initial few years, she should be referred to a lady doctor at the district women's hospital for investigation and treatment.

Pain with menstrual bleeding

- During menstrual bleeding, the uterus squeezes to push out the lining. The squeezing can cause pain in the lower belly or lower back. The pain may begin before bleeding starts or just after it starts.

What can the service provider do?

- Reassure the girl that the pain will be relieved spontaneously in a day or two.
- Counsel her to keep doing her daily work, exercise and walk.
- If pain is unbearable refer to lady doctor who may give some pain killer.

Pre-menstrual Syndrome

Some girls feel uncomfortable a few days before their menstrual bleeding begins. They may have one or more of a group of symptoms known as pre-menstrual syndrome. Girls who suffer from pre-menstrual syndrome may notice:

- pain in breasts
- a full feeling in the lower belly
- constipation
- emotions that are especially strong or hard to control.

What can the service provider do?

- Reassure the girl that there is nothing to worry as these symptoms are due to changes in the hormonal pattern every month and will go once her periods start.
- Counsel her to continue doing her regular work and exercise.

Hygiene and cleanliness during menstruation

To maintain menstrual hygiene, girls can use cloth or sanitary pads. If using cloth, clean cotton cloth should be used to soak the menstrual blood. Cotton has a good absorbing capacity. A synthetic cloth should not be used as it may not absorb well and may cause skin reactions. If she can afford to buy pads, she can use them. Cloth /pads can be used along with the underwear.

The cloth or pads should be changed 2 or 3 times a day. The cloth and panties should be properly washed with soap and water and dried in the sun. Sunlight kills all bacteria. After every period the washed and dried cloth should be stored in a clean bag in a clean place till the next period.

If pads are used, they should be wrapped in a paper bag and disposed.

The girl should take a bath every day during menstruation.

Handout V

Frequently Asked Questions (FAQs) about Menstruation

Ques 1 My periods are not regular. Why?

Ans Periods in the first few years after menarche may be irregular. This does not indicate any abnormality. The adolescent girl needs reassurance to be able to adjust to the periodicity. She needs to be told that it will normalise in the course of a few years. Emotional stress because of the cycles itself or otherwise needs to be addressed. The cycles are more likely to be longer than a month but in a few cases they may even be shorter or with no fixed pattern.

Ques 2 What if there is excessive or prolonged bleeding?

Ans Sometimes adolescent girls may experience heavy bleeding or it may last for a longer duration than the normal 3-5 days. This is likely to normalise as the cycles become regular and are accompanied by maturation of the egg. Excessive loss of blood may lead to anaemia which can be prevented or treated by dietary counselling and if required, iron supplementation. Treating worm infestation (if a common problem in the area) can help in preventing aggravation of anaemia.

Ques 3 Is scanty menstruation a matter of concern?

Ans The Amount of bleeding varies and is different from girl to girl. Even a lesser menstrual flow is normal especially if it is regular in occurrence and is not associated with any other problem. Reassuring the girl about her fertility is important.

Ques 4 How do I handle discomfort during periods?

Ans Young adolescent girls may face a few discomforts during menstruation. The usual discomforts are:

- Severe/incapacitating pain or cramps in lower abdomen
- Swelling of feet, breast, face
- Weakness and exhausted feeling
- Backache
- Breast Discomfort
- Itching in genital area

Weakness, feeling of exertion, tiredness and headache may be due to lack of proper nutrition. Since adolescent girls are growing they need a nourishing diet, especially rich in iron, to make up for blood loss during menstruation. Lack of iron intake/absorption leads to anaemia. Itching may be due to lack of cleanliness. Daily bath and maintaining hygiene and use of clean cloth should be encouraged. Explanation of menstrual process, physical exercise and reassurance are important aspects of management.

If the pain interferes with the daily routine of the girl and is not improving with the above mentioned measures she should be referred to a doctor who may prescribe some pain killers initially.

Ques 5 Why do I feel so low few days before my periods begin?

Ans Seven to ten days before menstruation girls may experience:

- Irritability, restlessness
- Gastro intestinal tract upset - constipation, colon spasm
- Feeling of fullness in breasts, abdomen, face and feet
- Some weight gain of 1 to 1.5 kg

Most girls will benefit by reduction of salt intake, regular exercise and emotional support. Severe cases may need treatment and should be referred to a doctor.

Ques 6 Can I become pregnant?

Ans An adolescent girl can become pregnant any time after she starts having her periods. As a fully mature egg is not released in the first few years after menarche the likelihood of her conceiving is very less. However, adolescent girls must know that even a single act of sexual intercourse can lead to pregnancy. It is important for all adolescents to know that sexual activity without the use of a contraceptive carries with it the risk of getting pregnant.

In some parts of our country, girls are married before menarche and as soon as they attain menarche, the marriage is consummated and they are expected to bear a child. This may not happen, as the earlier cycles are not producing a mature egg. The family of the married adolescent and she herself will need reassurance and counselling to tackle the related social pressures of proving her fertility. Girls should not be married before 18 years of age in the first place.

Ques 7 Is it normal to have discharge from the vagina?

Ans A certain amount of discharge is normal during the middle of the cycle at the time of the release of the egg and a few days before the beginning of the periods. This discharge is clear and not foul smelling. It could be profuse and accompanied by itching if it is due to poor personal or menstrual hygiene. Care should be taken to exclude sexually transmitted infections, if there is history of sexual activity.

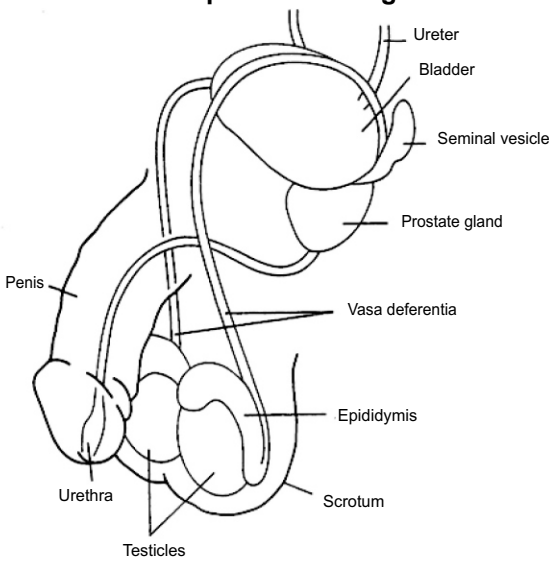
Handout V

The Male Reproductive System and its functions

The male genital tract is designed to

- Produce sperm
- Store sperm
- Release sperm as required
- Add regulatory components to sperm
- Add fluid (seminal fluid)

Male Reproductive Organs



- **Penis**: The male organ for sexual intercourse. Deposits sperm and semen in the female body through urethra, a thin, long tube passing through penis.
- **Scortum**: The pouch located behind the penis which contains the testes, provides protection to the testes, controls temperature necessary for sperm production and survival.
- **Two Testes**: Two round glands lying in the scortum which produce and store sperms from puberty onwards. They also produce the male sex hormone responsible for male characteristics and sexual performance.
- **Two Vas Deferens**: From each testis, a thin and long tube arises and is called vas deferens. Sperm are carried from each testis to the urethra by vas deferens.
- **Seminal Vesicles**: Two sac-like structures lying behind the urinary bladder, secrete a thick milky fluid that forms part of the semen.
- **Prostrate gland**: A gland located in the male pelvis which secretes a thick milky fluid that forms part of semen.

The sequence of Events in Sperm Formation

Sperms spend their life in the male body in a continuous series of tubes. Certain secretions are released in the epididymus that alter the sperms environment and its surface characteristics, among other things. In preparation for ejaculation, the sperm leaving the epididymus enter the vasa efferentia. The sperm move along each vas deferens and enter the vas deferens. As the sperm move along the vas deferens material are added to the sperm and to the extracellular fluid (forming semen) that surrounds them. The prostate gland and seminal vesicles add fluid and nutrients at the time of sperm ejaculation providing most of the volume of the ejaculate. This complex of fluid and sperm cells travels up the urethra to be released externally.

Glands and Secretions

Epididymus: stores sperm from seminiferous tubules; adds secretions; adds surface glycoprotein to sperm.

Prostate gland & seminal vesicles: add fluid, nutrients, etc. at time of ejaculation of the semen.

Erection of Penis

In response to thoughts, fantasies, temperature, touch or sexual stimulation, the penis fills with blood and becomes hard and erect for sexual intercourse. In young adolescents erections may take place even in absence of sexual thoughts or stimulation.

Ejaculation

The release of semen from the penis after sexual excitement is called ejaculation. This may occur at night and is commonly called a 'wet dream'. The Hindi and Marathi word "Swapna dosh", indicates defect/fault. But it is a natural and normal phenomenon – not a fault.

During ejaculation, the urethra is closed to urination.

Night Falls (Wet dreams)

In adolescent boys, once sperm formation starts and semen is formed, it sometimes gets ejaculated during sleep even without sexual intercourse. This is called night fall and is a normal growing up process. In absence of its knowledge, it is of great concern and worry for boys.

There are a lot of myths and misconceptions related to night fall.

Genital hygiene in boys:

- Wash genitals daily.
- Gently retract (push) foreskin back and wash the tip of the penis. Secretions accumulate under the foreskin and could cause infection if not cleaned regularly.
- Change underwear daily.
- Use cotton undergarments only. Synthetic garments to not absorb moisture and also increase the temperature.
- Wash undergarments everyday and dry in the sun.

What can health-care providers do to improve adolescents' access to sexual and reproductive health information and services?

Adolescents seek information and clues about sexual life from a variety of sources - parents, siblings, peers, magazines, books, the mass media, etc. Whilst they receive a great deal of information from diverse sources, not all of it is correct and complete. Many adolescents lack information concerning the physical changes that occur during adolescence, their implications, and how to take care of themselves. This is often because the subject of sexuality is a sensitive one in many societies. As a health-care provider, you can be a valuable source of accurate information and support to the adolescents you serve. You can present them with facts, respond to their questions, and provide reassurance.

In many societies, parents and other community members are concerned that the provision of information on sexuality can do more harm than good. As a health-care provider, it is important that you are very well aware that this is not true. Failure to provide adolescents with appropriate and timely information represents a missed opportunity for reducing the incidence of unwanted pregnancy and STIs, HIV and their negative consequences.

Involving gatekeepers, teachers, AWW and peers for counselling adolescents

Handout V

Annexure 1: Case Studies
Session 1, Activity 2

Case Study 1 — Pain during Periods

Rupa is a 15-year-old girl. For the last three years, She has been having her periods every month. They come with a lot of pain and heavy bleeding which scares Rupa very much. Bimla, her friend, says she does not have pain and heavy bleeding. Rupa is very worried about her condition and has spoken to her mother about it. She gave Rupa a concoction to drink but it did not help her. Rupa thinks she has a deadly disease.

Discuss:

- **What is Rupa's problem?**
- **What can an ANM/LHV do for her?**

Case Study 2 — Missed Period

Meera is a 17-year-old girl. She has not been getting her periods for the last two months. She is scared that she might be pregnant. Meera does not have the courage to tell her mother as she thinks that her mother will kill her if she comes to know that Meera may be pregnant.

Discuss:

- **What is the problem in this case?**
- **What more information is required to understand Meera's problem better?**

Case Study 3 — Young Couple with FP needs

Baldev is an 18-year-old boy. He got married to Sudha, a 16-year-old girl, due to a lot of family pressure. They do not want a baby for three years or so but Baldev's mother is keen that they become parents at the earliest and 'settle down'.

Baldev and Sudha are frustrated and are scared to have sex. They wish somebody would listen to them and understand their needs and tell them how they could postpone having their first baby.

Discuss:

- **What is good about this case?**
- **What are the problems in this case?**
- **What can an ANM/LHV do to help Baldev and Sudha?**

Handout V

Case Study 4 — Size of Breasts

Preeti is an 18 year old girl living in a small town in Punjab. She is thin and small built. Two weeks ago, preeti vwent with her friends to see the mela. Preeti wore a ghagra-choli. That day all the girls made fun of her and said that she did not look like a girl, as Preeti is flat chested, and that no boy would ever look at her. Preeti felt very bad and has been crying a lot since then. Preeti does not want to talk to her mother or her sister-in-law about it as she feels they will think she is a bad girl. Preeti keeps wondering why she is so abnormal and what will her future be like?

Discuss:

- **What is Preeti suffering from?**
- **What kind of a problem is this?**
- **What is the problem in this case?**
- **How can it be addressed?**

Case Study 5 — Drug Addiction

Mohan is a 16 year old boy living in an urban slum in Delhi and feels very happy that he has met a friend, Sohan, whom he likes very much. They play football and go to the cinema together. Days ago, Mohan discovered that Sohan was smoking a bidi. Mohan is terrified about this, because he has heard that this drug could have serious consequences on one's health. Mohan is not easily led to do things he does not approve of. Mohan certainly knows that he would never use bidi or cigarette. His worry is that if his parents find out about what Mohan's friend is involved in, they will not permit him to be friends with Sohan any more. Mohan really does not want to lose Sohan as a friend. Mohan does not know if he can help Sohan stop using tobacco.

Discuss:

- **What is the problem in this case?**
- **What adolescent characteristic is reflected in this case?**
- **What is good in this case?**
- **What can be done in this case to help the two boys?**

Case Study 6 — Unsafe Abortion

Madhu is an 15 year old girl married to Hari, an 17 year old boy from a village in Uttar Pradesh. Six months after their marriage, Madhu became pregnant. Her husband and Madhu didn't want a child so soon, so she went to a village woman who does abortions. The village woman put in some kind of stick inside Madhu. Madhu bled a lot and since then she is not feeling well. Madhu has not told this to anyone in her family. When her mother-in-law gets to know of this she will get very angry. Now Madhu wants to know what to do?

Discuss:

- **What is/are the problems in this case?**
- **What can be done to help Madhu?**

Annexure 2: Case Study
Session 2, Activity 2

Case Study - Surekha's case

Surekha, a 12-year-old girl, lived with two younger brothers and her parents in a small village. Hers was a middle-class family, and her parents cared for and loved their children very much. Surekha was a happy child.

One day, Surekha noticed that her underpants were feeling wet and uncomfortable. When she looked down at her dress, she noticed that it was splotched with blood. She was scared and did not know what was happening to her. She started crying.

Her mother asked her the reason for crying and when she told her condition, her mother signalled her to be quiet,sent her brothers to play outside the room and gave her a piece of cloth to use .She told Surekha that now you are a grown up girl so this will happen to you every month.Dont tell your condition to anyone.She said that now onwards she should not mix up with boys and behave properly.

That night Surekha went to bed with her mind in a whirl.She had`many, many fears and questions about her condition but did not know whom to ask.

Next day the ANM came to the village. Surekha wanted to ask ANM about her problem but as other woman were also standing nearby, she felt shy and was not sure how the ANM would react to her question.

Question 1

Why was Surekha so unprepared for this important event in her life?

What are the communication barriers in this case?

Handout V

Annexure 3: Problem Cards
Session 2, Activity 2

Problem Cards	Diagnosis	Would you deal with it if such a case comes to you?
1. Kajal is a 14-year-old girl. She is worried since she has not started having her periods.	It is not a problem and most probably she will begin having periods soon.	Re-assure her, give iron supplement, if needed. Tell her to report if no periods by age 16.
2. Lakshmi is 16-year-old and has not started having her periods. She is very worried.	It is a case of primary amenorhoea.	Refer her to a lady medical officer for investigation and treatment
3. Babita is 13 year old and has a lot of thin white discharge from her vagina	It is not a case of infection of reproductive tract and is a case of normal white discharge	Re-assure her that it is not an infection/disease normal at this age. Give some supplements like multi-vitamin, calcium, iron.
4. Saroj is 15-years-old unmarried girl who complains of foul smelling dirty discharge from the vagina, accompanied by itching in the genital region.	It is a case of RTI	Refer her to PHC for treatment of RTI,counsel her about menstrual/genital hygiene
5. Fatima is 12-year-old and has a lot of bleeding and pain abdomen during periods every month. She feels very weak.	It is a menstrual disorder which is common in girls esp when periods begin.	Re-assure her that it is not a disease, give symptomatic treatment for bleeding and pain, give iron supplement
6. Kamla is 16-years-old and she started her periods 4 years ago. She is anxious as she has not had her periods for last two months.	It is a case of amenorhoea. It could be secondary amenorhoea or pregnancy.	Counsel that girls of her age do miss their periods. Also explain and discuss if there is history of sexual contact, it could be pregnancy which can be detected by simple urine test. If not pregnant, refer her to a lady doctor for treatment of secondary amenorhoea.

Nutritional Needs of Adolescents and Anaemia

Handout VI

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Handout VI

Growth and Development in Adolescence

Adolescence is a significant period for physical growth and sexual maturation. Nutrition being an important determinant of physical growth of adolescents is an important area that needs attention. Growth retardation is one of the most important health concerns for adolescents and their parents as well as health care workers.

Inadequate nutritional intake during adolescence can have serious consequences throughout the reproductive years and beyond. Poor nutrition during adolescence can impair the work capacity and productivity of adolescent boys and girls in their later years. Further, an undernourished girl is at the risk of developing complications during pregnancy and the chances of her giving birth to a low birth weight baby increases, thus perpetuating a vicious cycle of malnutrition and ill-health.

Major components of food

Major components of food include protein, fats, carbohydrtes, minerals and vitamins which perform different functions.

Function of various food components

- Proteins are of greatest importance in nutrition. Proteins are required for bodybuilding and help in repair and maintenance of body tissues.
- Fats are high-energy foods and a source of energy. They also make the food more palatable and provide fat-soluble vitamins.
- Carbohydrates form the major component of most diets and are the main source of energy.
- Vitamins and minerals are required in small quantities. They do not yield energy but enable the body to use other nutrients and also play in important role in growth, repair and regulation of vital body functions.
- Requirements for iron and calcium are particularly increased in adolecence.
  - Calcium needs during adolescence are greater than they are in either childhood or adulthood because of rapid increase in lean body mass and skeletal growth
  - Zinc is espeically important in adolescence because of its role in growth and sexual maturation. Some sources of zinc are grains, nuts, meat, cheese and milk.

Balanced Diet

A balanced diet is one that provides all nutrients (carbohydrates, proteins, fats, vitamins and minerals) in required amounts and proportions for maintaining health and genreal well being and also makes a small provision for extra nutrients to withstand short duration of leanness. It can be achieved through a blend of four basic food groups, i.e. carbohydrates, proteins, fats, vitamins and minerals. As these are present in different types of food items like dals, chapati or rice, green vegetables, easily available fruits and milk it is important to eat these food items in the right mix everyday.

Recommended Dietary Allowance of Nutrients for adolescents in 24 hours						
	MALE			FEMALE		
	10-12 Yr	13-15 Yr	16-18 Yr	10-12 Yr	13-15 Yr	16-18 Yr
Energy (Kcal)	2200	2500	2700	2000	2100	2100
Protein (gms)	54	70	78	57	65	63
Calcium (Mg)	600	600	500	600	600	500
Iron (Mg)	34	41	50	19	28	30

Source: ICMR (1998)

Eating right and nutritious food during adolescence

- Helps in achieving rapid growth and full growth potential
- Helps in timely sexual maturation
- Ensures adequate calcium deposition in the bones and helps in achieving normal bone strength
- Establishes good eating habits and sets the tone for a lifetime of healthy eating. This prevents obesity, osteoporosis (weak bones due to deficiency of calcium), and diabetes in later life.

Young girls who have inadequate nutrition do not grow well and become stunted women. Adolecent girls often suffer from anaemia because of poor consumption of iron rich foods and also due to worm infestation and frequent infections. Because of severe malnutrtion and repeated illness, the growth spurt in early adolescence does not occur and a slower and prolonged pubertal growth period is seen in adolescents from lower socio-economic status. Hence, any damage to the body physiology during adolescence, which places extra nutrtional demand on the body, like early pregnancy, is detrimental as growth this still to be attained. Adolescent mothers are more likely to deliver low birth babies. Due to poor milk production the infant may not be able to gain enought weight and remain malnourished. If these babies are girls, they are likely to continue the cycle by being stunted in adulthood, and so on, if something is not done to break this cycle. Support is needed for nutrition at all stages - infancy, childhood, adolescence and adulthood.

Balanced Diet

Handout VI

Nutritional Anaemia

The need for iron increases with rapid growth and expansion of blood volume and muscle mass. As boys gain lean body mass at a faster rate than girls, they require more iron than girls. The onset of menstruation imposes additional needs for girls. Adolescents should be encouraged to consume iron rich foods (green leafy vegetables, jaggery, meat) complemented with a Vitamin C source like Citrus fruits (oranges, lemon) and Indian gooseberry (Amla). Adolescent girls need additional requirement of Iron to compensate for menstrual blood loss.

Iron deficiency in diet leads to nutritional anaemia.

What is anaemia?

Our blood contains a red pigment called haemoglobin, which carries oxygen and is rich in iron. Anaemia is the loss of oxygen carrying capacity of the blood due to deficiency of haemoglobin in the red blood cells.

Iron deficiency anaemia is a major nutritional problem in adolescent boys and girls in India. The ill effects of anaemia can be seen as:

- Reduced capacity to work and thus decreased productivity
- Increased risk to pregnant girls/women. (In India, 20-40% of maternal deaths are due to anaemia).
- Anaemia may increase susceptibility to infections by impairing the immune functions.

How can anaemia be prevented?

Anaemia can be managed through proper diet and iron supplementation. To prevent anaemia, increase the intake of green leafy vegetables and fruits. If an adolescent looks pale, fatigued or listless and anaemia is suspected, refer to the nearest PHC. Anaemia is treated by giving iron and folic acid tablets on a daily basis till 2-3 months after haemoglobin levels have returned to normal.

Other deficiency states

- Inadequate nutrition during adolescence can potentially retard growth so that the adolescent remains short and thin. The full height potential may not be reached and the adolescent may remain stunted. The sexual maturation may be delayed with late onset of puberty. Poor nutrition impairs work capacity and the boy/girl may feel tired all the time.
- Zinc deficient diet results in growth failure and delayed sexual maturation.
- Iodine deficiency leads to a much wider spectrum of disorders commencing with intrauterine life and extending through childhood to adulthood with serious health and social implications. Iodine deficiency disorders include mental deficiency imparied mental functions, neurological defects, increased stillbirths, and perinatal and infant mortality.

Annexure 1: Case Study
Session 3, Activity 1

Case Study 1 — **Sheela**

Sheela is a 15-year-old girl. Her family comprises of her parents, two brothers and a younger sister. Sheela goes to school and also helps her mother with all the household work. Her normal diet is made up of rice and watery dal twice a day. Vegetables are cooked once a while. As per the social custom in her family, Sheela and her sister eat after her father and brothers have eaten. Two months back, she suffered from malaria and since then has been feeling very weak and is always exhausted. She was brought to the PHC after she fainted on her way to school one day.

Discuss:

1. What do you think has happened to Sheela?
2. How can her condition affect her future?
3. How can you help Sheela?

Case Study 2 — **Raju**

Raju is 14 year old and lives in a village. Every morning he goes barefoot to the fields to defaecate.

He has upset stomach most of the times and passes loose motions

He dislikes vegetables, dal etc. and eats only rise with sugar everyday. He also likes to eat chat/pakori sold in the market.

He is feeling very weak and low since last 15 days.

His mother brings Raju to you.

Discuss:

1. What do you think has happened to Raju?
2. What investigations are required?
3. How will you counsel/treat him?

Pregnancy and Unsafe Abortions in Adolescents

Handout VII

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Handout VII

Magnitude of problems related to adolescent pregnancy

- Median age at first marriage for girls is 16.4 years and that for first cohabitation with husband is 17 years in India
- TFR amongst 15-19 years olds is 19% of the total fertility
- Half of the women in India have had their first child before their 20th birthday
- Unmet need of family planning in the 15-19 age group is 27%
- Pregnancy-related complications are the main cause of deaths for 15-19-year old girls and maternal mortality among adolescent girls under 18 years is several times higher than in those aged 18-25 years.
- Children born to adolescent mothers also face a higher risk of death, especially during the neonatal and perinatal periods.
- An important contributory factor to maternal morbidity and mortality among adolescents is their lack of access to safe abortion services and HIV/AIDS is an ever increasing danger that sexually active adolescents face.

Factors influencing adolescent pregnancy and childbirth

A range of social, cultural, biological and service delivery factors contribute to the high levels of adolescent pregnancy and childbirth:

- **Declining age of menarche –** The age of menarche (onset of first menstruation) has declined, especially in urban areas.
- **Duration of education and societal demands** – A growing number of adolescent girls are allowed to go for higher education and marry late as a result. But in rural areas, marriage still appears very early for young girls. They are then pushed into early motherhood.
- **Early initiation of sexual activity is on the increase.**
- **Sexual coercion and rape,** figures prominently in the lower socio-economic strata. Pregnancies are not the only result, but also serious physical and psychological consequences.
- **Disruption of education** also influences adolescent childbearing as women with little or no education are more likely to become mothers early.
- **Socio-economic factors** often force young girls into sexual exploitation and prostitution and compounded by lack of access to contraceptive services and inability to negotiate condom use, the young girl may soon become pregnant.
- **Lack of access to information** has a significant bearing on early pregnancy and childbirth.
- **Lack of access to services** leads to risky pregnancy and unsafe abortion,etc.
- Adolescent pregnancies tend to be highest in areas with the lowest contraceptive prevalence. Contraceptive prevalence has increased mostly among older, married women and not adolescents.

Why are complications more common in adolescent pregnancy and childbirth?

Pregnancy and childbirth in adolescence are risky for the health of both mother and baby

- **Biologically,** an adolescent's body is still developing and not yet ready to take on an added strain. The pelvic bones are not fully mature, and cephalo-pelvic disproportion could occur. Her body has special nutritional needs and when pregnancy occurs, it is a strain on already depleted reserves, especially if she belongs to a low socio-economic background.

  The young girl may not be mentally prepared for motherhood with all its added responsibilities, etc. and this could give rise to mental health problems like depression.

- **Socio-culturally,** pregnancy outside of marriage bears a terrible stigma and the above situation worsens when the girl is not married, in which case she does not get the emotional support she needs as well as support in terms of nutrition, rest, antenatal check-ups, etc.

- Shortcomings in **service delivery** deter adolescents from seeking timely medical help and intervention. At many health centers, pregnant adolescents who are unmarried are treated with none or very little respect by all staff, some of whom may not be aware of the risks associated with such pregnancies. So, even if the girl is able to access health services of some kind, she does not necessarily get the benefit of a sensitive and technically competent check up. This is the reason unmarried adolescents hide their pregnancies for as long as they can and medical help is delayed at great risk to their lives.

  This situation is not unique to unmarried adolescents as the married ones may not be aware of the importance of antenatal care. For various reasons, the adolescent woman is more likely to deliver at home. The older women in the home feel that a traditional birth attendant is equipped to carry out the delivery, her services are cheaper and she is easily accessible. A trained birth attendant or a hospital is usually thought of when things get out of hand and complications have already set in.

  The risks are high, starting from the antenatal period, through labour and the postpartum period. Adolescent mothers are most likely to give birth to low weight babies and both the mother and child face higher mortality and morbidity.

Pregnancy related complications that occur more commonly in adolescents than in adults

- Death
- Pregnancy-induced hypertension
- Anaemia during antenatal period
- STIs/HIV
- Higher severity of malaria
- Pre-term birth
- Obstructed labour
- Anaemia during postpartum period
- Pre-eclampsia
- Postpartum depression
- Too early repeat pregnancies
- Low birth weight
- Perinatal and neonatal mortality
- Inadequate child care and breastfeeding practices

Handout VII

• Problems in the antenatal period

- **Pregnancy-induced hypertension**: Studies report an increased incidence of the condition in young adolescents, when compared with women aged 30-34 years.
- **Anaemia:** There is an increased risk of anaemia in adolescents because of nutritional deficiencies, especially of iron and folic acid, and by malaria and intestinal parasites.
- **STIs/HIV:** Sexually active adolescents are at an increased risk of contracting STIs, including HIV infection, owing to their biological and social vulnerability. There is also the increased risk of mother-to child transmission of HIV in adolescents, because the HIV infection is more likely to be recent, and therefore associated with higher viral loads. The presence of other STIs (syphilis, gonorrhoea and chlamydia) with local inflammation may increase viral shedding, thereby increasing the risk of transmission during labour.
- **Higher severity of malaria** is often seen in first time pregnant women (which includes many adolescents) and is a common cause of anaemia in this group. This puts them at risk and their unborn babies at risk of intra-uterine death.6

• Problems during labour and delivery

- **Pre-term birth** is common in women under twenty years of age because of immaturity of the reproductive organs, social factors such as poverty, at play.
- **Obstructed labour** in young girls (below 15 years of age) occurs due to the small size of the birth canal leading to cephalo-pelvic disproportion. Lack of access to medical and surgical care can result in complications like vesico-vaginal and recto-vaginal fistulae.

• Problems in the postpartum period

- **Anaemia is commoner and** further aggravated by blood loss during delivery thereby also increasing the risk of infection.
- **Pre-eclampsia:** Several studies report that pre-eclampsia occurs more often in young adolescents. The symptoms may worsen and sometimes recognized only during the first postpartum days.
- **Postpartum depression** and common mental health problems are common due to reasons described above.
- **Too early repeat pregnancies,** especially in unmarried adolescents can occur because of the difficulty in accessing reliable contraception.

• Problems affecting the baby

- **Low birth weight**: There is a higher incidence of low birth weight (weight <2500 grams) among infants of adolescent mothers.
- **Perinatal and neonatal mortality** is increased in infants of adolescent mothers, compared with infants of older mothers.
- **Inadequate childcare and breastfeeding practices**: Young mothers, especially those who are single and poor, may find it hard to provide their children with the adequate care. This is reflected in their poor child feeding, including breastfeeding, practices.

Care of adolescents during pregnancy, childbirth and the postnatal period

Adolescent pregnancies and deliveries require much more care than adult pregnancies and all efforts must be made to reduce the occurrence of problems. This includes early diagnosis of pregnancy, effective antenatal care, effective care during labour and delivery, and during the postpartum period.

- ## Early diagnosis of pregnancy

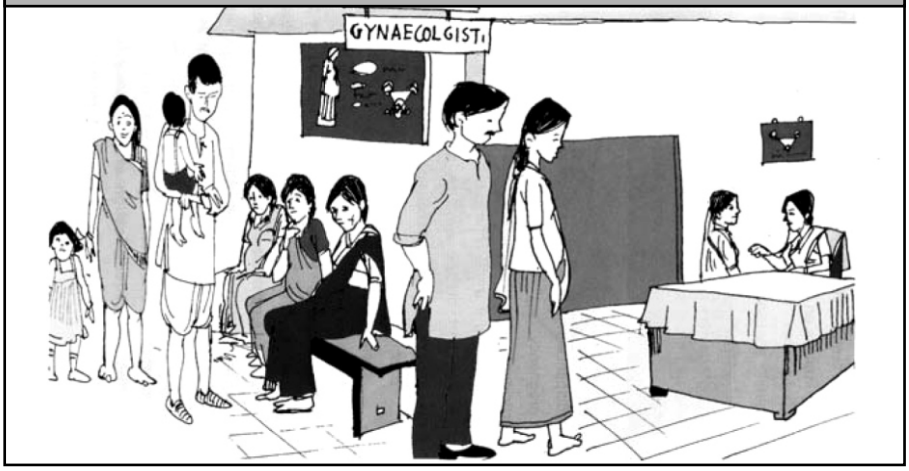
  Health service providers and other adults like family members in more regular contact with the adolescent, have the shared responsibility of creating an environment in which she feels able to share information about her situation, especially if she is unmarried. She may not know that she is pregnant because she may not remember the dates of her last menstrual period, or because her periods are not regular. She may even want to hide her pregnancy or seek ways of terminating it. Being aware of these issues, and being on the lookout for telltale signs of early pregnancy such as nausea will help ensure an early diagnosis of pregnancy so that care is started early and complications are avoided.

- ## Antenatal care

  Many complications can be detected and many can be avoided if the adolescent is able to access good antenatal services. **Pregnancy-induced hypertension** (Pre-eclampsia) can easily be detected and referred to the PHC for management. In case of more serious complications (such as **pre-eclampsia, eclampsia, and abruptio placentae**), referral to a woman's hospital is essential. **Anaemia** and **malaria** too can be detected and treated during routine antenatal care. Screening for **STIs** can lead to early referral and early treatment, if required. Iron and folic acid supplements will prevent anaemia to a large extent. Most importantly, antenatal visits could help identify those adolescents, who are at risk of **preterm labour**, though interventions to address this are limited.

- Antenatal care also provides a **valuable opportunity for the provision of information and counseling** support that adolescents need. This is especially important in the case of adolescents, especially unmarried ones, because of their greater need for support.

Anti-natal Visit



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- **Counseling during pregnancy**

Information and counseling support is the right of every pregnant woman who reaches a health centre and pregnant adolescents have special needs and questions and concerns of their own. They must be given an opportunity to raise and discuss these issues.

Their needs must be matched with competent and sensitive counseling support in terms of the socio-cultural environment that has to be faced, the options available in terms of the pregnancy; the access to health services for routine antenatal care and in case of emergency; the danger signs that need to be aware of, etc.

Counseling should also include care of the newborn and prevention of an early repeat pregnancy.

Since adolescents are more at risk of STIs including HIV/AIDS, voluntary counseling and testing (VCT) services should be made available to them. As ANMs/LHVs, you should know where the nearest VCT centres is, to be able to refer your clients for screening.

- ## Management of labour and delivery

If the pregnancy in an adolescent is normal and with no complications and anaemia is treated adequately, labour starts at term, and the infant is in cephalic presentation, labour is not at increased risk. Counsel the client for institutional delivery at PHC.

However, if the adolescent is severely anaemic, postpartum haemorrhage can be a dangerous possibilty. In very young adolescents, pre-term labour as well as obstructed labour are more likely to occur. Such adolescents are at high risk and it is advisable to encourage hospital delivery. The family should be advised to make arrangements for transportation to the hospital, when needed.

Besides observing and monitoring, supporting the woman is very important and studies have shown that continuous empathetic support during labour, provided by a technically qualified nurse or midwife results in many benefits both to the mother and the baby.

- ## Postpartum care

This includes the prevention, early diagnosis and treatment of postnatal complications in the mother and her baby. It also includes information and counselling on breastfeeding, nutrition, contraception and care of the baby. The adolescent mother will require special support on how to care for herself and her baby.

Contraception: It is very important that too early repeat and unplanned pregnancies should not occur for lack of access to contraceptive services. The postpartum period presents a good opportunity for taking steps towards pregnancy prevention and for promoting dual protection by encouraging condom use.

Nutrition of the mother: The lactating adolescent needs adequate nutrition to meet her own as well as the extra needs required for breast-milk production.

Breastfeeding: Exclusive breast feeding is recommended for 6 months. A young adolescent, especially one who is single – would require extra support in achieving breastfeeding successfully.

Many adolescents need ongoing contact through home visits on their return with their babies, especially if they are unmarried. In the latter case, both they and the babies are at a higher risk of abuse and maltreatment. Family counselling is therefore vital and provides a lifeline to the adolescent and her baby.

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Abortion

Adolescent pregnancy very often leads to unsafe abortion especially if the girl is unmarried. The consequences of this type of abortion can be life threatening. Although abortion is legal in India, it is estimated that four million Indian women a year still resort to illegal abortions because of social stigma, lack of awareness and lack ofa ccess to health facilities that offer technically competent services.

Medical Termination of Pregnancy Act

The Medical Termination of Pregnancy Act was passed in 1971. The Act was intended to grant women freedom from unwanted pregnancies, especially when there was social censure or medical risk involved. Apart from these benefits, it also ensured that abortion services became easily accessible.

The aim of the Act is to allow for the termination of certain pregnancies by registered medical practitioners. If a pregnancy is terminated by someone who is not a registered medical practitioner, it would constitute an offence punishable under the Indian Penal Code.

- ### When MTP is permitted

  According to the Act, abortion may be permitted only in certain cases:

  (a) Where the length of the pregnancy does not exceed twelve weeks or

  (b) Where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are, of opinion, formed in good faith, that, -

  (i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or

  (ii) there exists a substantial risk that the foetus would suffer from a severe physical or mental abnormality; or

  (iii) the pregnancy resulted from rape or incest; or

  (iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman; or

  (*c*) After the 20th week of the gestation period if a medical practitioner, after consultation with another medical practitioner or a registered midwife who has completed the prescribed training course, is of the opinion that the continued pregnancy—

  (i) Would endanger the woman's life;

  (ii) Would result in a severe malformation of the foetus; or

  (iii) Would pose a risk of injury to the foetus.

  As long as the above conditions are fulfilled, a doctor can terminate a pregnancy without fear of being prosecuted under the Indian Penal Code.

- ### Whose consent is required?

  A pregnancy can be terminated only with the informed consent of the pregnant woman; no other person's consent needs to be obtained.

  In the case of a pregnant woman, less than eighteen years old, and in the case of a pregnant woman, more than eighteen years old but of unsound mind, the consent of her guardian must be obtained in writing.

- ## Where can a MTP be performed?

  MTPs can be performed only at the centres certified by the government. These centers could be located in public or private sector.

- ## The rights of the pregnant woman

  Whenever a woman requests that her pregnancy be terminated, she must be informed of her rights under the Act.

  Also, whenever a pregnancy has been terminated, the medical practitioner should record the prescribed information. However, the name and address of the woman, who has requested or obtained a termination of pregnancy, should be kept confidential, unless she herself chooses to disclose that information.

- ## Penalisation

  If a person who is not a medical practitioner, who has not completed the prescribed training course, performs the termination of a pregnancy, can be convicted and penalised with a fine or imprisonment for a period not exceeding 10 years.

Handout VII

The Nature and Scope of Unsafe Abortions

In India, though abortion has been legalized since 1971, illegal and unsafe abortions are very common due to various reasons.

Legal abortion: implies termination of pregnancy by trained provider in Government approved health facility for the purpose and fulfilling the conditions mentioned in the Medical Termination Act.

Illegal abortion: implies termination of pregnancy by trained provider violating the Medical Termination of Pregnancy Act.

Unsafe abortion: implies interference of pregnancy by persons without the necessary knowledge and skills, or in conditions that are not conducive to good health. It can be within or outside of the law.

Apart from the women who die due to post-abortion complications, there are many more who survive but have to live with chronic health problems, and in many cases infertility.

Unsafe abortions are commoner among adolescents as they are easier to access, in terms of convenience of location and confidentiality (of prime importance in the case of unmarried girls or those who have been coerced or raped).

India was one of the first countries in the world to legalize induced abortion under the Medical Termination of Pregnancy Act (1972). It is estimated that each year nearly 6 million abortions are performed outside the ambit of the Act. Several categories of providers ranging from qualified providers (unregistered) to non-allopathic practitioners, paramedics or even traditional dais, offer these services on demand, often jeopardizing the life of the woman. Unfortunately many facilities offer both sex determination and abortion services despite legislation to the contrary (Prenatal Diagnostic Techniques, Regulation and Prevention of Misuse Act, 1994). Sex selective abortion is prohibited legally, though abortion is accepted and legally permitted.

Most sexually active adolescents are in their late adolescence. Lack of contraceptives use characterises the vast majority of sexual encounter among youth. Incidences of unintended teenage pregnancies and abortions have shown a steady increase. Unsafe abortions are a major source of reproductive mortality and morbidity.

Extensive practice of sex selective abortions, is a chilling indicator of gender discrimination and the unequal status of women in society. Overwhelming majority of these abortions are being sought from illegal sources.

To address the growing problem of sex selective abortions, the following steps should be taken, at the minimum:

- RH communications and education should include specific messages highlighting the importance of girl children, gender equality, the hazards of unsafe abortions and the illegality of pre-selection of sex followed by abortion.
- Statutory laws, e.g. the MTP Act (1972) and the PNDT Regulation and Prevention of Misuse Act (1994), need to be strictly enforced. Law-enforcing agencies, in partnership with community-based groups, and social service organisations, should take measures to identify offenders and proceed with a logical follow up in the court of law.
- Advocacy initiatives should be aimed to build up alliances among all partners for social mobilization to eliminate this practice and to also facilitate implementation of laws. Professional associations should be seen as important partners for self-regulation and also bringing peer pressure on those who continue to violate provisions of Act.

Incidence of unsafe abortions, especially in adolescents

- 60,00,000 Indian women a year still resort to illegal abortions.
- Accounts for up to 13% of all maternal deaths and 50% of all maternal deaths in the 15-19 age group.
- 38%-68% of abortion complications are in women under 20 years of age.

Handout VII

Factors contributing to Unsafe Abortions in Adolescents

Various factors contribute to the extent and severity of post abortion complications:

a. Delay in seeking care
b. Negative attitudes of trained providers
c. Resorting to untrained providers
d. Use of dangerous methods
e. Laws relating to abortion
f. Service-delivery factors.
g. Complications following spontaneous abortions

a. Delay in seeking abortion is the most important factor and the commonest cause of complications and death among adolescents. Delay is again due to ignorance (Not aware that pregnancy has occurred) or hoping to hide pregnancy till it becomes too late or the costs involved.

b. The judgemental and unwelcoming attitudes of health providers can also lead to delay in reaching them.

c. It is commoner among adolescents to go to untrained and unskilled providers especially when they are unmarried or the pregnancy is unintended and adolescent wants to get rid of it clandestinely (without informing the in-laws). The younger they are, it is more likely that they will be forced to opt for a potentially unsafe abortion conducted in an unhygienic condition by unskilled provider.

d. Use of dangerous methods are also common in adolescents especially unmarried girls who are advised by mothers, untrained birth attendants, quacks, to insert foreign bodies into the cervix unhygienically or ingest certain potions or drugs.

e. There is general lack of awareness among adolescents about the 'Medical Termination of Pregnancy' that can be availed of in all District Womens' Hospital and PHCs. These latter are however, inaccessible because of the family's need for secrecy and confidentiality and bowing to societal and community demands.

f. At present, health facilities do not offer user-friendly abortion services and some are not themselves aware of the rights of clients to these. Most clinets feel that privacy and confidentiality is difficult to be maintained in public system.

g. Even after a spontaneous abortion, an adolescent may have post abortion complications, if the abortion is not complete or some infection has set in due to retained products of conception and unhygienic practices of perineal region.

The extent of problems related to unsafe abortion among adolescents varies from state to state and within communities and depends on whether:

- Reproductive health information and services are available and accessible to adolescents;
- Early and safe abortion services are available and accessible;
- Health-care providers are sensitive and non-judgemental towards adolescents;
- Community and societal norms permit frank discussion about sexuality matters in adolescents;
- National law and policy makers ensure the dissemination of adequate knowledge related to reproductive health information and services.

Complications of Unsafe Abortions

Complications due to unsafe abortions are high for all women, the adolescent group is especially at risk. Within this group, those who are very young, who are primigravida and the very poor are even worse off. These complications can be categorised as medical and psychological complications.

- **Medical complications**

  The major short-term complications range from cervical or vaginal lacerations, pelvic infection or abscess, sepsis, haemorrhage, perforation of the uterus or bowel, intrauterine blood clots to tetanus and death. Post-abortal sepsis can rapidly develop into septicaemia. Haemorrhage is common and leads to or aggravates pre-existing anaemia. Both septicaemia and anaemia are common causes of death, especially in the immediate absence of antibiotics and safe blood. Even spontaneous abortions may lead to complications like incomplete abortion, infection, septicemia and haemorrhage.

  The major long-term medical complications (more than a month after the procedure) include secondary infertility (Akin to a life sentence in a society that equates a woman's worth with her ability to bear children), spontaneous abortion in subsequent pregnancy, and an increased likelihood of both ectopic pregnancy and pre-term labour.

- **Psychological Complications** - Guilt and depression.

Consequences of unsafe abortions

- **Medical consequences**

  Major emergency surgical interventions are often required and these are either not available or not accessible to the disadvantaged sections of society. Thus, in many cases, the unfortunate adolescents who are forced to resort to unsafe abortions, end up dying at a very young age or live with severely damaged reproductive tracts.

- **Psychological consequences**

  Within the confines of an unforgiving and rigid society, there is no psychological support for the adolescent recently traumatized by an unsafe abortion. In fact, even health providers do not see the need for this kind of a support. The girl is left alone in her misery, confusion and ignorance and guilt can set in compelling her to resort to risky behaviour and even suicide.

- **Socio-economic consequences**

  Girls who survive unsafe abortions face a range of social problems, from disapproval, rejection, even ostracism, from their families and communities. They can be thrown out by their families and forced into prostitution. Their options become very limited.

  The family faces grave economic consequences of unsafe abortion and is at times, reduced to bankruptcy and ruin.

Handout VII

Diagnosis and Management of Unsafe Abortions

The diagnosis of unsafe abortion or its complications should not differ between adolescents and adult women and history of missed menstrual period(s) followed by an attempt to terminate the pregnancy should be sought. The girl is usually brought to the health facility, bleeding from the vagina and going into shock.

Unlike adult women, adolescents (particularly very young girls) are often not willing and sometimes not able to give an accurate history. This is especially so when they are accompanied by their parents, relatives or other persons because of fear and embarrassment at having had sexual relations.

Compared with adults, adolescents with an unsafe abortion are more likely to:

- Be unmarried
- Be primigravida
- Have a longer gestation up to the time of abortion
- Have used dangerous methods to terminate pregnancy or ingested substances that interfere with treatment
- Have resorted to illegal providers
- Come to the health facility alone or with a friend
- Delay seeking help and therefore have more entrenched complications.

It is important for ANMs/LHVs to bear in mind that unwanted pregnancy may be the real problem, though other symptoms may be reported, and they should observe the adolescent's condition and behaviour carefully. This will assist in ensuring that the diagnosis of unsafe abortion is not missed. It would be important to employ a gentle, reassuring manner, and to tactfully ask the girl's parents or guardians to wait outside the consulting/examining room. This will enable the health-care provider to have a private and confidential conversation with the girl.

The clinical presentation will obviously depend on the condition of the patient. In case infection has set in, the adolescent is likely to have fever and dehydration. The other likely clinical signs are: a swollen, tender abdomen, bleeding and foul-smelling discharge from the vagina, with some products of conception still in the uterus and/or vagina. In case treatment has been delayed, the adolescent is likely to be in shock with impending respiratory and circulatory failure.

The management is based on the following principles:

- *Emergency resuscitation* may be necessary as many adolescents present in shock. Sub-centre ANMs should refer such cases immediately to a PHC with facilities of emergency obstetric care (EmOc) or district women's hospital. ANMs at PHCs with EmOc facilities can inform the doctor and other team members to provide care and/or referral to district hospital
- *Evacuation of the uterus* is necessary to remove all the products of conception for inevitable or incomplete abortion. Refer the client immediately to district hospital

In the second trimester, the risk of complications is higher. Because delay is so characteristic of adolescent abortion patients, many second trimester abortions are carried out in this age group.

- *Management and prevention of further complications* such as infection and injury is the need of the hour. Complications are more frequent and more severe in the case of self-induced abortions or those where foreign bodies have been inserted.
- *Arrangements for post-abortion care* should be thought of since such adolescents usually do not return for follow up. Establishing a good rapport with the patient and attendant/s and providing relevant information will facilitate a repeat visit. The patient must be given information on danger signs to look out for, such as fever and chills, nausea and vomiting, abdominal pain and backache, tenderness to pressure in the abdomen, heavy bleeding and foul-smelling vaginal discharge. She must also be provided with information on contraception for well-informed decision-making and use.

Handout VII

Prevention of Unsafe Abortions

Adolescent with unwanted pregnancies continue to resort to abortion, whether or not it is safe, putting their lives at great risk. Prevention of such pregnancies must therefore be one of the key objectives in any reproductive health programme.

All stakeholders like family elders and decision makers, communities, health-care providers, governments, etc should make all efforts to:

- **Improve access to reproductive health information and services**

  The need to improve adolescents' access to reproductive health information and services is of prime importance to give sexually active adolescents the right to a range of options. The contribution that emergency contraception could make in preventing unsafe abortion needs to be clearly spelt out and adolescents need to know that this method is available, and where it could be obtained when needed.

- **Address laws and policies on access to safe abortion services**

  Even in our country where abortion is legally available on demand, women (especially adolescents) experience difficulties in exercising their right to obtain these services. The reasons for this include an insensitive environment that cannot ensure confidentiality and non-judgemental behaviour, complicated administrative requirements, etc. Government authorities must emphasise the role that health-care providers have in the provision of abortion services.

- **Train health-care providers in comprehensive abortion care**

  ANMs/LHVs need to be trained in essential abortion care so that they can recognize the signs and symptoms of abortion-related complications early and counsel for prompt and appropriate referral to a district women's hospital or a CHC. They also need to be introduced to the concept of post abortion counselling. To be able to learn the latter, they need to examine their attitudes and beliefs, in order to prevent their own biases from hindering the provision of care.

  ANMs/LHVs are often faced with a dilemma because, though medical termination of pregnancy is legal, very often the adolescent patients are minors and need consent of parent, husband or guardian. Clear guidelines need to be issued for the management of post abortion complications due to unsafe abortion in the above context.

  ANMs/LHVs have a very important role to play in the communities they serve in providing safe abortion services to adolescents. First, however, they must overcome the barriers in their own minds about supporting and counselling (even the unmarried and girls from marginalised section of society) and providing the best counselling and support they can offer. They must work as 'Change-agents' and involve communities in discussions on unwanted pregnancy, unsafe abortion and its consequences. Their contribution could protect and safeguard the adolescents.

SUMMARY

- Adolescent pregnancy is common in India
- Many factors contribute to adolescent pregnancy
- Adolescents have higher maternal mortality than adults
- Their babies also have higher mortality
- Many of the complications during pregnancy and delivery have worse outcomes in adolescents
- There are important issues for health-care providers to be aware of in caring for adolescents throughout pregnancy, labour, delivery and the postpartum period
- Promoting safe pregnancy and childbearing in adolescence requires concerted actions beyond the health sector, like increasing the social and nutritional status of girls and increasing their access to education and job opportunities
- Illegal and unsafe abortions are common among adolescents in many countries.
- Unsafe abortion implies interference of pregnancy by persons without the necessary knowledge and skills, or in conditions that are not conducive to good health. It can be within or outside of the law.
- Adolescents opt for abortions because of socio-cultural and/or socio-economic reasons.
- Adolescents undergoing unsafe abortions tend to be single, pregnant for the first time and usually obtain their abortions later in their pregnancies than adult women.
- They are more likely to have resorted to illegal providers and to have used dangerous methods for inducing abortion.
- They tend to present later, and with more entrenched complications.
- They tend to face more barriers than adults, in accessing and using the health services they need.
- They are less likely to come for post treatment follow-up.
- The management of post-abortion client should include management of complications, post-abortion counselling, addressing contraception and other issues.

Handout VII

Annexure 1: Role Play Scenarios
Session 5, Activity 2

Scenario 1

During an OPD session, a 16-year-old unmarried girl is brought by her mother for a check up. She has been keeping unwell for a few weeks with occasional bouts of vomiting, especially in the morning. She seems to be the youngest among all the patients waiting there.

You do a check up and find that the girl is twelve weeks pregnant.

- **How would you break the news to the mother and daughter?**
- **What actions will you take to promote the health of the pregnant girl?**

Scenario 2

A 17-year-old pregnant girl is brought to you by her mother-in-law for an antenatal check up. The ANM/LHV finds that her nails and conjunctivae are very pale.

- **How would you manage the case?**

Scenario 3 **PNC with engorged breasts**

During her field visit, an ANM visits the home of Radha, a 15-year old girl who has delivered a baby girl a few days ago. She has engorged breasts.

- **How would you counsel her?**

Contraception for Adolescents

Handout VIII

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Handout VIII

Why Adolescents need Contraceptive Methods

Contraceptive use among adolescents

Most adolescents begin their sexual activity without adequate knowledge about sexuality or contraception or protection against STIs/HIV. In India, though adolescent marriages are very common in rural areas, the couple is less likely to use contraception than adults. Most women who marry young have the first child early.

For unmarried adolescents it is sometimes impossible to access contraceptives and the sexual activity often results in unintended pregnancy.

Whether married or unmarried, adolescents face potentially serious physical, psychological and social consequences from unprotected sexual relations, ranging from early and unwanted pregnancy and childbirth, unsafe abortion to STIs including HIV/AIDS. The consequences can also be far reaching and affect their entire life chances and options, especially in the case of girls.

Barriers to contraceptive use among adolescents

The barriers that adolescents face in accessing contraceptives are*:*

- The unexpected and unplanned nature of sexual activity
- Lack of information and knowledge about conception and contraceptives and their availability.
- Fear of medical procedures
- Fear of judgemental attitudes of providers
- Inability to pay for services and transport
- Fear of opposition from partner or parents
- Pressure to have children.

There is much that can and must be done to address these and other barriers.

In general, adolescents lack information about sexuality and specifically about contraception. Health-care providers are unaware and insensitive to the special needs of adolescents. This latter group needs to overcome its own attitudes and moral and tradition-related biases and respond to the special needs of adolescents by designing and reorienting health services to meet those needs.

Health care providers need to also be aware of gender inequalities that alienate and marginalize adolescent girls in their communities and prevent them from seeking technically skilled care. Violence, as in domestic abuse or sexual exploitation often come in the way of women and reproductive health services.

Providing Adolescents with Information and Education on Sexuality and contraception

In a country like ours where tradition and societal norms are very rigid, education on sexuality and reproductive health for adolescents has not spread beyond a handful of enlightened schools and individuals because of concerns that such knowledge would lead to promiscuity. On the contrary, failure to provide adolescents with appropriate and timely information represents a missed opportunity for reducing the incidence of unwanted pregnancy and STIs and their negative consequences.

Sexual and reproductive health education needs to be formalized and tailored to suit the needs of adolescents who have not begun sexual activity, and those who are already sexually active. Research into the sexual and reproductive health of young people clearly points to the fact that information provision and education alone do not necessarily lead to behaviour change. Increasing awareness and understanding is only the first step in preventing unwanted pregnancy and STI/ HIV. Also, adolescents must know where to locate such services.

ANMs/LHVs should involve important members of the community such as school teachers, influential elderly ladies and men, local pharmacist, youth leader to help promote information and education on sexuality and contraception during any informal contact they have with adolescents or their parents. For this you can hold meetings with these "gate keepers" to sensitise them to contraceptive needs of the adolescents.

Handout VIII

Providing Adolescents with Contraceptive Services

Health care providers can contribute as change-agents within the families and communities to address these issues, thus preventing the consequences of too early and unprotected sexual activity in this group.

Dual protection provided by available contraceptive methods

Some adolescents are at a higher risk of STIs/HIV because of their sexual behaviour (like having multiple partners) and they specially need to be aware of the dual protection against both pregnancy and STIs/HIV offered by certain contraceptives.

When used correctly, male condoms are the most effective method of preventing STIs/HIV/AIDS and pregnancy. Another way of simultaneous protection against both pregnancy and STIs is the 'Dual use method', i.e. use of condoms along with another method such as combined oral contraceptives or injectables.

The following **Table 1** lists the effectiveness of the available contraceptive methods in preventing pregnancy and in providing protection from STIs/HIV.

TABLE 1
Contraeption Methods

Method	Effectiveness against pregnancy		Protection against STI/HIV	Comments & Considerations
	As commonly used	Used correctly and consistently		
Abstinence and non-penetrative sex	Not effective	Very effective	Protective	Most protective method for dual protection but needs to be used correctly and consistently
Male condom	Somewhat effective	Effective	Protective	Only provides limited dual protection when used correctly and consistently.
Female condom	Somewhat effective	Effective	Protective	Only provides limited dual protection when used correctly and consistently.
Spermicides	Somewhat effective	Effective	Somewhat protective	Only provides limited dual protection when used correctly and consistently.

Combined oral pills	**Effective**	**Very effective**	**Not protective**	**Only protective against pregnancy if used correctly and consistently. If at risk of STIs/HIV, recommend switching to condoms or using condoms along with this method.**
Fertility awareness based methods (Standard Days Method)	**Somewhat effective**	**Effective**	**Not protective**	**Only protective against pregnancy when used correctly and consistently. If at risk of STIs/HIV, recommend switching to condoms or using condoms along with this method.**
Lactational amenorrhoea – LAM (During first 6 months postpartum)	**Effective**	**Very effective**	**Not protective**	
Withdrawal	**Somewhat effective**	**Very effective**	**Not protective**	
IUCD (Copper T)	**Very effective**	**Very effective**	**Not protective**	**IUCD not first method of choice for nulliparous women. Not recommended for women at risk of STIs/HIV, unless other methods are not available.**
Emergency contraceptive Pills	**Effective**	**Very effective**	**Not protective**	**Only protective against pregnancy when need correctly and consistently**

Emergency Contraception

Progestin only OCPs containing the hormone levonergstrel can be used for emergency contraception. If the correct dose is started within 72 hours after unprotected intercourse, it reduces the chances of pregnancy. Now oral contraceptives are being packaged as emergency contraceptive pills, and levonorgestrel-only tablets are more effective and cause less nausea and vomiting. Emergency contraception has a special role for adolescent girls and women who are subjected to sexual violence, to prevent unwanted pregnancies. There is a need to increase access to ECPs by training healthcare providers and also by ensuring easy availability of ECPs. All adolescents are eligible for ECP, without restriction on repetative use.

Handout VIII

Counselling

Adolescence is a critical period in an individual's life when at the threshold of adulthood, they experiment with new behaviours, and struggle with issues of independence, and peer group pressure.

The first step towards counseling adolescents is to develop a rapport with them and also speak in a language they understand. A supportive and non-judgemental environment, where confidentiality is ensured, is essential but is easier said than done. Health-care providers need special training in sexuality counselling skills so that they can deal with the needs, concerns and problems of adolescents. They also need to overcome their own barriers about sexual behaviour, morality, etc.

The special needs adolescents may have include bodily changes, information regarding 'Normal and abnormal' feelings and actions. Service providers who are not comfortable discussing these issues with adolescents, should refer them to those who are.

Counselling should cover responsible sexual behaviour and needs to be directed at both males and females. Male adolescents should be encouraged to share the responsibility for contraception and STI/HIV prevention with their female partners.

While adolescents may choose to use any contraceptive method available to them, some may be more appropriate for a variety of social and behavioural reasons. Many of the needs and concerns of adolescents that affect their choice of a contraceptive method are similar to those of adults seeking contraception. For example, using a method that does not require a daily regimen, such as oral contraceptive pills do, may be a more appropriate choice for an individual.

In helping an adolescent make a choice of which method to use, health-care providers must provide them with information about the methods, and help them consider their merits and demerits. In this way, they could guide their adolescent clients to make well-informed and voluntary choices of the method that is most suitable to their needs and circumstances (taking eligibility, practicality and legality into consideration).

Available Contraceptive Methods

- Abstinence and non- penetrative sex
- Fertility awareness based methods
- Lactational amenorrhoea
- Withdrawal
- Male condom
- Combined oral pills
- IUCD
- Emergency Contraceptive Pills (ECP) (both combined oral pills and Levonorgestnel pills)

Age does not constitute a medical reason for withholding the provision of any method. However age is a factor to be taken into account when considering the use of three methods:

- **Sterilization:** This is not a procedure that is recommended for a young woman or man.
- Progestin-only injectables (such as Depomedroxy Progesterone Acetate (DMPA), and Norethisterone Enanthate (NET-EN)) are not the first method of choice for those under 18, as there is a theoretical concern that bone development could be hindered.
- Intra-Uterine Contraceptive Devices (IUCD) are not the first method of choice for those under 20, as the risk of expulsion is higher in young, nulliparous women.

The information provided should address the following issues:

- Effectiveness of the method
- Information on protection against STIs/HIV
- Common side-effects of the method
- Potential health risks and benefits of the method
- Information on return to fertility after discontinuing use of the method
- Where the method can be obtained and how much it costs.

After a method is chosen, it is also important to discuss correct use of the method and follow-up information, such as signs and symptoms that would necessitate a return to the clinic.

It is important to remember that even if married, adolescents may have other special information needs.

They may be particularly concerned about their return to fertility after discontinuing use of a method. Most women would be under considerable pressure to have children, and thus may want to keep their contraceptive use private from their spouse or in-laws.

Unmarried adolescents will be less likely to seek contraceptive services at health facilities because of the need for secrecy and fears that the staff may be hostile or judgemental. For those who do seek contraceptive services, it is important to discuss abstinence or non-penetrative sexual activity as options, even with those who have already had sexual intercourse. With support, individuals can delay sexual activity until they are older, and thus be better able to deal with its social, psychological and physical implications. This requires commitment, high motivation, self-control and negotiation skills.

For the unmarried, condoms alone or in combination with another method – are the best recommendation and are easily available.

Handout VIII

Adolescents who are coerced into having sex

Adolescents who have been subjected to sexual coercion and abuse will require special care and support. Emergency contraception is part of a package of services that should be made available in such circumstances. Health-care providers need to be sensitive to these issues. They must also be well aware of how to access the health and social services that these adolescents may need.

SUMMARY

- Most adolescents enter their reproductive years with no knowledge of how to protect and safeguard their sexual and reproductive health.
- Access to appropriate information and services with confidentiality is absolutely necessary for all adolescents, especially those who are unmarried.
- To help ensure contraceptive use among sexually active adolescents, information and services must be made easily available through community based facilities and outreach services.
- By providing the above-mentioned contraceptive services that respect adolescents' rights and respond to their needs, the community and society at large will be benefited immensely.

Annexure 1: Role Play Scenarios
Session 3, Activity 2

Scenario 1

Raju, an 18-year-old boy comes to your sub-centre. He tells you that he does not feel well, he feels very weak. Apparently, you find Raju to be of a good built and healthy. He looks a little apprehensive and anxious. You understand that may be Raju has some other problem and is not telling it openly. You ask further questions about his family and his neighbours. You can see Raju getting more relaxed and free in his communication. Then you ask him again that what is Raju's real problem. Shyly, he says that he and Rani his neighbour's daughter are friends. Sometimes, they manage to have sexual relations also. Raju tells you that he is worried that some day Rani may get pregnant. He does not want this to happen as he loves Rani very much and does not want to harm her. Raju, requests you for some advice to prevent pregnancy.

What will you now say to Raju and how will you go about to help him?

Scenario 2

Champa, a girl aged 19 and her husband, Raghu, aged 21 come to the sub centre. They tell you that they have been married for 2 years and that Champa has recently given birth to a daughter. They tell you that they do not wish to have another child for the next 3 years and want to adopt a safe contraceptive method.

How will you repond to their need?

RTIs, STIs and HIV/AIDS in Adolescents

Handout IX

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Handout IX

What are Reproductive Tract Infections (RTIs)

RTIs include all infections of the reproductive tract, whether transmitted sexually or not, for example, Bacterial Vaginosis or Candidiasis which are caused by a disturbance in the equilibrium of the vaginal flora or Pelvic Inflammatory Disease caused by iatrogenic infection (infections introduced or contacted at a health facility during a clinical procedure). These are examples of reproductive tract infections that have not been sexually transmitted. On the other hand, pathogens like which are commonly transmitted by sexual contact (Human Immune Deficiency Virus, Hepatitis -B, C, D, etc.) do not always or at all cause an infection of the reproductive tract.

RTIs can also be iatrogenic infections (e.g., infections introduced to the reproductive tract by use of unclean hands and instruments during delivery, IUD insertion, abortion or medical and surgical procedures, etc.)

What are Sexually Transmitted Infections (STIs)?

Sexually Transmitted Infections (STIs) refer to infections transmitted from one person to another primarily by sexual contact. Some STIs can be transmitted by exposure to contaminated blood, and from a mother to her unborn child.

STIs are among the most common illnesses in the world, and have far-reaching health, social and economic consequences for millions of men, women and infants.

In addition to their sheer magnitude, the incidence and prevalence of STIs among adolescents is increasing in both developed and devloping countries. This is a major public health problem for two reasons:

- STIs result in serious negative medical and psycho-social effects in the infected invidual. In case of infected females, there is the added risk of infection and illness in the unborn child.
- STIs, especially those with genital ulcers, facilitate the transmission of HIV between sexual partners. The prevention and treatment of STIs therefore needs to be a key component of a strategy to prevent the transmission of HIV.

The four most prevalent STIs are chlamydial infection, gonorrhoea, syphilis and trichomoniasis. These STIs can be prevented and cured provided that adequate antibiotics are availale and standardised treatment protocols are employed.

Symptoms of RTIs/STIs

Some of the symptoms in an adolescent who seeks advice either from a health centre could be:

- For both adolescent boys and girls:
  - Genital ulcers (sores)
  - Burning sensation while passing urine
  - Swelling in the groin
  - Itching in the genital region
  - Pain during sexual intercourse
- For adolescent girls:
  - Unusual vaginal discharge
  - Pain in lower abdomen
  - Change in menstrual flow
- For adolescent boys:
  - Discharge from the penis

Why adolescent boys and girls more prone to STIs?

In today's world, adolescents face heightened risks of exposure to STIs. In many societies, sexual activity begins during adolescence, either within the context of marriage or - increasingly - before marriage occurs.

Sexual relations during adolescence are often unplanned and sporadic, and sometimes the result of pressure, coercion or force. Adolescents start sexual activity before they have:

- Experience and skills in self-protection.
- Adequate information about STIs and how to avoid contracting these infections.
- Access to preventive services and protective supplies (such as condoms).

Adolescent girls are thought to be more susceptible to STIs than adult women because of both biological and social reasons:

- Protective, hormonally-driven mechanisms have not yet had time to develop fully. The inadequate mucosal defence mechanism and the immature lining of the cervix in adolescence (especially in early adolescence) provide a poor barrier against infection. Further, the thin lining and the relatively low level of acidity in the vagina render it more susceptible to infection.
- Because of financial pressures, young women - and even girls - are forced to sell sex for favours or for cash to pay for school fees or to support their families.

Adolescent boys in many cultures feel they have to prove themselves sexually; to indicate this graduation to adulthood. Studies confirm that adolescent boys and young men often have high rates of STIs, and that they frequently ignore such infections, or rely on self-treatment.

In addition to increasing the risk of STIs, unprotected sexual activity increases the risk of other reproductive health problems such as too early, unwanted pregnancy and unsafe abortion.

Factors that increase risk of RTIs

- Poor general health
- Poor genital hygiene
- Poor menstrual hygiene in girls
- Unhygienic practices by services providers during delivery, abortion or IUD insertion.

Factors that increase risk of STIs

- History of unprotected sexual activity in the recent past
- Having sex with partner having sore on the genital region or urethral or vaginal discharge
- Multiple sexual partners

Handout IX

What are the consequences of STIs among adolescents?

The consequences of STIs contracted during adolescence are more severe than in adults. This is especially true in the case of female adolescents.

Consequences of STIs for adolescents

- Pelvic inflammatory disease (PID): Chlamydia infection during adolescence is more likely to result in (PID) and its complication (such as infertility);
- Cancer of the cervix: exposure to infection (such as Chlamydia and Human Papilloma virus) during adolescence is more likely to result in cancer of the cervix;
- Tertiary Syphilis: Heart and brain damage as a long-term consequence of an untreated Syphilis infection;
- Stigma and embarrassment associated with STIs can impair psychological development and attitudes towards sexuality later in life
- 8-10 times more risk of HIV
- Bad outcomes of pregnancy

Prevention of RTIs/STIs

- Maintaining proper genital hygiene is important. Girls should also maintain good menstrual hygiene.
- Practicing responsible sexual behaviour. Being faithful to one partner.
- Practicing safe sex
- Avoiding sexual contact, if either of the partner has an STI
- By not neglecting any unusual discharge
- Ensuring complete treatment of self and sexual partner (partner treatment)
- Opting for institutional delivery or home delivery by a trained birth attendant
- Availing safe abortion services

What are the main factors thathinder a prompt and correct diagnosis of STIs in adolescents?

Adolescents often lack information about the services that are available. For example, they may not know of existing services, where and when they are provided or how much they cost. Even if they have this information, they are often reluctant to seek help for diagnosis and treatment because of embarrassment, because they do not want to be seen by people they may know, and because of fear of negative reactions from health-care workers.

In many countries adolescents with STIs go to traditional healers or buy remedies from street vendors. This is likely to result in improperly and inadequately treated infections. The symptoms and signs of some STIs disappear without treatment; in these situations, adolescents may believe that the disease has resolved spontaneously when in fact it has not done so.

STIs may be asymptomatic, especiallly in young women. Adolescents may not be aware of the differences between normal and abnormal conditions (such as normal and abnormal genital discharges), and hence do not seek help. Asymptomatic and mildly symptomatic STIs are likely to be missed when health-care providers apply the syndromic approach for diagnosis and management. Symptomatic STIs may also be missed if health-care providers do not have adequate skills to undertake a clinical examination or to elicit the needed information from adolescents who are not fully knowledgeable about their bodies.

What are the main factors that could hinder the effective management of STIs in adolescents?

As indicated above, adolescents may be reluctant to use services due to factors such as inadequate information, difficulties in accessing services, and lack of money to pay for them. They often tend to self-mediate when they believe that they have exposed themselves to the risk of an STI.

Adolescents often have difficulty in complying with treatment because it may be lengthy (e.g. in the case of chlamydia) or painful (e.g. in the case of venereal warts), and sometimes they need to conceal medication so that the STI is not revealed to others. In many places, medicines for the treatment of STIs can be bought at pharmacies, without a prescription, they can also be bought from vendors in a market. It is therefore important for the health-care worker to ascertain if the adolescent has tried/taken any medication for the STI, before coming for help.

Main issues: Adolescents by nature are

- Shy not wanting to discuss personal matters
- Embarrassed to seek help
- Worried about the news to leak
- Anxious because of serious consequences
- Defensive about being in unfamiliar atmosphere
- Inadequate to describe the condition
- Marginalised

Handout IX

HIV/AIDS

HIV stands for :

Human

Immunodeficiency

Virus

AIDS stands for

Acquired : Not genetically inherited but get it from some body

Immuno-deficiency: Inadequancy of the body's main defence mechanism to fight external disease producing organisms

Syndrome : A group of disease or symptoms

AIDS results from infection with HIV, which stands for human immuno-deficiency virus. HIV gradually destroys the body's capacity to fight off infections by destroying the immune system. As a result a routine infection can turn life threatening, as the body is not able to produce antibodies to protect against them. The HIV infected person becomes more susceptable to a variety of infections known as opportunistic infections like tuberculosis.

HIV can be transmitted through

- Different forms of sexual contract including unprotected anal, vaginal or oral sex.
- From an infected mother to her child (MTCT) during pregnancy, delivery, or breastfeeding.
- Sharing of infected syringes and needles contaminated with infected blood and other body fluids, such as injectibe drug users, use of contaminated skin-cutting tools, needle stick injuries in health care settings.
- Transfusion of infected/unsafe blood or blood products.

The most commong route of transmission in our ocuntry is through the sexual route and about 85% of cases have acquired HIV through this mechanism. However, in north eastern India, the epidemic is mainly among intravenous drug users.

Diagnosing HIV infection

It is not possible to tell whether or not a person has HIV/AIDS by the way he or she looks and acts.

Sometimes, it is possible to suspect this infection from the presence of certain symptoms either in isolation or in combination. However, these cannot be relied upon solely for the diagnosis, as they are usually nonspecific and common to other illnesses as well.

Signs and Symptoms of AIDS

Some of the salient features of AIDS besides signs and symptoms of specific opportunistic infection:

- An unexplained loss of weight lasting at least one month
- Diarrhoea lasting for more than 1 month
- Intermittent or constant fever for more than 1 month
- A cough that persists for more than one month
- Enlarged glands (lymph nodes) in the neck, armpits, or groin

Only a laboratory test can confirm the presence of HIV

Knowing one's HIV status enables an indivdual to make informed decisions about treatment and care and learn how to avoid passing the infection on to others. Many people infected with HIV have no symptoms, and, therefore, there is no way of knowing with certainty that the person is not infected unless he or she has repeatedly tested negative for the virus - and has not engaged in any risky behaviour between tests.

ELISA test is the most common screening test used for initial testing. Whenever, this screening test is positive, a confirmatory test is done. The Western blot is used to confirm screening tests results. Both these tests detect the presence of antibodies against HIV.

Sometimes it is possible to test negative in the very early stages of HIV infection. This period is called the 'window period'. This is because the test is looking for antibodies that have not yet developed. In this case the test should be repeated after a duration of three months.

Maintaining confidentiality of test results is of utmost importance because disclosure of a person's staus may be detrimental not only for the individual concerned but also for the people around him such as their family members. They may be alienated or stigmatised due to the lack of accurate information as well as the prevailing myths and misconceptions about the infection in the society.

Testing must always be voluntary and with informed consent of the client. Pre and post-test counselling are an integral part of testing. Such voluntary counselling and testing services are now available free of cost at many government health facilities.

Voluntary Counselling and Testing (VCT)

HIV voluntary Counselling and Testing (VCT) has shown as positive role in both HIV prevention and as an entry point to care. It providers people with an opportunity to learn and accept their HIV resostatus in a confidential environment. VCT is a relatively cost-effective intervention in preventing HIV transmission. Improving information to advocate the benefits of VCT and raising community awareness will contribute greatly to promote utilization of this service. The NACO has plans for the expansion of HIV testing facilities in each district of the country in a few years. HIV testing services address multiple needs and rights of individuals at risk or already infected so that effective counselling, condom supplies and peer and community support are also available. Such efforts to reduce stigma and discrimination will normalize community perceptions of HIV infection and AIDS, and make counselling services available to all who seek them, regardless of their willingness to be tested.

Counselling guidelines clearly state that no HIV testing is to be undertaken without pretest and post test counselling. Therefore, counselling services have to be improved bearing this issue in mind. Voluntary HIV counselling and testing is the process by which an individual undergoes counselling enabling him or her to make an informed choice about being tested for HIV. This decision must be the choice of the individual and he or she must be assured that the process will be confidential. However, in concurrence with the Supreme Court decision, Partner notification is necessary and this makes it imperative for the attending physician to disclose the HIV status to the spouse or sexual partner of the person. Inspite of this all efforts must be made to counsel the person for disclosure of HIV status to the spouse or sexual partner.

Handout IX

Benefits of VCT

The potential benefits of VCT are:

- Improved health status through good nutritional advice.
- Earlier access to care and treatment
- Prevention of HIV related illness
- Emotional support
- Better ability to cope with HIV related anxiety
- Awareness of safer options for reproduction and infant feeding.
- Motivation to initiate or maintain safer sexual practices.
- Motivation for drug related behaviour
- Safer blood donation

Care and support for people living with HIV/AIDS (PLWHAs)

The HIV positive person should be guaranteed equal rights to education and employment as other member of the society. HIV status of the person should be kept confidential and should not in any way affect the fundamental rights of the person.

PLWHAs should be provided a continuous of comprehensive care comprising of clinical management of common illnesses, access to drugs, counselling and psychosocial support through home based care without any discrimination. Resources in the community, NGOs support should be mobilized for this purpose. Family of the PLWHAs should be counselled how to take care of the patient in terms of good sanitation, nutrition, promoting physical activity and providing psychosocial support..

Annexure 1: Role Play Scenarios Session3, Activity 2

Role Play 1

Deepak, a 16-year-old boy is brought to you by his mother. She says that he told her that he had been injured in his groin, playing football with his friends. You notice that the boy is silent and does not interrupt his mother, or add to anything that she says. You tell the mother that you would like to talk to Deepak separately. Taking him to another room, you ask Deepak what the problem is? The boy is silent. After a few minutes, you gently probe once again. He replies in a low voice and asks you to promise not to repeat anything he says to his mother. He tells you that he had once visited the local sex workers. After some days, he is he having itching in the groin and discharge from his penis. He is afraid now that something bad may happen to him and he will be punished by his parents if they come to know about what he had done. Deepak also tells you that he feels ashamed now to meet his friends also.

How will you deal with Deepak and his mother?

Role Play 2

Pramod, a 19-year-old boy comes to you with a urethral discharge. He tells you that he has been suffering from this, on and off, for a year. He knows that this is an STI, but does not seem very concerned about it. On enquiry, you learn that the young man got married to a 16 year old girl 3 months ago.

How would you deal with this situation?

Role Play 3

Laxmi, a 17-year old married girl comes to you with her mother. She complains of itching and genital discharge for the last 2 months. Laxmi reveals that her husband works in the city. Two months ago, he came home to the village for 10 days. Her complaint started soon after his visit.

How would you deal with the situation?

Concluding Module

Handout X

CONTENTS

Handout X

How to make my workplace Adolescent Friendly?

Making a Plan of Action

Purpose

The purpose of this exercise is to help one with designing the outline of a personal plan to improve one's work for and with adolescents. The plan incudes the following elements:

- The proposed changes one intends to make;
- The importance of the proposed changes;
- How to assess whether or nor one is successful in making these changes;
- The personal and professional challenges and or problems one may face in making these changes ;
- The ways in which these challenges and or problems may be addressed assistance requaried

General instructions

- Please use the tables entitled *"Plan of Action",* which appear on the following pages, to record five changes you intend making in the way you work with or for adolescents.
- Please designate one sheet for each change you intend to make. This way you will have extra writing space.
- For each change you propose in column 1, complete columns 2,3,4 and 5.
- In monitoring your own change and application of this plan, it would be useful to set yourself target dates to review your progress your plans.

Under the RCH-2 Programme, a frame work is proposed for operationalising ASRH Services within the context of the Public Health System. Actions are proposed at the level of sub-center, PHC and CHC through routine OPDs and a dedicated once a week teen clinic for few hours at the PHC.

Proposed Service delivery provision at the level of sub center & PHC/CHC			
Level of care	Service provider	When	Services
Sub-Centre	• HW (F)	During routine sub center clinics	• Enroll newly married couples • Provision of spcaing methods • Routine ANC care and institutional delivery • Referrals for early and safe abortion • STIs/HIV/AIDS prevention education • Nutrition counselling including anaemia prevention
Primary Health Centre/ Commu-nity Health Centres	• Health Assistant (F)/LHV • Medical Officer	Once a week: teen clinic will be organised at PHC for 2 hrs	• Contraceptives • Management of menstural disorders • RTI/STI preventive education and management • Counselling and services for services termination • Nutritional counselling • Counselling for sexual problems

We wish you all success in your endeavours to improve your work with and for adolescents.

PLAN OF ACTION (An Example)

Column 1	**Column 2**		**Column 3**		**Column 4**	**Column 5**	
The changes I plan to make in my every day work with or for adolescents.	Why is this change important.		Measuring the extent of success of this change.		Challenges and/or problems anticipate in working with adolescents.	Assistance	
	Who/what will benefit?	Why?	How to measure?	When to measure?		Assistance required	Source
1. Contact the local schools to provide information on the new adolescents-friendly health services being provided by our clinic.	Students in local schools. Friends of students, and family members of school staff who are not in local schools.	They will find it easier to obtain the services they need. — " —	A steady increase in the number of students who come to the clinic to obtain services.	Six months after making contact with the schools.	Lack of interest from the school principal. Resistance from the teachers.	Support from the block education authority. A meeting to convince them of the value of this work.	The MO of the PHC could request this. Village Leaders parents and inflential people .

PLAN OF ACTION

Column 1	Column 2		Column 3		Column 4	Column 5	
The changes I plan to make in my every day work with or for adolescents.	Why is this change important.		Measuring the extent of success of this change.		Challenges and/or problems anticipate in working with adolescents.	Assistance	
	Who/what will benefit?	Why?	How to measure?	When to measure?		Assistance required	Source

Post-Test

Orientation Workshop for ANMs/LHVs on Adolescent-Friendly Reproductive and Sexual Health Services

Pre/Post-Test

Name of State _____ Name of District _____

Name of Block _____ Designation _____

Name of Participant _____

Dates of Programme _____ Date of Test _____

Note: Answer all questions. Multiple choice questions have only one correct answer. Please read each question and the multiple choices carefully and put a " mark on correct answer.

1. Adolescents come under which age group?
   a) 8 -10 years
   b) 8 -15 years
   c) 10 -19 years
   d) 19 -35 years
2. What are the important changes that take place in the individual as he/she goes through adolescence?
   a) Physical
   b) Mental
   c) Emotional
   d) All of the above
3. What are health related concerns of adolescents?
   a) Menstrual problems in girls and night fall in boys
   b) RTIs/STIs - Hygiene
   c) Teenage pregnancy
   d) Anaemia
   e) Unsafe abortions
   f) Drug/substance abuse/smoking
   g) All of the above
4. We should invest in adolescents health because:
   a) a healthy adolescents grows into a healthy adult.
   b) health benefits for the adolescent's present and future.
   c) economic benefits to avert future health cost.
   d) Good health is adolescents' right
   e) all of the above
   f) none of the above
5. How do you think an adolescent feels when he/she walks into your health centre?
   a) shy, embarrassed, worried, confused
   b) happy and confident

Handout X

6. How would you strike a rapport with an adolescent client?
    a) By not asking too many questions and not making eye contact
    b) By friendly, warm and non-judgmental behaviour with positive non-verbal cues.
    c) Frowning and stern behaviour.
    d) None of the above.
7. Adolescents do not utilise available health services because:
    a) they fear the health providers will inform their parents.
    b) they are not interested.
    c) they do not recognise illness.
    d) they do not know where to go.
    e) All of the above.
    f) None of the above.
8. What are the barriers to good communication?
    a) Service provider use simple words and language
    b) Client feels comfortable
    c) Lack of privacy
    d) Adolescents are unable to talk because of fear
    e) Insufficient time to explain
    f) (a) and (b)
    g) (c, d and e)
9. What problems are caused by lack of menstrual hygiene?
    a) Anaemia, weakness, diarrhoea
    b) Malaria, worm infestation
    c) Vaginal discharge, burning during urination and genital itching
10. According to you, how will you rate masturbation for adolescent boys and girls.
    a) Normal behaviour
    b) Abnormal behaviour
    c) Shameful behaviour
11. Lack of nutrition in adolescence can cause-
    a) Protein - energy malnutrition
    b) Stunting of growth
    c) Anaemia
    d) All of the above
    e) None of the above
12. Night fall in boys is
    a) Abnormal
    b) Normal
    c) Sign of serious illness

13. What is the risk of maternal death among women aged 15-19 years as compared to women aged 20-35 years?
    a) Lower
    b) Higher
    c) Equal
14. What can an ANM/LHV do to prevent unsafe abortions in pregnant adolescents?
    a) Counsel and refer to appropriate facility for termination of pregnancy
    b) Conduct termination of pregnancy yourself
    c) Scold her for getting pregnant and tell her to continue her pregnancy now and take some contraception after delivery
15. Which contraceptive methods are appropriate for adolescents?
    a) Abstinence, condoms and oral pills
    b) Sterilisation, Fertility-awareness based methods and IUCDs
16. What can ANMs/LHVs do to prevent STIs among adolescents?
    a) Cannot do anything
    b) Counsel them that abstinence, being faithful to one's partner and use of condoms protect from STIs
    c) Criticise unmarried sexually active and inform the parents of sexually activer unmarried adolescents of their shameful behaviour
17. After unprotected sex, emergency contraceptive pills can be given to:
    a) Married adolescents
    b) Unmarried adolescents
    c) Both
    d) None of the above
18. Which services can you ANM provide to adolescents?
    a) _____
    b) _____
    c) _____
    d) _____
19. What are the most important characteristics of adolescent-friendly health facilities?
    a) _____
    b) _____
    c) _____
    d) _____
20. Which contraceptive methods are protective against pregnancy and STIs/HIV (dual protection)?
    a) _____
    b) _____

IEC Division,
Ministry of Health and Family Welfare
Government of India