World Health Organization

Orientation Programme on Adolescent Health for Health-care Providers

Handout

NEW MODULES

DEPARTMENT OF CHILD AND ADOLESCENT HEALTH AND DEVELOPMENT

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Handout for

Module A

Introduction

This handout provides information to complement the material covered in the module *Introduction* to the Orientation Programme (OP) on adolescent health. The facilitator may refer to the text in this handout during the sessions and you may be asked to read some extracts.

References are included at the end.

THIS HANDOUT PROVIDES INFORMATION ON THE FOLLOWING:

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3. Intended participants A-5
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1. Overall aim of the Orientation Programme

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 core and optional modules. While organizations, institutions and other entities that wish to implement the Orientation Programme are required to conduct all core modules, the optional modules can be selected according to local needs and priorities.

2. Expected outcomes of the Orientation Programme

It is expected that at the end of the programme, the participants will:

- Be more knowledgeable about the characteristics of adolescence and adolescent development
- Be more sensitive to the needs of adolescents
- Be better-equipped with information and resources
- Be better able to provide adolescent-friendly health services
- Have prepared a personal plan indicating the changes they will make in their work.

What does the Orientation Programme not do?

The Orientation Programme is not designed to develop improved clinical or counselling skills in adolescent health service provision.

3. Intended participants

The Orientation Programme has been developed to address the needs of health-care providers in their work with adolescents. Adolescents can be participants in the Orientation Programme and their inclusion will ensure that their point of view is heard. Representatives from other relevant professional groups (e.g. youth workers, social workers, psychologists, nutritionists and teachers) are also invited to participate in the programme to give it a multisectoral perspective.

4. Orientation Programme modules

Figure 1 shows the core and optional modules which have been prepared. All participants in the Orientation Programme must follow the core modules, and the programme organizers will decide which of the optional modules will be used, based on local needs and resources.

FIGURE 1

Modules of the Orientation Programme

Core modules

A. Introduction
B. Meaning of adolescence and its implications for public health
C. Adolescent sexual and reproductive health
D. Adolescent-friendly health services
E. Adolescent development [1]
F. Concluding

Optional modules

G. Sexually transmitted infections in adolescents
H. Care of adolescent pregnancy and childbirth
I. Unsafe abortion in adolescents
J. Pregnancy prevention in adolescents
K. Substance use in adolescents
L. Mental health of adolescents
M. Nutrition in adolescents
N. HIV/AIDS in adolescents [1]
O. Chronic diseases in adolescents [1]
P. Endemic diseases in adolescents [1]
Q. Injuries and violence in adolescents [1]

[1] Under development

5. Methodology

The teaching and learning methods used throughout the Orientation Programme are participatory and appropriate to working with adults who always bring a wealth of personal experience to any learning event. It is recognized that the main group of intended participants already have extensive clinical and/or other experience of working with adolescents and adolescent health issues.
A participatory approach enables the individual to draw on his/her own experience and learn in an active way. It also enables a more equal relationship between participants and facilitators than is possible in the more conventional trainer-learner or teacher-student approaches.

The Programme uses a range of methods and approaches, from direct input in the form of short mini lectures to problem-solving in small groups and role play sessions.

Ground rules for participatory learning

Experience has taught us that it is sometimes necessary to establish some ground rules when using participatory approaches. The following are some examples of such rules:

- Treating everyone with respect at all times, regardless of gender, age or cultural differences;
- Ensuring and respecting confidentiality so that facilitators and participants are able to discuss sensitive issues (such as those relating to sexual and reproductive health, mental health and substance use) without fear of repercussions;
- Agreeing to respect and observe time-keeping and to begin and end the sessions on time;
- Making sure that everyone has the opportunity to be heard;
- Willing to accept and give critical feedback;
- Drawing on the expertise of other facilitators and the participants in difficult situations.

Adherence to these rules will help to ensure an effective and enjoyable learning environment.

Visualization in Participatory Programmes (VIPP) methods

The Orientation Programme also uses Visualization in Participatory Programmes (VIPP) methods (*1, 2*). VIPP is a people-centred approach to planning, training, and other group events. It combines techniques of visualization with methods for interactive learning. Central to VIPP is the use of a large number of multi-coloured paper cards of different shapes and sizes on which you express your key ideas in letters or diagrams, large enough to be seen by the whole group. Using this method, everyone takes part in the process; even participants who are shy or hesitate can find a means of expression. Those who might normally dominate the group are required to let others have a say.

Some rules for card-writing so that VIPP will be successful:

- Write only one idea per card
- Write a maximum of three lines on each card
- Use key words
- Write large letters in both upper and lower case
- Write legibly
- Use different sizes, shapes and coloured cards to creatively structure the results of discussions
- Follow the colour code established by the facilitator for different categories of ideas.

VIPP cards can be used in plenary sessions or small groups for you to put down your responses to a question. The use of cards enables the responses to be organized in a logical way and to show areas of consensus and disagreement.

6. References

1. *VIPP (Visualization in Participatory Programmes): A manual for facilitators and trainers involved in participatory group events.* UNICEF, Bangladesh, 1993.
2. *Games and exercises. A manual for facilitators and trainers involved in participatory group events.* Visualization in Participatory Programmes (VIPP). UNICEF Eastern and Southern African regional office, Nairobi and UNICEF headquarters, New York, 1998.

Handout for

Module B

Meaning of adolescence and its implications for public health

This handout provides information to complement material covered in the module *Meaning of adolescence and its implications for public health*. The facilitator may refer to the text in this handout during the sessions and you may be asked to read some extracts.

This handout provides information on the following:

1. Definitions of the term “adolescence” and of the age groups “young people”, “adolescents” and “youth” B-5
2. Global demographic and socio-economic information on adolescents B-6
3. The nature and sequence of changes during adolescence B-8
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1. Definitions of the term "adolescence" and of the age groups "young people", "adolescents" and "youth"

Adolescence

Adolescence has been described as the 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. It is important to keep this in mind for a more complete understanding of the behaviours of adolescents as you read through this handout.

Age groups

WHO defines adolescents as individuals in the 10-19-year age group and "youth" as the 15-24-year age group. These two overlapping age groups are combined in the group "young people", covering the age range 10-24 years (*1*).

WHO clearly recognizes that "adolescence" is a phase rather than a fixed time period in an individual's life. As indicated above, it is an phase of development on many fronts: from the appearance of secondary sex characteristics (puberty) to sexual and reproductive maturity; the development of mental processes and adult identity; and the transition from total socio-economic and emotional dependence to relative independence.

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

2. GLOBAL DEMOGRAPHIC AND SOCIO-ECONOMIC INFORMATION ON ADOLESCENTS

Population

There are more than 1.1 billion adolescents worldwide today – that is, one in every five people on the planet is aged between 10 and 19 years. Approximately 1.5 billion of today's world population are young people between 10 and 24 years old; 85% of them live in developing countries (*2, 3*). Table 1 shows the global and regional distribution of adolescent populations.

TABLE 1

Distribution of the global adolescent population in the year 2000

Region	Total population (' 000)	Adolescent population	Adolescent population (%)
World total	6,055,049	1,153,822	19
More developed regions	1,187,980	159,849	13
Less developed regions	4,867,069	993,973	20
Least developed regions	644,678	152,562	24
Africa	784,445	184,611	24
Latin America and the Caribbean	519,143	105,821	20
North America	309,631	43,751	14
Asia	3,682,550	715,862	19
Europe	728,887	98,866	14
Western Pacific	30,393	4,907	16

Source: Reference (2).

Education

Formal education is of great importance for the development of adolescents. Schools provide an environment for acquiring knowledge, and for building literacy, numeracy, and thinking skills. Education is a vital tool for socio-economic development (through improved economic opportunities available to those who are educated) and also for its positive impact on health. Schools are a major source of education and guidance on specific health issues and, in addition, offer a setting for the provision of health screening and health services. National policies and the available resources determine whether schooling for adolescents is obligatory and accessible. Adolescents in developing countries have fewer opportunities for education than their counterparts in developed countries, and girls have fewer opportunities for schooling than boys. In the least developed countries, only 13% of the girls and 22% of the boys enrol for secondary education (*4*).

Employment

Many adolescents do not complete their secondary school education. A substantial proportion seeks work in the informal sector. Worldwide there are an estimated 73 million adolescents aged between 10 and 14 years who work under conditions that are detrimental to their health (*5*). In addition, throughout the world many millions of adolescents live and work on the streets, putting them at a high risk of sexual abuse and/or substance use (*6*) and injuries.

It has been estimated that between 1970 and 2025 the urban adolescent population in developing countries will grow by 600% (*7*). The projected rapid growth in the number of adolescents living in economically deprived urban areas poses considerable challenges to governments and civil society.

Poverty

Despite many development gains in the last century, both absolute and relative poverty continue to increase in many parts of the world. Although poverty affects all age groups, it brings particular risks to the health and development of adolescents. For instance, the pressure to earn a living at a young age could hinder their ability to stay in school and gain a proper education, and could also expose them to exploitation and abuse by unscrupulous adults.

3. The nature and sequence of changes during adolescence

Adolescence is characterized by a rapid rate of growth and development. During this period the body develops in size, strength and reproductive capabilities, and the mind becomes capable of more abstract thinking. Social relationships move from being centred on the family base to a wider horizon in which peers and other adults come to play significant roles in the adolescent's life. It is also a time when new skills and knowledge are acquired and new attitudes are formed.

Although the decade of life from 10 to 19 years provides a time-bound definition of adolescence, it is important to realize that the changes occurring during this period may not correspond neatly with precise ages. This is because of variations in the onset and duration of changes between individuals. Moreover, this period of transition is perceived differently by different cultures; its perception is clearly mediated by social, economic and cultural factors. Hence, the experience of adolescence differs among individuals and by sex in any given society, and by varying conditions and circumstances such as disability, illness, socioeconomic status and poverty (*8*).

Peak rates of growth and development during adolescence are exceeded only by those during foetal life and infancy. However as indicated above, in comparison with infancy and early childhood, there is much greater individual variation both in the timing of developmental milestones, and in the degree of changes in rates of growth (*9*).

Adolescence is sometimes divided into early, middle and late periods, which are respectively the 10-14, 15-17 and 18-19-year age groups. These periods roughly correspond with the phases in physical, social and psychological development in the transition from childhood to adulthood (Table 2). While these stages are not universally accepted, and vary as above, they provide a basic framework to understand adolescent development.

TABLE 2

Stages of adolescence

Category of change	EARLY 10-13 to 14-15 years	MIDDLE 14-15 to 17 years	LATE 17-21years (variable)
Growth	Secondary sexual characteristics appear Growth accelerates and reaches a peak	Secondary sexual characteristics advanced Growth slows down, approximately 95% of adult stature attained	Physically mature
Cognition	Concrete thinking Existential orientation Long-range implications of actions not perceived	Thinking is more abstract Capable of long-range thinking Reverts to concrete thinking when stressed	Established abstract thinking Future-oriented Perceives long-range options
Psychosocial	Preoccupied with: Rapid physical growth Body image Disrupted change	Re-establishes body image Preoccupation with fantasy and idealism Sense of all-powerfulness	Intellectual and functional identity established
Family	Defining boundaries of independence/ dependence	Conflicts over control	Transposition of child-parent relationship to adult-adult relationships
Peer group	Seeks affiliation to counter instability	Needs identification to affirm self image Peer group define behavioural code	Peer group recedes in favour of individual friendship
Sexuality	Self exploration and evaluation	Preoccupation with romantic fantasy Testing ability to attract opposite sex	Forms stable relationships Mutuality and reciprocity Plans for future

Source: Reference (10).

4. GLOBAL MAGNITUDE OF SELECTED PRIORITY HEALTH PROBLEMS AFFECTING ADOLESCENTS

Most adolescents are healthy – that is, they show lower levels of mortality and morbidity compared to children and adults. Most adolescents also believe that they are healthy. For instance, a study of almost 16,000 adolescents conducted in nine countries in the Caribbean found that 80% of the adolescents surveyed considered themselves healthy and 88% felt comfortable about their appearance. Two-thirds of them had not had sexual intercourse, and 89% did not use alcohol and other psychoactive substances. The majority liked school (94%) and got along with their teachers (96%), and felt that their parents and family members cared about them (*11*).

There is growing recognition, however, that some adolescents do in fact develop health problems, and in addition many more adopt unhealthy behaviours that lead to health problems in their adult lives. The health problems and problem behaviours affecting young people in developing countries have been classified by WHO (Table 3).

TABLE 3

Classification of diseases and health-related behaviours of young people in developing countries

Diseases which are particular to young people	Diseases and unhealthy behaviours, which affect young people disproportionately	Diseases which manifest themselves primarily in young people but originate in childhood	Diseases and unhealthy behaviours of young people whose major implications are on the young person's future health	Diseases which affect fewer young people than children, but more of them than adults
Diseases: Disorders of secondary sexual development Difficulties with psycho-social development Suboptimal adolescent growth spurt	**Diseases:** Maternal mortality and morbidity STIs (including HIV) Tuberculosis Schistosomiasis Intestinal helminths Mental disorders	**Diseases:** Chagas disease Rheumatic heart disease Polio	**Diseases:** STIs (including HIV) Leprosy Dental disease	**Diseases:** Malnutrition Malaria Gastroenteritis Acute respiratory infections
	Behaviours: Alcohol use Other substance abuse Injuries		**Behaviours:** Tobacco use Alcohol and drug use Poor diet Lack of exercise Unsafe sexual practices	
Young people will contribute a substantial number of cases because they form a large proportion of the population in most developing countries				

Studies suggest that there are significant sex differences in adolescent morbidity and mortality rates. Boys worldwide have higher rates of morbidity and mortality from injuries due to inter-personal violence, accidents and suicide, while adolescent girls have higher rates of morbidity and mortality related to sexual behaviour (*12*).

Attempts have been made to quantify the burden of morbidity and mortality among adolescents, using the measure Disability-Adjusted Life Years (DALYs). Box 1 contains a brief explanation of the term and provides estimates of the burden of disease among young people.

BOX 1

Estimates of the burden of disease among young people

The Disability-Adjusted Life Year (DALY) is a measure used to quantify burden: it is a time-based measure, which captures the impact of premature death (in years), and the time (in years) lived with a disability. One DALY is one lost year of healthy life. A recalculation of the global burden of disease estimates among adolescents, youth and young people gave the following findings:

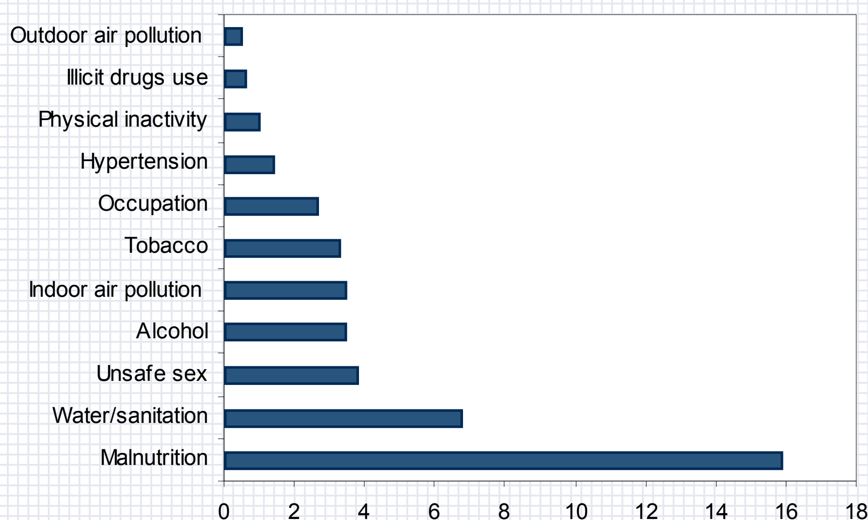
- The burden of disease and injury between the ages of 10 and 24 represents 15% of the total burden worldwide.
- 90% of the DALYs are lost in developing countries.
- 42% of DALYs result from noncommunicable diseases, 29% from injuries, and 29% from communicable, maternal, perinatal and nutritional conditions.
- The DALY distribution for adolescents and youth is very different from the pattern observed in children or adults – with STIs, HIV, maternal conditions, depression, alcohol and drug use, injuries, and road traffic accidents predominating among adolescents.
- Patterns of burden are very distinct between the sexes: DALY rates for injuries (and suicide) in males tend to be twice that in females. Exceptions to this are the suicide rates among females in China and India, which are higher than those among boys.

Source: Reference (13).

Attempts have also been made to estimate the contribution of selected risk factors to the global burden of disease. Figure 1 contains estimates of the contributions made by unsafe sex, use of alcohol, tobacco and other substances, and physical inactivity – all risk behaviours established during adolescence – to diseases, disability and death both during adolescence and beyond.

FIGURE 1

Risk factors for global burden of disease



Source: Reference (14).

Drawing upon data from around the world, a list of "priority" health problems affecting adolescents has been developed (Box 2). Each of the problems on the list meets the following three criteria. Firstly, they cause mortality or morbidity either during the adolescent period, or in later life as a result of behaviours initiated during this period. Secondly, they cause significant levels of mortality and morbidity. Thirdly, many of these health problems and problem behaviours are inter-related. For instance, substance use is associated with depressive states, and alcohol use is associated with road traffic accidents.

BOX 2

Health problems established during adolescence

- Intentional and unintentional injuries
- Sexual and reproductive health problems (including HIV/AIDS)
- Substance use and abuse (tobacco, alcohol and other substances)
- Mental health problems
- Nutritional problems
- Endemic and chronic diseases
- Each of these problems is described briefly below

Intentional and unintentional injuries

Unintentional injuries are the leading cause of death among young people, especially traffic accidents. Of the estimated 195,000 adolescents killed each year in traffic accidents, more than 60% are boys (WHO GPE 2000). Many of these traffic accidents are related to the use of alcohol and other psychoactive substances. For every young person killed in traffic accidents, an estimated 10 more are seriously injured or maimed for life.

Interpersonal violence is a form of intentional injury, which is increasing among young people, with girls especially being victimized (*15*). Although boys are far more likely than girls to be perpetrators of violence, research is now showing that boys are also victims of violence.

Data on the incidence of sexual violence and rape are not well-established. A review in 1994 confirmed that rape is not rare. Data from legal statistics and rape crisis centres show that a high proportion of rape victims in many developing countries are under 15 years of age and that most perpetrators are known to their victims (*16*). Sexual abuse of girls and boys is an even more widespread problem, with three times as many girls as boys being affected.

Sexual and reproductive health – consequences of unsafe sex

Adolescence is a time for sexual exploration and expression. For many adolescents sexual relations begin in adolescence, in or outside of marriage. The consequences of unprotected sex in adolescents include too early and unwanted pregnancy, and sexually transmitted infections, including HIV.

When adolescents become pregnant, especially in early adolescence, they are at risk of complications both during pregnancy and during delivery. Moreover, the risk of mortality and morbidity is higher in infants born to adolescent mothers, than for older women.

Lack of knowledge and skills, poor access to contraceptive methods including condoms, as well as vulnerability to coerced sex puts adolescents at high risk of unwanted pregnancies and infections. Further, a range of obstacles to their utilization of health services may make it difficult for them to obtain the advice and health services they need (*17*).

Unwanted pregnancy is often seen only as a problem for adolescent girls, but recent research shows that adolescent fathers face some of the same issues that young mothers face: too-early role transition from adolescent to parent; social isolation; unstable relationships; and social and family opposition to their involvement as fathers.

In developing countries, maternal mortality in girls under 18 years of age is two to five times higher than in women aged 18-25 years (*18, 19*). Worldwide, more than 13% of all births are to women 15-19 years old. There are however considerable variations both between and within countries (*20*). Adolescent mothers in many developing countries face many health and social problems.

Unsafe abortions in adolescents are estimated at 2,5 million a year, representing 14% of all unsafe abortions. A further 4,8 million (or 26%) unsafe abortions take place in young women 20-24 years old (WHO, RHR, 2002).

Every year, more than one out of 20 adolescents will contract a curable sexually transmitted disease (STD), not including viral infections (*22*), and every year a third of the estimated 333 million new STDs occur in young people under 25 years (*23*).

HIV/AIDS

The HIV/AIDS pandemic is one of the most important and urgent public health challenges facing governments and civil societies around the world. Adolescents are at the centre of the pandemic both in terms of its spread, and in terms of the potential for changing the attitudes and behaviours that underlie this disease.

An estimated 30% of the 40 million people living with HIV/AIDS (i.e. 10.3 million) are young people aged 15-24, and half of all new infections – over 7000 daily – occur among young people (*17*). The vast majority of young people who are HIV-positive do not know that they are infected, and few young people who are engaging in sex know the HIV status of their partners.

Young people are vulnerable to HIV because of risky sexual behaviour, substance use, and their lack of access to HIV information and prevention services. Many young people do not believe that HIV is a threat to them, and many others do not know how to protect themselves from HIV.

Substance use

Harmful substance use (tobacco, alcohol and illicit substances) will increase the risk of cancers, cardiovascular diseases, and respiratory illnesses later in life (*15*).

If tobacco use begins at all, it usually begins in adolescence; few people begin to smoke regularly after the age of 18 (*3*). Alcohol is the most common element in substance-use related deaths of young people. The earlier the age of onset of drinking the greater the chance of developing a clinical alcohol disorder later in life (*24*). More importantly, there is growing evidence of the “clustering” of behaviours risky to health. A recent review of evidence from around the world, carried out by WHO, showed that the use of substances by adolescents, is associated with a greater likelihood of early sexual initiation (*26*).

Mental health

Young people are often vulnerable to the kinds of stresses (including the challenges of growing up and exposure to risky behaviours) that contribute to mental ill health. It is during adolescence that some mental health problems first appear. Mood disorders such as depression, and psychotic disorders such as schizophrenia, are two types of mental illnesses for which early recognition and intervention are critical for a successful and long-lasting recovery (*27*).

Suicide is one of the three leading causes of death for young people. Suicide rates among adolescents are rising faster than among any other age group. There are 90,000 suicides committed by adolescents each year. For every completed attempt of suicide, there are at least 40 unsuccessful attempts (*27*).

There appear to be clear gender patterns in the way in which young people respond to stressful and traumatic life events (*11*). Various studies have shown that in times of stress or trauma, boys are more likely than girls to respond to stress with aggression (either against others or against themselves), to seek diversion in physical activity, and to deny or ignore stress and problems. On the other hand, adolescent girls more frequently turn to friends and pay attention to health needs resulting from stress. These gender patterns of coping with stress can also be seen in gender differences in suicide.

Nutrition

During adolescence, nutritional problems originating earlier in life can potentially be corrected, in addition to addressing those that begin during adolescence. Malnutrition is estimated to account for 16% of all disability-adjusted life years in the general population and is the largest single factor contributing to ill health. Among adolescents malnutrition is not one of the main causes of ill health as it is for instance in children under the age of 5. However, under- and over-nutrition, anaemia and lack of micronutrients, especially relevant for pregnancy, are increasing problems in both developing and developed countries (*28*). The adolescent's need for iron, increased by growth, development and menstruation, are hampered by malaria, hookworm infestation and schistosomiasis, which affect young people disproportionately (*28*).

Chronic and endemic diseases

Data show that malaria and tuberculosis (TB) are among the 10 major causes of death in adolescents (125,000 deaths each year from malaria and 75,000 due to TB) (*3*). It is important to ensure that adolescents are addressed in programmes to combat these conditions, as well as others such as schistosomiasis and helminth infestations.

Chronic conditions include noncommunicable diseases such as asthma, epilepsy, cystic fibrosis, juvenile diabetes and haemoglobinopathies such as sickle-cell disease. In general, the focus on chronic conditions has been greater in developed countries but there is growing awareness that they need to be addressed in developing countries as well.

Chronic conditions could adversely affect adolescent development. Factors such as growing autonomy and sensitivity to peer pressure, characteristics of an emerging adolescent identity, could hinder compliance to diet and treatment regimens in individuals with chronic conditions. It can hence be a challenge to manage these conditions in adolescents within the context of all the other changes that are taking place. The management of these conditions requires comprehensive care and support addressing both biomedical and psychosocial issues in an ongoing manner, rather than the application of a "diagnose and treat" approach.

Differences in perspectives

The data provided above present information on the major problems facing adolescents as perceived by health planners and policy-makers. However, adolescents themselves often have very different perceptions of their health-related needs and problems. Their concerns often relate to issues such as body size, acne, and relationships with their peers and members of the other sex. Box 3 shows the different priorities given to young people's health by two different stakeholders: health planners and young people themselves.

BOX 3

Priorities in young people's health – two viewpoints

Health planners	Young people
■ STIs/AIDS	■ Relationships
■ Injuries	■ Appearance
■ Psychiatric problems	■ Bullying
■ Too early pregnancies	■ Stress (e.g. due to schooling, exams, lack of employment)
■ Schistosomiasis	■ Access to contraception
	■ Pregnancy

Source: Reference (3).

To be truly meaningful, programmes intended for adolescents must make every effort to understand and address their viewpoints and perspectives. Additionally, adults who interact with adolescents (e.g. parents and other family members, teachers, youth leaders and religious leaders) are important groups to be consulted and involved (*29*). This will make it possible for all the key stakeholders to make their own special contributions to the health and development of adolescents.

5. Why invest in adolescent health and development?

The behaviours and lifestyles learned or adopted during adolescence will influence health 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.

The three main reasons for investing in the health and well-being of adolescents are shown in Box 4.

It is estimated that every year about 1.4 million adolescents die – mostly from accidents, violence, pregnancy-related problems and illnesses that are either preventable or treatable. Many more develop behaviours that could destroy their chances for personal fulfilment and their ability to contribute to society (*27*). Investing in adolescent health and development will reduce the morbidity and mortality in this age group. It will maximize their opportunity to develop to their full potential and to contribute the best they can to society.

BOX 4

Three main reasons for investing in adolescent health

Health benefits for the individual adolescent – in terms of his/her current and future health, and in terms of the inter-generational effects.

Economic benefits: improved productivity, return on investments, avert future health cost.

As a human right: adolescents (like other age groups) have a right to achieve the highest attainable level of health.

Source: Reference (13, 30).

Investing in adolescent health and development will also reduce the burden of morbidity and mortality in later life because healthy behaviours and practices adopted during adolescence tend to last a lifetime. Today's adolescents are tomorrow's parents, teachers and leaders. What they learn today, they will teach to their own children and to other children tomorrow.

Investing in Adolescent Health and Development (ADH) makes economical sense: better-prepared and healthy adolescents will result in productivity gains when they enter the workforce. Return on investments made in early childhood health and development are being safeguarded by continuing attention to ADH. When adolescents develop suboptimally or die prematurely this means a waste of earlier investments. Investing in prevention and promotion during adolescence also averts future health costs: smoking prevention averts health costs much later in life.

Promoting and safeguarding adolescent health should not only be regarded as an investment, but also as a basic human right. The UN Convention on the Rights of the Child (CRC), which has been ratified by nearly every government in the world, declares that young people have a right to life, development, and (in Article 24) "*The highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health*" (*33*). The CRC also gives young people the right to preventive health care and requires 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.

6. Guiding principles and a conceptual framework for promoting and protecting adolescent health and development

Working in conjunction with UNFPA and UNICEF, WHO has developed a framework for country programming for adolescent health (*29*). The framework spells out the twin goals of programming – promoting healthy development in adolescents on the one hand, and preventing and responding to health problems if and when they arise, on the other. It lists the interventions that need to be delivered – as a package – to meet these goals: the creation of a safe and supportive environment, the provision of information, building life skills, and the provision of health and counselling services. It also lists the settings wherein these interventions could be delivered and the players who could deliver them (including both adults and adolescents themselves).

The framework is a truly comprehensive one, and there are many challenges in translating this broad vision into reality. The framework lists key challenges – building political commitment, identifying priorities for action, sustaining the implementation of programmes, and monitoring and evaluating them. Based on experiences around the world, it outlines the guiding concepts (Box 5) that should underpin our work with adolescents as well as keys to success.

BOX 5

Guiding concepts for programming for adolescent health and development

- Adolescence is a time of opportunity and risk
- Not all adolescents are equally vulnerable
- Adolescent development underlies prevention of health problems
- Problems have common roots and are interrelated
- The social environment influences adolescent behaviour
- Gender considerations are fundamental

Source: Reference (29).

Adolescence is a time of opportunity and risk: Generally speaking, adolescence is a healthy period of life. However, some adolescents do lose their lives and many more develop health problems, or problem behaviours, that could lead to disease and premature death in adulthood. In that sense, adolescence is in fact a time of risk; but it is also a time of opportunity for an individual to grow and develop (physically, psychologically and socially) to his/her full potential, in preparation for adulthood.

Not all adolescents are equally vulnerable: Adolescents are not a homogeneous group; their needs for health information and services depend on their age, stage of development and circumstances. Because of their circumstances, some adolescents tend to be more vulnerable than others to health and social problems.

Adolescent development underlies prevention of health problems: The two overlapping goals of promoting healthy adolescent development on the one hand, and preventing and responding to health problems on the other, cannot be viewed as separate and distinct because they are closely linked to one another. The provision of preventive and curative health services for specific health problems is important. However, the prevention of health problems (and problem behaviours) through actions to enhance protective factors (such as positive relationships with parents and teachers and a positive school environment) and reduce the risk factors (such as early initiation of unprotected sex and the use of tobacco, alcohol and other drugs) is even more important.

Problems have common roots and are interrelated: Research shows that the health problems of adolescents are interrelated. This is because the underlying behavioural causes of many of these health problems are the same. For example, studies from around the world – gathered and analyzed by WHO – point to the fact that adolescents who engage in other risk behaviours, such as using alcohol and other substances, are more likely to initiate sexual intercourse early (*26*) (Figure 2).

FIGURE 2

Early sexual initiation

Risk or protective factors for adolescents	Africa	Asia	Caribbean	South America	North America
A positive relationship with parents	+	+	+	+	?
A positive relationship with teachers	+	+	?	+	Not significant
Friends who are sexually active	-	?	-	-	?
Engaging in other risky behaviours	-	?	-	?	?
Having spiritual beliefs	?	+	+	?	+

Key: + protective factor; - risk factor; ? not measured.
Source: Reference (25).

The social environment influences adolescent behaviour: A safe (free from danger of disease and injury) and supportive (nurturing) environment is critical for an individual to develop to his/her full potential, and for him/her to be healthy. For example, the synthesis of studies by WHO, referred to above, points to the fact that adolescents who have positive relationships with parents and with other adults in the community are less likely to experience depression (*29*). Unfortunately, many adolescents in today's world are living, studying and working in unsafe and unsupportive environments, with negative effects on their health and development (Figure 3).

FIGURE 3

Depression

Risk or protective factors for adolescents	Africa	Asia	Caribbean	South America	North America
A positive relationship with parents	+	+	+	+	+
Parents encourage self-expression	+	+	+	+	+
Conflict in the family	-	Not significant	-	-	-
A positive attitude towards school	Not significant	+	+	Not significant	+
Positive relationship with adults in the community	+	+	+	Not significant	Not significant
Having spiritual beliefs	+	+	+	Not significant	Not significant

Key: + protective factor; - risk factor; ? not measured.
Source: Reference (25).

Gender considerations are fundamental: A good understanding of the biological differences in the growth and development of males and females (through the years of adolescence), and of the different ways in which they are affected by health problems is important. Equally important is a good understanding of the different social and cultural influences on males and females, and how this affects the way in which adolescent males and females view themselves and relate with others.

What health care providers need to do when working with and for adolescents

A fundamental principle in working with/serving adolescents is "putting them at the centre", in other words, making their needs and problems, thoughts and feelings, view points and perspectives central to your work with them. Some key issues are listed in the Box 6.

BOX 6

Putting adolescents at the centre

- Regarding the adolescent as an individual, not just as a case of this or that health problem
- Striving to understand the specific needs of each individual adolescent
- Acknowledging – and heeding – the viewpoints and perspectives of the adolescent in line with his/her evolving capacity
- Taking into primary consideration, the best interests of the adolescent, when making decisions – or taking actions – that affect him/her
- Respecting the rights of the adolescent (as laid out in the UN Convention on the Rights of the Child), while at the same time taking into account the rights and responsibilities of parents
- Striving to prevent personal beliefs and attitudes, preferences and biases from influencing one's professional assessments and actions

All these issues will be touched on and developed further in all the Orientation Programme modules. One concrete method which health workers could use to understand the adolescent they are working with is to use the HEADS approach (*31*) (Box 7). This approach consists of a checklist of questions to carry out a rapid assessment to provide information on the psychological and social dimensions of the adolescent's life. It could be used in combination with a medical history to provide information on Box 7.

BOX 7

Areas addressed by the HEADS approach to assess the psychological situation and the social circumstances of adolescent patients

- Home: about the family
- Education: about their interest and performance
- Eating: about their habits
- Exercise: about their habits
- Ambition: about their hopes for the future
- Activities: about their social and recreational activities
- Drug use: whether they smoke and use other psychoactive substances
- Sexuality: their thoughts and feelings about their sexual activity
- Suicide: how they feel and whether they have thought of hurting themselves

Source: Reference (31).

A final point worth noting is that since many of the factors that affect adolescent health and development are interrelated, they cannot be completely addressed by the health sector alone. Health-care providers can, however, work with other sectors including the education and social welfare sectors to address collectively the health issues of adolescents. Health staff can also become more aware of the role and responsibilities of the other sectors and be well informed of what services are available for adolescents outside the health sector. As you will see later in these modules, there are also many things that health care providers can do within the health sector to make the services more adolescent-friendly.

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Annex 1

Spot checks

Session 1: ACTIVITY 1-2

SPOT CHECK 1

What are important changes that take place in the individual as he/she goes through adolescence?

please provide three answers

SPOT CHECK 2

What are the most important actions to do when working with or for adolescents?

please provide three answers

SPOT CHECK 3

What are the four most important health problems facing adolescents in your area?

please provide four answers

SPOT CHECK 4

We should invest in adolescents because ...

please provide four answers

SPOT CHECK 5

Do you agree that adolescents should be primarily involved in the development, planning and evaluation of health programmes that serve them?

please mark your answer with a spot anywhere along the line

agree — possibly — disagree

Annex 2

Group exercise

Session 3: ACTIVITY 3-2

Events / changes that occur	Early adolescence (10-13)	Middle adolescence (14-16)	Late adolescence (17-19)
Physical			
Psychological: *Cognitive* *Emotive*			
Social			

Annex 3

Group exercise

Session 4: ACTIVITY 4-2

Characteristics of adolescence	Implications for public health

Annex 4

Examples of letters

Session 5: ACTIVITY 5-1

These are typical examples of letters written by adolescents to an "Agony Aunt" or to a personal column or health column in a newspaper or magazine, which illustrate the health-related predicaments of adolescents and their need for advice and help. Please select three or four letters reflecting issues which you think adolescents in your country may be experiencing, for discussion during the session.

LETTER 1

Dear Dr (please insert local name),

I am a 19-year old girl, still in school, and have a steady boyfriend who is also 19. Our love is very strong, but we never get involved in sexual acts. Recently, he proposed to have sex with me. I refused because it is against my religion to have sex before marriage. He tells me that since we will get married anyway, it would be okay to have sex. I love him very much and do not want to lose him.

What must I do to keep my boyfriend, but without having sex with him?

LETTER 2

Dear Dr (please insert a local name),

I'm an 18-year old girl who is dating a much older man. He is about 37 or 39 and is very nice to me. He always helps me with buying books, clothes and other things I need for school. We have had sex once but I am worried that I could be pregnant. I'm afraid that he might leave me because he already has a wife.

How can I know for sure that I am pregnant? Do I tell him? What if he leaves me? What should I do?

LETTER 3

Dear Dr (please insert a local name),

I am 17 years old and have sex very often with my boyfriend. I recently read that failure to use a condom could lead to STIs or AIDS. I talked to him about using a condom. He threatened to leave me and go back to his old girlfriend if I open this subject again. I do not want to lose him by insisting that he should use a condom. My friend told me that if I washed immediately after having sex, I would not get an STI or AIDS. This is what I am doing now.

Is this the right thing to do? Can this help?

LETTER 4

Dear Dr (please insert a local name),

I am a 16-year old boy and feel very happy that I have met a friend whom I like very much. We play football and go to the cinema together. Some days ago I discovered that he is using a drug called Ecstasy. I am terrified about this finding because I have heard that this drug could have serious consequences on health. I am not easily led to do things I don't approve of. I certainly know that I would never use any drugs. My worry is that if my parents find out about what my friend is involved in, they will not permit me to be friends with him any more.

What can I do to ensure that nobody knows what my friend is doing and how can I help him stop using the drug? I really do not want to lose him as a friend.

LETTER 5

Dear Dr (please insert a local name),

I am a very unhappy 18-year old girl. I had an affair with a boy of my age a year ago. We were so much in love that we even had sex on several occasions. After discovering that I was pregnant, my boyfriend deserted me. I went ahead and terminated the pregnancy with the help of a girlfriend. Apart from my ex-boyfriend and my girlfriend, nobody knows what I did.

However, I feel very guilty about what I have done. I do not seem able to forget it. This is affecting the way I deal with people. I do not want to be with people as I feel that they can see through me.

What must I do to get on with my life without carrying this heavy burden?

LETTER 6

Dear Dr (please insert a local name),

We are two brothers who need your help about a terrible family problem. Our father is an alcoholic and drinks daily. Each time he comes home drunk he picks a fight with mother and beats her up badly. This has been going on for a long time. We can no longer bear to see our mother suffering like this. We are also afraid that he could kill her.

We have thought about leaving them but are anxious that something could happen to us as we do not know of a place to go to and find some peace. Our parents would kill us if they found out that we are writing to you about our problems.

Where can we go to without our parents knowing our whereabouts?

LETTER 7

Dear Dr (please insert local name),

I am in tears as I write this letter. My father decided that I should quit school and be married to his 40-year old rich cousin who already has two wives and children older than me. I am used to calling him uncle, so how can I marry him? My father says he is rich and will take good care of me.

I love school and am doing really well, my teacher says. I want to go to university and become a teacher. No one at home, not even my mother would listen to my begging and crying. I am still young; I don't want to get married now. Maybe the best thing to do is to kill myself.

Can you help me?

LETTER 8

Dear Dr (please insert a local name),

I'm so very scared that I am writing to ask for your help. Our neighbour offered to give me a ride home from school a week ago. You know how far it is as it was your school as well. I thanked him and got into the car. He was very nice to me, gave me sweets and told me that I had turned into a beautiful young woman. He then took the back roads because they were nicer, he said. He then drove into the forest and started kissing me and ripped off my clothes. I begged him to stop and tried to get away, but he was very strong. He hurt me and raped me. He told me that he would kill me and hurt my little brother if I told anyone. He demands that we get together again. Last month in school we had a talk about AIDS and I think I may have got the disease. My poor mother works so hard and I'm afraid to tell her. I feel so guilty and I am in pain.

I don't know what to do. Can you help me?

Handout for

Module C

Adolescent sexual and reproductive health

This handout presents background information, which is the foundation for the optional modules on *Adolescent sexual and reproductive health*.

This handout provides information on the following:

1. Definitions of sexual and reproductive health C-5
2. Puberty C-6
3. Initiation of sexual relations in adolescents C-7
4. Protective and risk factors influencing adolescent sexual behaviour C-8
5. Sexual abuse and commercial sexual exploitation C-9
6. Consequences of unprotected sexual relations C-10
7. Promoting the sexual and reproductive health of adolescents C-12
8. What can health-care providers do to improve adolescents' access to sexual and reproductive health information and services? C-13
9. References C-14

Annex 1. Spot checks. Session 1 – Activity 1-2 C-15

Annex 2. Case studies. Session 5 – Activity 5-1 C-19

1. Definitions 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. It has been defined as follows: "… the positive integration of physical, emotional, intellectual and social aspects of sexuality. 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." (*1*)

Reproductive health

WHO defines reproductive health as "...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. Reproductive health therefore 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. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases." (*2*)

2. Puberty

Adolescence is a period of transition from childhood into adulthood. It is marked by dramatic physical, psychological and social changes. The onset of puberty "announces" an important step on the road to adulthood. Puberty refers to the physiological changes that occur in early adolescence (sometimes beginning in late childhood) which result in the development of sexual and reproductive capacity.

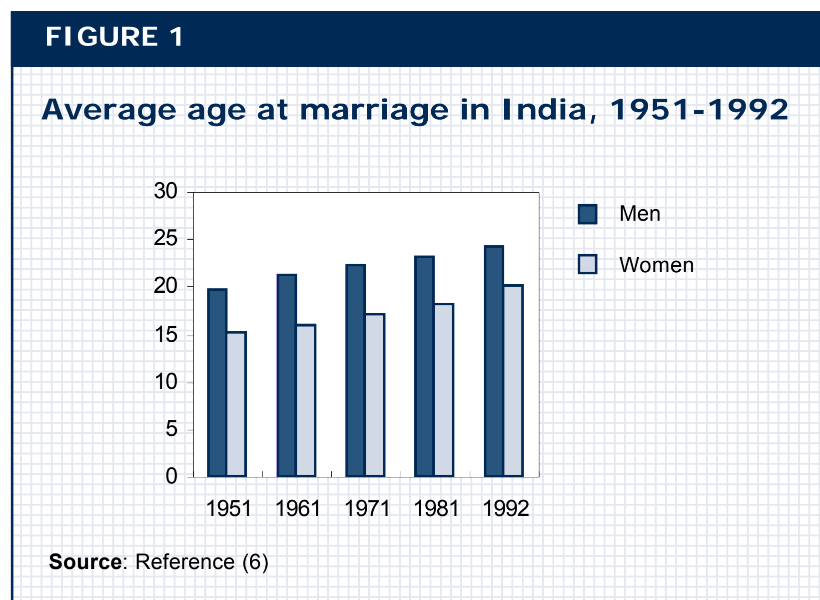
Physical growth and development manifest in a growth spurt during which there are marked changes in the size and shape of the body. Differences between boys and girls are accentuated. For instance, girls experience breast development and hip enlargement, whereas in boys, there is the appearance of "man-like" musculature.

These changes are accompanied by others such as the appearance of the axillary and pubic hair in both boys and girls, and the change in the pitch of the voice and the appearance of facial hair in boys. There is rapid maturation of the sexual organs. The onset of menstruation and the initiation of sperm production are important milestones at this time.

In many traditional cultures, elaborate rituals were carried out to commemorate the onset of puberty, to "announce" sexual readiness and to celebrate the "arrival" of an adult into the community. Even in modern times, the onset of puberty is a defining moment in an individual's life, and in the way in which his/her place and role in the family and community are perceived.

In both developed and developing countries, puberty is occurring at an earlier age than it did in previous generations. This is attributed to improved nutrition and health status (*3*). The changes generally occur over a 5-year period, but range from 18 months to 6 years. In general, girls start puberty about 18 months earlier than boys. Girls today enter puberty between the ages of 8 and 13, and boys between 9 and 14 years (*4*).

In many parts of the world, both in developed and developing countries, girls are reaching puberty at earlier ages. Most of the change is attributed to improved health and nutrition status. Declining trends in the age of onset of puberty are accompanied in many countries by increasing age at marriage (Figure 1). This has important implications for sexual and reproductive health of adolescents.



3. Initiation of sexual relations in adolescents

As their bodies change and mature, many adolescents will develop an interest in sex. A recent synthesis of behavioural case studies in 20 developing countries in Africa, Asia and Latin America points to the fact that adolescence is the period during which sexual activity is initiated in a substantial proportion of individuals (*6*). The report goes on to say that "much of this activity is risky; the practice of contraception and condom use is often erratic, and unwanted pregnancies and unsafe abortions are observed in many settings. Sexual relations are not always consensual: force and coercion are far from unknown. While young people tend to be generally well informed, they have only patchy in-depth knowledge of issues related to sexuality. Moreover expressed norms often conflict with behaviour. Lastly, there are wide gender-based differences in sexual conduct, and in the ability to negotiate sexual activity and contraceptive use". (*6*)

Studies from around the world confirm that a larger percentage of boys report being sexually active than do girls of the same age. Further, boys report that they begin sexual activity earlier (Table 1).

Demographic and Health Surveys (DHS) data indicate that the reported ages of sexual debut for boys are generally decreasing in nearly all countries for which DHS data are available, while the reported ages at first sexual experience for girls has decreased in only a fifth of these countries (*7*). The earlier age of puberty, combined with the delayed age of marriage and the declining age of first sexual experience (for some groups of adolescents) means that many more adolescents are having sexual relations before marriage.

TABLE 1

Premarital sexual intercourse in Latin America and the Caribbean

Country and year of survey	Females		Males	
	% reporting intercourse age 15-19	Mean age at first intercourse	% reporting intercourse age 15-19	Mean age at first intercourse
Brazil, 1989	16	16.8	69	15.1
Chile, 1988	19	17.9	48	16.0
Costa Rica, 1991	19	17.9	48	16.0
Guatemala, 1986	12	16.7	65	14.8
Jamaica, 1993	59	15.9	75	13.9
Mexico, 1985	13	17.0	44	15.7

Source: Reference (4)

Sexual expression

Sexual relations are often seen to be only those which involve penetrative sexual intercourse. However, there are many other ways of expressing sexual feelings that do not involve penetration and that are safe in terms of preventing pregnancy and infection from STIs and HIV. These behaviours include holding hands, hugging, kissing, body rubbing, masturbation and mutual masturbation.

Another factor which is often overlooked in discussions of sexual relations is that of same sex relationships. Providers of sexual and reproductive health-care services often assume that all clients are heterosexual. Yet research shows that adolescent same-sex experimentation is probably more common than is believed, especially among boys (*6*).

4. Protective and risk factors influencing adolescent sexual behaviour

A range of factors influence aspects of adolescent sexual behaviour (such as the initiation of sex, type and number of sexual partners, and the use of any form of contraception). These factors include characteristics of the adolescents themselves, those of their families, friends and communities, as well as the relationships of adolescents to these entities. Some of these factors are protective for adolescent sexual behaviour and others are not.

Table 2 presents results from studies carried around the world, of factors that influence the early initiation of sexual activity (*8*). They suggest that protective and risk factors can explain differences in adolescent behaviour, even after accounting for variables such as age, sex, ethnic group and socio-economic status.

FIGURE 2

Early sexual initiation

Risk or protective factors for adolescents	Africa	Asia	Caribbean	South America	North America
A positive relationship with parents	+	+	+	+	?
A positive relationship with teachers	+	+	?	+	Not significant
Friends who are sexually active	-	?	-	-	?
Engaging in other risky behaviours	-	?	-	?	?
Having spiritual beliefs	?	+	+	?	+

Key: + protective factor; - risk factor; ? not measured.
Source: Reference (8).

From the table we can conclude that:

- Families matter: Adolescents who have a positive relationship with parents are less likely to start sexual intercourse early.
- Schools matter: Adolescents who have a positive relationship with teachers are less likely to start sexual intercourse early.
- Friends matter: Adolescents who believe that their friends are sexually active are more likely to start sexual intercourse early.
- Beliefs matter: Adolescents who have spiritual beliefs are less likely to start sexual intercourse early.
- Risk behaviours are linked: adolescents who engage in other risk behaviours, such as using alcohol and drugs, are more likely to start sexual intercourse early.

Clearly, an individual's experience of sexual relations is mediated by biological factors (such as the age of puberty), cultural norms (such as the age of marriage) and social factors (such as power relations between men and women). Perhaps the most profound societal influence on an individual's sexuality comes from prescribed gender roles – the social norms that shape the relative power, responsibilities, and behaviour of women and men (*9*).

Young men often believe that sexual initiation affirms their identity as men and provides them status in the male peer group. For many adolescent boys worldwide, sexual experience is seen as a

rite of passage to manhood and an accomplishment or an achievement. In some cultures, sexual "conquests" are often shared with pride within the male peer group, while doubts or inexperience are frequently hidden from the group (*10*). On the other hand, the prescribed role of girls and women in sexual relations is often to be passive. They are not encouraged, or given support, to make decisions regarding their choice of sexual partners, to negotiate with their partners the timing and nature of sexual activity, to protect themselves from unwanted pregnancy and disease, and least of all to acknowledge their own sexual desire (*9*).

5. Sexual abuse and commercial sexual exploitation

Adolescent girls often lack the power, confidence and skills to refuse to have sex or to negotiate safer sex. Gender norms can place them at high risk of sexual violence including coerced or forced sex (*11*).

Sexual abuse, coercion and rape are tragic realities that affect young people in developing and developed countries alike. They can and do result in problems such as unwanted pregnancy and sexually transmitted infections, including HIV, in addition to having long-lasting psychological consequences. The extent to which young people worldwide fall victim to non-consensual sex and sexual coercion is difficult to measure because surveys vary greatly in the way in which they define involuntary sex.

Economic hardships can force young girls and boys to leave home and seek a livelihood and support elsewhere. Commercial sexual exploitation and prostitution are sometimes consequences of this. In other instances, the adolescent may leave home because of abuse by family members and end up living on the street, or in sexually exploitative relationships.

6. Consequences of unprotected sexual relations

Whether they are married or unmarried, and engage in heterosexual or homosexual acts, adolescents can face potentially serious physical, social and economic consequences from unprotected sex. Some of these consequences are described below (*12, 13*).

Health risks to both adolescent males and females

Sexually transmitted infections

At the time of first sexual contact, adolescents often lack knowledge about sexuality and reproduction. Indeed first sex is often experimentation and adolescents generally do not prepare for it by obtaining and using condoms or contraception, even if they know where to and can get them. Adolescent girls may lack the power, confidence and skills to refuse to have sex. The gender roles of the submissive female and the dominant male make it more difficult for the girl to say no. In some places, gender norms condone early initiation of sexual activity by adolescent boys (by older women including sex workers) and encourage sex with multiple partners. Some adolescents are subject to sexual abuse of varying degrees, including incest or rape.

If contraceptives, particularly condoms, are not readily available, or are not used, adolescents of both sexes risk getting sexually transmitted infections and girls risk having an unwanted pregnancy. Many young women do not even know they have contracted a sexually transmitted infection because they have no symptoms or because they are unaware of them. Undiagnosed and untreated, the disease continues to plague them into adult life and may lead to pelvic inflammatory disease, ectopic pregnancy and eventually infertility, as well as damaging eyesight and general health of any children they may have.

Another disease of women – cervical cancer – shows itself only in later life but research shows that a woman's risk of this disease is doubled if her first sexual activity was in early adolescence.

Health risks to the adolescent mother

Too early pregnancy

Many adolescents have healthy pregnancies and healthy babies. They give birth without complications and enjoy their role as mothers. But all too many do not. Although their bodies may be mature enough to become pregnant, some adolescents are not sufficiently physically developed to have a safe pregnancy and delivery.

Pregnant adolescents are more likely to suffer eclampsia and obstructed labour than women who become pregnant in their early twenties. In the early adolescent years, a girl is still growing and her pelvis has not reached its full adult size. Pregnancy increases the body's nutritional needs and can slow down the girl's growth. Obstructed labour is far more likely if a girl's pelvis is not full size at childbirth.

A particularly devastating complication of obstructed labour is obstetric fistula, a hole between the vagina and the bladder or rectum. The woman constantly leaks urine or faeces, smells offensive and is often ostracized both by her family and by the community. Studies in Asia and Africa show that adolescents having their first baby are much more likely to suffer obstetric fistula than older women giving birth for the first time (*12*).

Girls who become pregnant in their adolescent years are less likely to seek prenatal care than older women. Yet pregnant adolescents are more likely to have health problems than women over 20. Studies in several countries have shown that the risk of death during childbirth is higher among adolescents than among older women (*14*).

Even if a pregnant adolescent is physically developed, she may lack the social and emotional maturity to cope with the experience of becoming a mother and the changes it means to her life. Her male partner, if he is an adolescent, is also not likely to be ready to shoulder the responsibilities of fatherhood.

Unsafe abortion

In cultures where early marriage is common, adolescent pregnancy is generally welcomed by the family, if not always by the adolescent girl. If the pregnancy occurs outside marriage, social sanctions may be severe and induced abortion often seems the only way of avoiding public shame and rejection. Adolescents account for a very high proportion of abortion complications, primarily because they are likely to obtain clandestine illegal abortions, or delay seeking abortion until late in the pregnancy.

Health risks to the baby

Babies born to young adolescent mothers also face more health risks than babies of older women. Babies of adolescent mothers are more likely to have low birth weight, run a higher risk of being premature and have a higher rate of perinatal mortality.

A major problem arises from "children having children". A young adolescent mother, barely out of childhood herself and certainly not an adult, may not have the parenting skills needed to raise a child.

Social costs of pregnancy to the adolescent mother

Unmarried pregnant young women run the risk of being rejected by family and community. One problem is often linked to others. Adolescents who have babies are often unable to continue their schooling. A young woman with a baby often has less chance of finding employment, and if she has not completed her education, she will be at an added disadvantage. Her income is likely to be low in comparison to most others. Poverty and poor health often go hand in hand, rendering the mother even less able to cope and setting the child back in its development.

The cost to the community

Early pregnancy has negative consequences not only for the mother and baby, but also for the community. The poor unmarried mother with little education is not only unable to contribute to the development of the community, but she and her family may become a burden on it. It is in the community's interest for all families – whether two-parent or single-parent – to be economically viable, and early pregnancy certainly does not help that to happen.

7. Promoting the sexual and reproductive health of adolescents

The UNFPA, UNICEF, WHO common agenda for action in adolescent health and development (*15*) calls for the implementation of a package of actions, tailored to meet the special needs and problems of adolescents and includes the provision of information and skills, health and counselling services, and the creation of a safe and supportive environment (*15*). Promoting the sexual and reproductive health of adolescents involves the implementation of the same set of actions.

- Information helps adolescents understand how their bodies work and what the consequences of their actions are likely to be. It dispels myths and corrects 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 well adolescents stay well, 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 healthy 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 middle-class family is likely to be very different from those of a boy of the same age who is fending for himself on the street. 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 characterize 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.

8. 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. You can also work with your colleagues to make your services more sensitive and responsive to the needs of the adolescents you serve. For more information on this, please refer to module D. *Adolescent-friendly health services.*

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. A review of scientific studies from around the world, conducted by UNAIDS in 1997, evaluated the impact of sex education programmes on adolescent knowledge and behaviour and found half of the studies that evaluated sexual health education and HIV/AIDS education initiatives neither increased nor decreased sexual activity and attendant rates of pregnancy and STIs. Moreover, 41% of the studies reported that HIV/AIDS and/or sexual health education either delayed the onset of sexual activity, reduced the number of sexual partners, or reduced unplanned pregnancy and STI rates. Little evidence was found to support the contention that sexual health and HIV education promote sexual activity. If any effect is observed, almost without exception, it is in the direction of postponed initiation of sexual intercourse and/or effective use of contraception. 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 (*16*).

In conclusion, it would be useful to recall a statement made by Dr Gro Harlem Bruntland, the former Director-General of WHO, at a ministerial conference on Population and Development (The Hague, Netherlands, 1999): *"Young people need adult assistance to deal with thoughts, feelings and experiences that accompany physical maturity. By providing this help, we are encouraging responsible life styles. Evidence from around the world has clearly shown that providing information and skills on human sexuality and human relationships helps avert health problems, and creates more mature and responsible attitudes."* She then went on to stress that health-care providers and other adults have a major role to play in promoting adolescent sexual and reproductive health: *"Think of the costs of failing to ensure that young people – our common future – have the knowledge, skills and services they need to help them make healthy choices in their sexual and reproductive health lives."*

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Annex 1

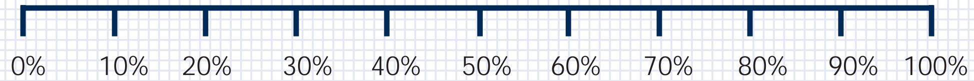
Spot checks

Session 1: ACTIVITY 1-2

SPOT CHECK 1

What percentage of your male adolescent patients do you think are sexually active by the age of … years ?

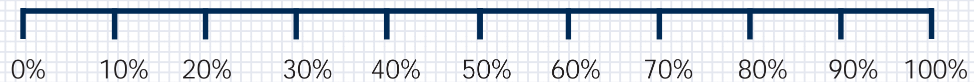
please mark your estimate with a spot anywhere along the line



SPOT CHECK 2

What percentage of your female adolescent patients do you think are sexually active by the age of…?

please mark your estimate with a spot anywhere along the line



SPOT CHECK 3

Adolescents engage in sex because...

please fill in the blanks

SPOT CHECK 4

Adolescents can get the information and health services they need

please answer with one spot and give one reason for your answer

- Yes, because ...
- No, because ...
- Don't know ...
- Not sure ...

SPOT CHECK 5

The problems that too early sexual activity in adolescence can result in are:

please fill in the blank spaces

Annex 2

Case studies

Session 5: ACTIVITY 5-1

CASE STUDY 1

Aloo, a 14-year old in Kenya, attended a girl's boarding school and was the top pupil in her class. Her closest friend, Maria, was in the same class and they were the two star students in their class. Aloo came from a rural village in Western Kenya. Maria was the daughter of a prosperous businessman in Nairobi.

The two girls shared many secrets. They were both virgins and members of the Christian Union. One weekend in their second year in high school, while attending a student camp, they became friends with two boys from a nearby school. They ended up having sex, their first time. This was one month before the school holidays.

The following month they both missed their menstrual periods. They were on vacation and did not share this secret until the school opened. Could they be pregnant? As the school was near Nairobi, Maria's mother used to visit her every month. On her next visit Maria disclosed to her mother the problem. The mother immediately understood what was going on. She asked for permission for Maria to attend a family emergency, took her home and arranged for an immediate termination of pregnancy by her gynaecologist. Maria was back in school that Monday.

Aloo remained in school and soon the teachers started suspecting that she might be pregnant. She had been frequently unwell and moody, her performance in class deteriorated, and the school nurse was summoned to examine her. Aloo had to miss class in order to get to the clinic during working hours. Pregnancy was confirmed and according to the school's policy she was immediately suspended and given a letter to take to her parents. Aloo was devastated. She had no money to go home. Her parents were elders in their church and would kill her if they heard what had happened.

Terrified, she went to the local clinic to seek help. Being the only young woman in the clinic, she felt self-conscious as all the adult patients and workers kept staring at her. She came up against a lengthy registration process that required the signature of her parents. The health-care provider scolded her for her immoral behaviour and told her that she would not receive any services without her parents' consent. She had to leave.

Maria gave her some money and Aloo left school and travelled to Nairobi to see her uncle, a construction worker who lived in one of the slums. When her uncle returned from work in the evening Aloo feigned sickness and told him that she had been sent away because of school fees. The uncle sympathized with her but could not raise any money. He therefore sent a letter by post to Aloo's parents, asking them to send the money.

Aloo was now four months pregnant and it became more difficult to hide. At six months her uncle's wife noticed the pregnancy. Her uncle was furious and chased her out of his house. Lonely, with no money and nowhere to go, Aloo accepted accommodation from a young man in their neighbourhood.

Two months later Aloo delivered a premature baby boy at a nearby health centre. The baby had to be kept in the nursery for two weeks. When Aloo was discharged from the hospital she found that the young man who had accommodated her had moved.

She was now desperate! A 15-year old with a premature newborn, no money and homeless. Aloo took refuge in the only place that could accept her. A businesswoman selling gin in the slum area employed her to help serve her customers. That became Aloo's life.

CASE STUDY 2

Surekha, a 12-year old girl, lived with two younger brothers and her parents in Ahmedabad, a city in Western India. Hers was a middle-class family, and her parents cared for and loved their children very much. Surekha was a happy child. She was a good student and was liked by her teachers and her class mates.

One day, when Surekha was in class, she noticed that her underpants were feeling wet and uncomfortable. When she looked down at her dress, she noticed that it was splotched with blood. The girl sitting beside her noticed this too and went and told the teacher about it. The teacher stopped the lesson, took Surekha to the staff room and asked her to use the toilet to clean herself and apply a pad. Surekha did not know what had happened to her, or what to do. She was in shock.

Her teacher explained the situation to the other teachers who were present, told her to sit in a corner of the staff room and went back to her class. None of the other teachers took any notice of her. Surekha sat in silence for two hours till the school day came to an end. She did not know what was happening to her, and prayed hard that there was nothing seriously wrong with her. After all the teachers had left, she tiptoed outside to check if the coast was clear, went to her class, took her things and walked home covering her soiled dress.

When she reached home, she burst into tears and told her mother what had happened. Her mother signalled her to be silent, shooed Surekha's brothers out of the room, and took her to the bathroom. Her mother told her that this was a sign that Surekha was no longer a girl. Her mother told her what to do, and said that the bleeding would last a few days. She also told her that this would happen every month for the rest of her life.

Surekha went to bed with her mind in a whirl. She had many, many questions, and decided to speak to Sita, a girl in a senior class whom she knew.

Handout for

Module D

Adolescent-friendly health services

This handout provides information to complement the material covered in module D *Adolescent-friendly health services*. The facilitator may refer to the text in this handout during the sessions and you may be asked to read some extracts.

This handout provides information on the following:

1. An agenda for change D-5

2. What health services do adolescents need? D-7

3. Do existing services meet the needs of adolescents? D-9

4. What makes health services "adolescent-friendly"? D-11

5. How are services best delivered to adolescents? D-15

Annex 1. Spot checks. Session 1 – Activity 1-2 D-17

1. An agenda for change

Adolescents complete their physical, emotional and psychological journey to adulthood in a changing world that contains both opportunities and dangers.

Most adolescents are full of optimism and represent a positive force in society, an asset now and for the future as they grow and develop into adults. When supported, they can be resilient in absorbing setbacks and overcoming problems.

However, adolescents are exposed to risks and pressures on a scale that their parents did not face. Globalization has accelerated change while the structures that protected previous generations of young people are being eroded. Adolescents receive contradictory messages on how to address the daily choices which have lifelong consequences for healthy development.

Millions are denied the essential support they need to become knowledgeable, confident and skilled adults. They miss out on schooling for economic reasons or because their communities are displaced or disrupted by war or conflict.

While most young people have loving families who protect and care for them, many grow up with no adults committed to their welfare or where the ability of caring adults to support them has been damaged.

Adolescents are at risk of early and unwanted pregnancy, of sexually transmitted infections (STIs) including HIV and AIDS, and vulnerable to the dangers of tobacco use, alcohol and other drugs. Many are exposed to violence and fear on a daily basis. Some of the pressures adolescents are under, or the choices they make, can change the course of their young lives, or even end them. These outcomes represent personal tragedies for young people and their families. They are also unacceptable losses that put the health and prosperity of society at risk.

Addressing the needs of adolescents is a challenge that goes well beyond the role of health services alone. The legal framework, social policy, the safety of communities and opportunities for education, employment and recreation are just some of the factors of civil society that are key to adolescent development.

However, within an integrated approach, health services can play an important role in helping adolescents to stay healthy and to complete their journey to adulthood; supporting young people who are looking for a route to good health, treating those who are ill, injured or troubled and reaching out to those who are at risk.

Effective health services reach adolescents who are growing up in difficult circumstances as well as those who are well protected by their communities. Health services need to link with the other key services for adolescents, so that they become part of a supportive structure that protects young people against dangers, and helps them to build knowledge, skills and confidence.

This is far from being the case in many countries. Health services often regard adolescents as a healthy group who do not need priority action, and so provide a minimum subset of adult or paediatric services with no adjustments for their special needs.

There is evidence that many young people regard such health services as irrelevant to their needs and distrust them. They avoid such services altogether, or seek help from them only when they are desperate.

“Adolescent-friendly” health services meet the needs of young people sensitively and effectively and are inclusive of all adolescents. Such services deliver on the rights of young people and represent an efficient use of precious health resources. Their characteristics are further spelled out in this handout.

SUMMARY

- Adolescents represent a positive force in society, now and for the future
- They face dangers more complex than previous generations faced, and often with less support
- The development needs of adolescents are a matter for the whole of civil society
- Health services play a specific role in preventing health problems and responding to them
- Many changes are needed in order for health services to become adolescent-friendly.

2. 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.

Essential services

Is it possible to define essential health services for adolescents? A regional consultation carried out by the Pan American Health Organization suggested that a core package for improving adolescent health and development should:

- Monitor growth and development.
- Identify and assess problems and problem behaviour, managing these where possible or, referring young people if they cannot.
- Offer information and counselling on developmental changes, personal care and ways of seeking help.
- Provide immunization. (Immunization programmes are run for young children but not for an older sister or brother. Adolescent girls need protection from rubella before they become pregnant. Vaccines are also available for meningitis, hepatitis and tetanus.)

A WHO consultation in Africa in October 2000 agreed that "adolescents have a right to access health services that can protect them from HIV/AIDS and from other threats to their health and well-being, and that these services should be made adolescent-friendly". The consultation recognized that health and development needs cannot be met by health services alone, but outlined an essential list of clinical services:

- General health services for tuberculosis, malaria, endemic diseases, injuries, accidents and dental care;
- Reproductive health including contraceptives, STI treatment, pregnancy care and post-abortion management;
- Counselling and testing for HIV, which should be voluntary and confidential;
- Management of sexual violence;
- Mental health services, including services to address the use of tobacco, alcohol and drugs;
- Information and counselling on development during adolescence, including reproductive health, nutrition, hygiene, sexuality and substance use.

However, an appropriate range of essential services must be decided by each country, based on local needs assessments and resource availability.

The Global Consultation on Adolescent-Friendly Health Services, held by WHO in Geneva in March 2001, concluded that a core package could not be a "fixed menu". Instead, the Global Consultation suggested that each country must develop its own package, negotiating its way through economic, epidemiological and social constraints, including cultural sensitivities. It declared: "What is needed is a process by which government ministries can make decisions about what is most appropriate for their situation, taking into account cost, epidemiological factors and adolescent development priorities."

To take one example, South Africa has developed a package of essential adolescent health-care services at a primary level, focused on reproductive health – HIV, STIs, pregnancy – and on violence, which is often sexual in nature. It includes counselling, contraceptives, pregnancy tests and HIV testing at primary care level, and that abortions should remain legal. This South African package focuses on the priority issues for young people and develops an approach that is culturally acceptable to most people. Another country might develop a different set of priorities, or a different method of working.

SUMMARY

- 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 their health problems and deal with personal difficulties.
- Health-care providers cannot meet all these needs alone. They can join or create networks that act together and maximize resources.
- A package of basic health services must be tailored to local needs, including growth and development monitoring and immunization.
- Reproductive health services, counselling and voluntary testing for HIV and other sexually transmitted infections are a high priority in most places.
- Mental health services and counselling are important elements to support adolescents.
- There is no single "fixed menu" suitable for every country. Each country must develop its own package, according to economic, epidemiological and social circumstances.

3. Do existing services meet the needs of adolescents?

Surveys in many countries suggest that when young people are looking for urgent treatment for what they consider to be sensitive conditions, health services are often their last resort. Health-care providers are often dismayed by these findings, as they want to be a resource for young people – but they do not know how. Yet adolescents can be excluded by poor service delivery, their own lack of awareness or a combination of legal, physical, economic and psychological barriers.

- Lack of knowledge on the part of the adolescent

  Most young people do not have the knowledge or experience to distinguish between conditions that go away of their own accord and those that need treatment. They do not understand their symptoms or the degree of risk they may be taking. They do not know what health services exist to help them, or how to access them.

- Legal or cultural restrictions

  Reproductive health services, such as family planning clinics or abortion services, are often restricted. Abortions may be illegal, although the health system deals with the consequences of unsafe abortions. Even if condoms are available, health-care workers may withhold them from adolescents. Young people need consent from their parents for medical treatment.

- Physical or logistical restrictions

  Services may be a long way from where the young person lives, studies or works, or available only at inconvenient hours. Some services may be inaccessible to the general public – for example, it may only be possible to access a drug treatment programme via the criminal justice system.

- Poor quality of clinical services

  Quality may be poor because health-care providers are poorly trained or motivated, or because a health facility has run out of medicines or supplies.

- Unwelcoming services

  Of special concern is the way in which services are delivered. Young people are very sensitive to privacy and confidentiality, and do not want their dignity to be stripped away. Adolescents are more likely than older people to be deterred by long waiting times and administrative procedures, especially if they are made to feel unwelcome. Unfriendly health-care providers who do not listen or are judgemental, make it difficult for young people to reveal concerns. They may not return for follow-up care.

- High cost

  Young people usually cannot afford to pay for health services but must ask an adult to support them. When desperate, young people will "beg, borrow or steal" money for treatment, but may then seek help in the private sector so as to protect their privacy, even if this treatment is more expensive and less effective.

- Cultural barriers

  In many countries a culture of shame discourages adults and children from talking about their bodies or sexual activity. This can inhibit parents from discussing sensitive issues with their children, and make a young person reluctant to use sexual or reproductive health services. It may also be difficult to seek help after violence and sexual abuse. Not every adolescent has the same concerns and not all services are equally sensitive, but these factors are widely applicable across cultures, for both sexes and especially among adolescents who have low self-esteem or who feel vulnerable.

- Gender barriers

  Some barriers are especially associated with the sex of the young person. Adolescent girls are very reluctant to be examined by males, while young men may find it difficult to discuss intimate symptoms with a female health-care provider. Sensitivities above may be especially cultural powerful disincentives for girls to use services. There are many cultural barriers associated with gender. It takes two to make a baby, but it is girls who become pregnant. It is very difficult for a 16-year old girl to attend a local clinic for a pregnancy test or for contraception, if she knows that she will be seen by a relative or neighbour. Girls who do not leave the house much may have less access to information and in some cultures have to seek consent from a parent or spouse before treatment. Girls may even be denied treatment by health-care workers, despite being legally entitled to them.

- Peer pressure

  Adolescents often consult their friends about where they should seek treatment, and in this way, one person's experience becomes the criteria by which a group of young people make their health-care decisions. Some may seek out useful sources of help such as trained pharmacists, but others turn to street vendors, or unlicensed practitioners. Many seek no help at all with potentially catastrophic results. This reluctance to seek early help goes beyond reproductive and sexual health matters. Street children presented late and usually did not complete their treatment, although they represented a significant source of hidden illness and infection. Young people in boarding schools or colleges also presented late because they wanted to hide the diagnosis from their peers, the school authorities and their families. In both cases, the adolescents were protecting their privacy above their need for medical care. This resulted in poor treatment, missed classes and an inability on the part of the hospital to provide effective contact tracing. When young people are confident that hospitals and clinics protect confidentiality, they ask for help sooner.

SUMMARY

- Adolescents lack knowledge about what services are available and how to access them
- There may be legal restrictions on the use of services or cultural reasons why young people do not wish to be seen there
- Adolescents give high priority to confidentiality
- They are put off if the services are a long way away or are expensive
- They will not use unfriendly services or those with poorly trained staff.

4. What makes health services "adolescent-friendly"?

Adolescent-friendly health services represent an approach which brings together the qualities that young people demand, with the high standards that have to be achieved in the best public services. Such services are accessible, acceptable and appropriate for adolescents. They are in the right place at the right time at the right price (free where necessary) and delivered in the right style to be acceptable to young people. They are equitable because they are inclusive and do not discriminate against any sector of this young clientele on grounds of gender, ethnicity, religion, disability, social status or any other reason. Indeed they reach out to those who are most vulnerable and those who lack services. The services are comprehensive in that they deliver an essential package of services to the whole target group.

They are effective because they are delivered by trained and motivated health-care providers who are technically competent, and who know how to communicate with young people without being patronizing or judgemental. These providers are backed up by adolescent-friendly support staff and have access to equipment, supplies and basic services. They also maintain a system of quality improvement so that staff are supported and remotivated to keep up their high standards. Finally the services are efficient so that they do not waste money, and they record enough information to be able to monitor and improve performance.

The gold standard for adolescent-friendly health services is that they are effective, safe and affordable, they meet the individual needs of young people who return when they need to and recommend these services to friends. Even if this ideal cannot be achieved immediately, improvements bring results.

Making services adolescent-friendly is not primarily about setting up separate dedicated services, although the style of some facilities may change. The greatest benefit comes from improving generic health services in local communities and by improving the competencies of health-care providers to deal effectively with adolescents.

The characteristics of adolescent-friendly health services were discussed during the global consultation process initiated by WHO in 2000, and continued during the discussions by the expert group convened by WHO in Geneva in 2001.

These characteristics are intended for application sensitively in each country, bearing in mind the cultural, social, economic and political context and the need to support health-care providers to deliver the best possible service to adolescents.

Technical competence

Doctors and nurses need a good knowledge of normal adolescent development and the skills to diagnose and treat common conditions, such as anaemia or menstrual disorders in adolescent girls, and to recognize signs of sexual or physical abuse. They need access to the correct drugs and supplies to treat common conditions and prevent health problems. They should know where to refer adolescents for specialist physical or psychological treatment. Such referrals may be to people or services outside the health system for counselling or social support.

See the person, not the problem

Technical competence must be accompanied by respect and sensitivity to draw the young person out and to discover underlying problems that may not be the immediate cause of a visit. As well

as conditions that only a clinician can understand, such as a "suboptimal adolescent growth spurt", a doctor, medical officer or nurse must be able to recognize a young person who is confused or frightened. Adolescents often lack confidence and may present with a "safe" symptom, to test the service before revealing their real concerns. By focusing on the person, rather than the symptom, providers can discover underlying concerns. Technical skills and a sympathetic professional approach should be combined with a non-judgemental approach. Health-care providers do not need to abandon their own belief systems or values, but they do need to understand a situation from an adolescent's point of view and not to allow their own views to dominate the interaction.

Training and staff support

Technically competent and empathetic staff need a system of ongoing support. An adolescent-friendly approach should include repeated training sessions to refresh the skills of current staff as well as developing new skills for new staff. Training and peer-review sessions should cover everyone from doctors (who may believe they need no further training) to the receptionist and cleaner, who may be surprised that they are part of the team. These staff may be the first person an adolescent meets at a health facility. If they are unfriendly or indiscrete, an adolescent may never return. Management and supervision should be aimed at creating a supportive environment and at developing systems to maintain and improve quality. Health-care providers should be involved in drawing up protocols and guidelines covering key quality issues. They should also develop self-assessment and peer review mechanisms which create a culture of openness. Monitoring systems should encourage adolescents to provide feedback on services.

Making the service physically accessible

Services need to be provided in places that adolescents can reach, at times that they can get there. This may involve holding special clinics in youth centres, or other places where adolescents go. Clinical staff can take turns to do late duty rotas so that a clinic can run in the evening or at weekends, when young people are not at school, college or working.

Physical surroundings are important. Many places have no special adolescent centre, but still provide a welcoming health facility. Attention can be paid to the paintwork, posters on the walls, cleanliness and whether there are enough chairs where people wait. A general adolescent health clinic can advertize its name at the entrance, while an STI clinic may want a discrete entrance. Adolescents themselves may help to decide on a creative name that will be welcoming but not stigmatizing. A busy city hospital with little money for capital development can create an "adolescent health corner", by putting up a partition, so that young people can be seen in privacy, or by using a rear door where they can enter without stigma. Some clinics give young people numbers when they arrive so that they can be called to see the doctor or nurse without having to sit in a queue "on display" and without having their name called out. While waiting they should be able to look at health promotion literature, or even view a video.

Confidentiality and privacy

Adolescents need to be assured of privacy during a consultation and confidentiality afterwards. Young people should not be expected to undress or be examined where people can see them. Those waiting outside should not be able to hear a doctor giving a diagnosis. Patients must be confident that medical records will not be left on view and that receptionists will not gossip. In most countries there is a legal obligation for doctors to report sexual assault, a road traffic accident or gunshot wounds. There are also legal restrictions on treatment to young people below a certain age without parental consent. These and other legal constraints need to be explained as the only

exceptions to a strict policy of confidentiality. This policy itself can be jointly developed with adolescents and health-care providers so that everyone understands and feels comfortable with the ground rules. The confidentiality policy, including exceptions, needs to be explained to all adolescent users and to parents or guardians, and needs to be clearly understood by referral agencies.

Services that are acceptable to the local community

Simply making services "adolescent-friendly" will not increase usage, unless young people feel that it is acceptable to be seen to use them. Community support for the service must also be sought. The community should have an opportunity to understand why services are important for adolescents, and why these should include sexual and reproductive health services and confidential counselling. Local meetings may be held for parents, and community and religious leaders should be approached for support. Services may even be located in community settings. There are many examples of services being delivered in schools, community centres or on the street. Where public support is difficult to achieve (as is often the case for health services for sex workers or for injecting drug users) the services can be run in a low key way, or through community outreach workers.

Involving adolescents

Services that reach a high quality are those that closely involve adolescents in their planning and monitoring. Through the involvement of young people service providers can be confident that they are providing services in the right place, at the right time and in the right style. The involvement of adolescents in planning and monitoring delivers on their right to have their views heard. It also increases the confidence that other young people place in those services.

SUMMARY

Characteristics of adolescent-friendly health services

Adolescent-friendly health services need to be accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient. These characteristics are based on the WHO Global Consultation in 2001 and discussions at a WHO advisory group meeting in Geneva in 2002. They require:

1. Adolescent-friendly policies that

- fulfil the rights of adolescents as outlined in the UN Convention on the Rights of the Child and other instruments and declarations;
- take into account the special needs of different sectors of the population, including vulnerable and under-served groups, do not restrict the provision of health services on grounds of gender, disability, ethnic origin, religion or (unless strictly appropriate) age;
- pay special attention to gender factors;
- guarantee privacy and confidentiality and promote autonomy so that adolescents can consent to their own treatment and care;
- ensure that services are either free or affordable by adolescents.

2. Adolescent-friendly procedures to facilitate

- easy and confidential registration of patients, and retrieval and storage of records;
- short waiting times and (where necessary) swift referral;
- consultation with or without an appointment.

1 of 2

SUMMARY

Characteristics of adolescent-friendly health services

3. Adolescent-friendly health-care providers who

- are technically competent in adolescent-specific areas, and offer health promotion, prevention, treatment and care relevant to each client's maturation and social circumstances;
- have interpersonal and communication skills;
- are motivated and supported;
- are non-judgemental and considerate, easy to relate to and trustworthy, devote adequate time to clients or patients;
- act in the best interests of their clients;
- treat all clients with equal care and respect;
- provide information and support to enable each adolescent to make the right free choices for his or her unique needs.

4. Adolescent-friendly support staff who are

- understanding and considerate, treating each adolescent client with equal care and respect;
- competent, motivated and well supported.

5. Adolescent-friendly health facilities that

- provide a safe environment at a convenient location with an appealing ambience;
- have convenient working hours;
- offer privacy and avoid stigma;
- provide information and education material.

6. Adolescent involvement, so that they are

- well informed about services and their rights;
- encouraged to respect the rights of others;
- involved in service assessment and provision.

7. Community involvement and dialogue to

- promote the value of health services; and
- encourage parental and community support.

8. Community based, outreach and peer-to-peer services to increase coverage and accessibility

9. Appropriate and comprehensive services that

- address each adolescent's physical, social and psychological health and development needs;
- provide a comprehensive package of health care and referral to other relevant services;
- do not carry out unnecessary procedures.

10. Effective health services for adolescents

- that are guided by evidence-based protocols and guidelines;
- having equipment, supplies and basic services necessary to deliver the essential care package;
- having a process of quality improvement to create and maintain a culture of staff support.

11. Efficient services which have

- a management information system including information on the cost of resources;
- a system to make use of this information.

2 of 2

5. 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 health-care 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.

Services at health centres or hospitals

Basic health services are usually delivered at ordinary health centres in local communities 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.

There are also dedicated health centres which provide a full range of services especially for adolescents. Such centres may be in large towns or cities, where they are relatively cost-effective, or they may be run by NGOs as “beacon” services that show what can be done. Such services can provide training and inspiration for other health-care providers, but they usually only have an impact in one area, and they cannot be replicated in mainstream services, because of the cost.

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.

Health services linked to schools

Schools provide a natural entry point for reaching young people with health education and services. In the five years to 1996, it was estimated that the number of children enrolled in primary education increased by approximately 50 million, and the increase was most rapid amongst girls. Secondary school enrolment is also increasing.

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.

Health services linked to workplaces

Employers and trade unions both have an interest in services that help to keep the workforce healthy, and many workers in workshops and factories are adolescents. Peer education on HIV/AIDS has been carried out in workplaces in some countries. In other countries, the Ministries of Labour provide outreach programmes in boarding houses and factory-based education sessions to meet the reproductive health education needs of young women working in the factories. The Ministries also conduct a general skills course for the large number of female workers.

SUMMARY

- Adolescent-friendly 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.

Annex 1

Spot checks

Session 1: ACTIVITY 1-2

SPOT CHECK 1

Health facilities should reach out to adolescents and become adolescent-friendly because…

please fill in the blank spaces

-
-
-
-
-
-

SPOT CHECK 2

Adolescents often do not make the best use of available health services because...

please tick three of the most important reasons

- …they expect that the staff will inform their parents ○
- …they do not like waiting or filling in forms ○
- …they are not interested ○
- …they do not recognize illnesses ○
- …they want to spend money on other things ○
- …they do not like the way health staff deal with them ○
- …they do not want to draw attention to themselves ○
- …they find it easier to talk to their friends than to health-care workers ○
- …they do not know where to go ○

SPOT CHECK 3

What are the most important characteristics of adolescent-friendly health services?

please fill in the blank spaces

SPOT CHECK 4

How adolescent-friendly do you believe the health facility you work in is?

please mark your answer with a spot anywhere along the line

not adolescent-friendly	somewhat adolescent-friendly	very adolescent-friendly

Handout for

Module F

Concluding

This handout provides information to complement the material covered in module F *Concluding*. The facilitator may refer to the text in this handout during the sessions.

This handout provides information on the following:

1. Adolescents at the centre F-5

2. Health-care providers and the needs of adolescents F-6

Annex 1. Activity sheet. Session 3 – Activity 3-1 F-7

Annex 2. Scenarios. Session 5 – Activity 5-1 F-17

1. Adolescents at the centre

Many individuals and institutions have important contributions to make to the health and development of adolescents. It may be useful to think of them in concentric circles of contact and influence. At the centre is the adolescent himself or herself. Parents, siblings and some other family members are in immediate contact with the adolescent and constitute the first circle. The second circle includes people in regular contact with them such as their own friends, family friends, teachers, religious leaders and others. The third circle includes musicians, film stars and sports figures who have a tremendous influence on them from afar. Finally in the fourth circle, politicians, journalists and bureaucrats (within the government and private sectors) affect their lives in small and big ways, through their words and deeds.

Health-care workers fit within the second circle in this scheme. They need to play a role in helping ill adolescents get back to good health (by diagnosing health problems/detecting problem behaviours and managing or referring them elsewhere). They also need to play a role in helping well adolescents stay well and develop into healthy adults, by providing information, advice and preventive services (or products). Unfortunately, in many places health-care workers do not make the valuable contributions that they could, either because they do not have the technical competencies needed or – which is often the case – they are unable or unwilling to relate to and work with adolescents.

2. Health-care providers and the needs of adolescents

This OP has been developed for health-care providers like you – nurses, clinical officers, doctors and others who provide preventive and curative health services to adolescents (as well as to other segments of the population). It is intended to assist you in responding to your adolescent patients more effectively and with greater sensitivity. In practical terms, it is intended to provide you with ideas and practical tips to two key questions:

- What do I, as a health-care provider, need to know and do differently if the person who walks into my clinic is aged 16 years, rather than 6 or 36?
- How could I help? in the clinic? away from the clinic? are there other influential people in my community who understand and respond better to the needs and problems of adolescents?

Health-care providers like yourself, who have participated in OP workshops conducted around the world, have said that they have learned new things and more importantly learned to see things in new ways. We hope you have found this OP workshop both useful and interesting. We expect that you have gained new knowledge and understanding from the facts and figures, concepts and case studies presented by the facilitators, from the insights and experiences shared by your co-participants and most importantly, from yourself – as you reflected on your professional and personal experiences.

Applying what we have learned to change the way in which we do things – either in our professional or in our personal lives, is not easy to do. The OP is carefully structured to help you clearly define the changes you want to make, and the support you would need to make them. If you are in a powerful position – perhaps as the nursing superintendent or the head of the paediatrics department of a big hospital – you could possibly make a wide range of changes. Even if you are a junior doctor or nurse beginning your professional career in a small rural health centre, there could still be meaningful changes beginning with yourself, then reaching out to your colleagues, and then to the community beyond the walls of the health centre. Something that you should certainly do is to identify the competencies you need for your work (e.g. in counselling young people with HIV infection, or in managing young people with overdoses of psychoactive substances) and to search for opportunities to develop them.

There are likely to be times when you ask yourself: "Why should I take this on when I have more than enough on my hands?" At times like this, it may be helpful to think of the adolescents whose lives could have been changed because they were inspired by a few words from you, or whose lives were saved because of prompt medical intervention by you. Or you could recall the statement made by Dr Gro Harlem Bruntland, the former Director-General of the World Health Organization, at a ministerial conference on Population and Development in 1999: "*Think of the costs of failing to ensure that young people – our common future – have the knowledge, skills and services they need to help them make healthy choices in their sexual and reproductive health...*"

Annex 1

Activity sheet

Session 3: ACTIVITY 3-1

The improvements you propose to make in your work for and with adolescents

Purpose

The purpose of this exercise is to help you prepare the outline of a personal plan to improve your work for and with adolescents. In this plan you will identify the changes you intend making in the way you will work. The plan includes the following elements:

- The proposed changes you intend to make;
- The importance of the proposed changes;
- How you will assess whether or not you are successful in making these changes;
- The personal and professional challenges and problems you may face in making these changes;
- The ways in which you are likely to address these challenges and problems, and the support you will need.

General instructions

- Please use the tables entitled "*Individual implementation plan*", which appear on the following pages, to record five changes you intend making in the way you work with or for adolescents.
- Please review the example on page F-11.
- 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 changes and application of this plan, it would be useful to set yourself target dates to review your progress and reassess your plans.

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

Sample Individual Implementation Plan

Column 1	Column 2		Column 3		Column 4	Column 5	
The changes I plan to make in my everyday work with or for adolescents.	Why I believe this change is important: who or what will benefit and why?		How will I know whether or not I have been successful and when will I know this?		Any challenges or problems I anticipate in carrying out the changes.	What help am I likely to need and who could provide me with this help?	
	Who/what will benefit?	Why?	How?	When?		Help needed	Source
EXAMPLE							
Contact the local schools to provide information on the new adolescent-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 administration. Resistance from the teachers.	Support from the district education authority. A seminar to convince them of the value of this work.	The director of the local hospital could request this. Leaders of the parent-teachers association.

Individual Implementation Plan							
Column 1	Column 2		Column 3		Column 4	Column 5	
The changes I plan to make in my everyday work with or for adolescents.	Why I believe this change is important: who or what will benefit and why?		How will I know whether or not I have been successful and when will I know this?		Any challenges or problems I anticipate in carrying out the changes.	What help am I likely to need and who could provide me with this help?	
	Who/what will benefit?	Why?	How?	When?		Help needed	Source

Individual Implementation Plan

Column 1	Column 2		Column 3		Column 4	Column 5	
The changes I plan to make in my everyday work with or for adolescents.	Why I believe this change is important: who or what will benefit and why?		How will I know whether or not I have been successful and when will I know this?		Any challenges or problems I anticipate in carrying out the changes.	What help am I likely to need and who could provide me with this help?	
	Who/what will benefit?	Why?	How?	When?		Help needed	Source

Individual Implementation Plan								
Column 1	Column 2		Column 3		Column 4	Column 5	
The changes I plan to make in my everyday work with or for adolescents.	Why I believe this change is important: who or what will benefit and why?		How will I know whether or not I have been successful and when will I know this?		Any challenges or problems I anticipate in carrying out the changes.	What help am I likely to need and who could provide me with this help?	
	Who/what will benefit?	Why?	How?	When?		Help needed	Source

Individual Implementation Plan

Column 1	Column 2		Column 3		Column 4	Column 5	
The changes I plan to make in my everyday work with or for adolescents.	Why I believe this change is important: who or what will benefit and why?		How will I know whether or not I have been successful and when will I know this?		Any challenges or problems I anticipate in carrying out the changes.	What help am I likely to need and who could provide me with this help?	
	Who/what will benefit?	Why?	How?	When?		Help needed	Source

Individual Implementation Plan

Column 1	Column 2		Column 3		Column 4	Column 5	
The changes I plan to make in my everyday work with or for adolescents.	Why I believe this change is important: who or what will benefit and why?		How will I know whether or not I have been successful and when will I know this?		Any challenges or problems I anticipate in carrying out the changes.	What help am I likely to need and who could provide me with this help?	
	Who/what will benefit?	Why?	How?	When?		Help needed	Source

Annex 2

Scenarios

Session 5: ACTIVITY 5-1

Please review your assigned scenario and reflect on the following questions:

- How do you think health-care providers would respond when faced with this situation?
- Why?

SCENARIO 1

A young man comes into your clinic and says that he has no problem. He just wants some condoms for "protection". When you begin taking the history, he tells you that he is 18 years old, knows about AIDS, and does not want to listen to a lecture on morality. How would you react to this situation?

SCENARIO 2

A young woman of 16, whom you have known as a child and whose parents and siblings you know very well, comes to your clinic for help. She says that she thinks she is pregnant, and wants you to give her or prescribe for her some emergency contraceptive pills. She insists that she does not want her parents to know about this. How would you react to this situation?

SCENARIO 3

A girl of 14 is brought to your clinic by her mother. The mother says that the girl has been complaining of abdominal pain and backache for the past two weeks, and that she thinks that the pain is related to menstruation. When taking the history, you notice that the girl is silent – even shy – and allows her mother to speak on her behalf. You gently persuade the mother to wait in the consultation room when you take the girl into the examination room. Soon after the door is shut, the girl tells you that the problem is that her father forces her to have sex with him whenever they are alone at home. With tears in her eyes, she asks you to promise not to tell her mother, because it would break her heart. What would you do in this situation?

SCENARIO 4

A young man of 18 bursts into your room, slams the door and walks towards you. He reaches your table and remains standing. You can see that he is very angry – literally trembling and there are tears in his eyes. He thumps the table and shouts at you: "When I saw you last week you promised me that no one would come to know about my problem. Yesterday, my mother said that she knew everything! She said that one of the nurses in your clinic, who is her friend, told her. I will never trust you people with white coats again…".

Handout for

Module G

Sexually transmitted infections in adolescents

This handout presents background information to complement the material in module G entitled *Sexually transmitted infections in adolescents*. The facilitator may refer to the text in this handout during the sessions and you may be asked to read some extracts.

This handout provides information on the following:

1. What are sexually transmitted infections (STIs)? G-5
2. Global estimates of STIs in adolescents G-6
3. What are the factors contributing to STIs in adolescents? G-7
4. What are the consequences of STIs among adolescents? G-8
5. What are the main factors that hinder getting a prompt and correct diagnosis of STIs in adolescents? G-8
6. What are the main factors that could hinder the effective management of STIs in adolescents? G-9
7. What can health-care providers do to overcome the reluctance of adolescents to seek STI treatment? G-9
8. What do health-care providers need to know about STI management in adolescents? G-10
9. What are the key aspects of diagnosis and good management practice of STIs in adolescents? G-11
10. Linkages with community or outreach programmes G-14
11. References G-15

Annex 1. Spot checks. Session 1 – Activity 1-2 G-17

Annex 2. Scenarios. Session 6 – Activity 6-2 G-21

Annex 3. Role plays. Session 7 – Activity 7-2 G-25

1. 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 developing countries. This is a major public health problem for two reasons:

- STIs result in serious negative medical and psycho-social effects in the infected individual. 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 available and standardized treatment protocols are employed.

2. Global estimates of STIs in adolescents

BOX 1

Global data on STIs in adolescents and young people

- Every year more than one out of 20 adolescents contracts a curable STI, not including viral infections.
- The age at which STIs are acquired is becoming younger.
- Of the estimated 333 million new STIs that occur in the world every year, at least one third occur in young people under the age of 25.
- Globally, more than half of all new HIV infections (over 6,500 each day) are among young people aged 10-24 years.

Source: Reference (1,2,3).

The available epidemiological data indicate that sexually transmitted infections are a major health risk to all sexually active adolescents (Box 1).

Epidemiological data show that there are notable differences in the incidence and prevalence of STIs between different groups within a population. These differences reflect a number of social, cultural and economic factors. STIs tend to be higher in urban residents, among unmarried individuals and in young adults, and they tend to occur at a younger age in females than males.

The differences in the epidemiology of STIs in adolescents compared to adults have not always been apparent. This is due to the common practice of reporting data on adolescents (aged 10-19 years) in the same category as “youth” (15-24 years) or together with “women of reproductive age” (15-49 years) (*4*).

The high prevalence of STIs in young people presents a real challenge to health-care providers, many of whom feel uncomfortable dealing with adolescent sexual health needs. As the size of the problem becomes more evident, health professionals are being called upon to provide an effective and confidential clinical service for them (*5*).

There is a dearth of representative age- and sex- specific STI data from developing countries, especially for adolescent males. This largely reflects the recognition that the burden of morbidity associated with STIs is far higher for women than for men (*6)* and that men are more likely to seek treatment for STIs.

3. What are the factors contributing to STIs in adolescents?

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 (*7*). Adolescents start sexual activity typically 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 (*8*). 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 (*9*).
- 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 (*10*).

Adolescent boys in many cultures feel they have to prove themselves sexually; and in some cultures they may even regard STIs as "warrior marks" to indicate the transition to adulthood. Studies in various parts of the world 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 (*11*).

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.

4. 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 (Box 2).

BOX 2

Consequences of STIs for adolescents

- Pelvic inflammatory disease (PID): Chlamydia infection during adolescence is more likely to result in (PID) and its sequelae (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.

Source: Reference (12).

5. What are the main factors that hinder 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 (*13*).

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, especially 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.

6. 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-medicate when they believe that they have exposed themselves to the risk of an STI (*14*).

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.

7. What can health-care providers do to overcome the reluctance of adolescents to seek STI treatment?

Health-care providers have important roles to play in relation to this, both as service-providers and as change-agents in the community. These issues are discussed in detail in module D titled *Adolescent-friendly health services*.

8. What do health-care providers need to know about STI management in adolescents?

Currently adolescents with STIs are managed in the same way as adults. However, adolescents have special needs and STIs in adolescents may be more difficult to diagnose and to manage than in adults. The challenge is to identify and treat infected individuals, in order to ensure cure and to prevent them from passing on the infection to others. Ideally, this should be done using a risk assessment approach, and selecting screening tests and treatments most appropriate to the local context (*16*). To do this well for adolescents requires a good understanding of the social, economic and cultural context (including the gender context) in which adolescents live (*15,16*). For these reasons, the World Health Organization is developing reference materials and job-aids for health-care providers.

WHO recommends the use of the *Syndromic approach* to the management of STI. This approach is especially appropriate where human resources and laboratory facilities are not available for etiological diagnosis to be made in resource-poor settings since etiological diagnosis, requiring laboratory facilities, is costly (*17*). Seven syndromes have been identified which enable health-care workers at the primary level to treat infections using signs, symptoms and a risk assessment. Flow charts and accompanying guidelines and training materials for the management of the seven syndromes have been widely disseminated and are currently in use in many countries (Box 3).

BOX 3

Flow charts are available for seven syndromes

- Vaginal discharge (in women)
- Urethral discharge (in men)
- Genital ulcer disease (in men and women)
- Swollen scrotum (in men)
- Lower abdominal pain (in women)
- Inguinal bubo (swelling) (in men)
- Eye discharge (in babies)

The syndromic approach can be used for STI assessment in adolescents because the presentation of symptoms is similar irrespective of age. However, health-care providers must be aware of the factors discussed earlier, which could hinder prompt and correct diagnosis and effective management of STI in adolescents. Some STIs are asymptomatic or mildly symptomatic in adolescents. The syndromic approach – which is based on symptomatic individuals presenting for help – will have little impact on them.

9. What are the key aspects of diagnosis and good management practice of STIs in adolescents?

Respect for their adolescent patients, acknowledgement of their rights to health information and services, and concern for their well-being should guide the words and actions of health-care providers.

In some countries, adolescents have the right to ask for and receive the health services they need. In others, the prevailing laws prohibit the provision of some sexual and reproductive health services to individuals below a certain age. Specifically, the consent of parents/guardians or spouses may be needed before STI treatment can be provided. In dealing with such situations, health-care providers must do everything in their power to safeguard the health and well-being of their adolescent patients.

Health-care providers may find themselves in the situation of trying to find a balance between the rights of parents to know about the problems of their offspring who are still minors, and the rights of adolescent patients to privacy and confidentiality. As discussed earlier, they should deal with such situations in a balanced and responsible manner.

There are some things that health-care providers need to be aware of and do differently when they are dealing with adolescent patients. These are listed in Box 4 and are described in more detail below. Some of the points are specific to adolescence, others are not. Only some of them are "new", but following them faithfully will enable health-care providers to deal with their adolescent patients more effectively and with greater sensitivity.

BOX 4

Factors to consider when treating an adolescent with a STI

- Being aware of the help-seeking and care-seeking practices of adolescents;
- Establishing a good rapport;
- Eliciting information about the nature of the problem by taking a good history;
- Carrying out a physical examination;
- Arriving at a diagnosis;
- Communicating the diagnosis and its implications, discussing treatment options, and providing treatment;
- Responding to the psychological needs and helping the individual deal with any social implications;
- Preventing recurrence of the problem and other STIs;
- Tracing and contacting other infected persons.

Being aware of the care-seeking practices of adolescents

Health-care providers need to be aware of what adolescents do when they have an STI – in other words, where they seek help and why.

Establishing a good rapport

Health-care providers can help adolescent patients to overcome their anxiety by using kind words and gestures and, where appropriate, the adolescents' special vocabulary. Non-communicative, and sometimes even abrasive, behaviour from the adolescent may be due to anxiety. Health-care providers should keep this in mind and handle such situations calmly, without being offended or intimidated by their adolescent patients.

Eliciting information about the nature of the problem

With an open and non-threatening manner, health-care providers could make it easier for their adolescent patients to relax and be forthcoming about their problems. History-taking can be intimidating and threatening to the adolescent. Therefore the health-care provider should gently explain that the series of questions being posed are important to reach the right diagnosis and provide the right treatment. The adolescent should also be informed that the information provided would be treated as confidential.

Health-care providers may not approve of an adolescent's sexual or other activities, but it is important for them to be non-judgemental in their dealings with adolescents. Demonstrating irritation and anger can contribute to a breakdown in communication, and make the adolescent reluctant to return for help.

Health-care providers must also refrain from making instinctive assumptions (for instance, that a young woman with a vaginal discharge has an infection that has been contracted sexually).

Carrying out a physical examination

Both male and female adolescents are likely to be anxious about their genitalia being examined by a health-care provider. In addition, females are likely to be particularly anxious about undergoing a pelvic examination. The health-care provider should make every effort to ensure that the experience is not a traumatic one – physically or psychologically.

The presence of a chaperone should be offered to all patients having intimate examinations, irrespective of the sex of the health-care provider. Some patients prefer to have a person of the same sex examine their private parts; health-care workers need to be sensitive to cultural norms and social taboos in this respect.

It is also important for health-care providers to have a proper understanding of the physical – and psychological – changes that occur at puberty.

Arriving at a diagnosis

Risk assessment for syndromic diagnosis and management in developing countries is different from the approach to diagnosis in developed countries. In the latter context, a detailed sexual history would be taken and, based on the behavioural risks, the clinician would select appropriate screening tests, whether or not the patient is symptomatic.

Syndromic management for urethral discharge in men and genital ulcers in men and women has proved to be both valid and feasible. It has resulted in adequate treatment of large numbers of infected people and is inexpensive, simple and cost-effective. However, there have been some problems with the algorithms for the syndromic management of women with symptoms of vaginal discharge and/or lower abdominal pain. The notable problem is in the management of cervical (gonococcal and chlamydia) infections. Endogenous vaginitis is the main cause of vaginal discharge rather than STIs in general, especially in low-prevalence settings and in adolescent females.

Experience has shown that risk assessment questions based on demographics, such as age and marital status, tend to incorrectly classify too many adolescents as being at risk of cervical infection. Therefore, there is a need to identify the main STI risk factors for adolescents in the local population and to tailor the risk assessment accordingly. For adolescents as for adults, it is important to tailor the risk assessment appropriately, to match the reality of the particular country – or district – in order to improve the sensitivity and specificity of the behavioural risk assessment.

Communicating the diagnosis and its implications, discussing treatment options, and providing treatment

It is important for adolescents to understand the diagnosis and its implications. They will also need to know what services are available to them at the health facility, and what exactly they should – and should *not* do – to ensure that they can take the full course of treatment and are cured of the problem.

An important issue is ensuring treatment compliance. The factors that may hinder compliance in adolescents have been discussed earlier. The health-care provider needs to raise this issue and to tailor the treatment regimen (as and when possible) to make it easier for adolescents to complete their treatment.

Responding to psychological needs and helping the individual deal with any social implications

The STI should be correctly diagnosed and managed. At the same time health-care providers need to assess the psychological state of the adolescent and his/her social circumstances so that appropriate advice or referral to other services can be made. This is especially important in cases where the STI has been the result of rape or sexual abuse.

Counselling aims to assist individuals to deal with problems and situations by enabling them to understand their situation, examine the available options, deal with the problem, and help them make sound decisions accordingly. Counsellors are trained to help clients make decisions about life situations, including how to avoid STIs.

There is a need to arrange for the adolescent to return to the health facility in order to assess the effectiveness of the treatment. The purpose of such a visit must therefore be explained clearly.

Health-care providers should use the opportunity presented by the adolescent's presence at the health facility to determine his/her need for other services that could be provided by the health centre (e.g. contraceptive services). Information should be provided on other forms of assistance that are available, such as referral to other agencies or organizations providing social support.

Preventing a recurrence of the problem and infection with other STIs

Adolescents presenting for treatment of an STI would have had unprotected sexual contact with an infected person. They will therefore need information, skills and supplies to avoid infections in the future:

- Information that builds on existing knowledge and experience, and relevant to the individual's stage of development and circumstances;
- Skills that will enable them to cope with the realities of their everyday lives;
- Supplies, such as condoms and contraceptives.

Health-care providers should make every effort to provide their adolescent patients with this assistance, or to refer them to other organizations when necessary. Adolescent patients should be encouraged to inform their partner(s) about their infection, and to encourage them to seek treatment.

NOTE

It is impossible in practice to force people to identify or even notify their partner(s). People may not know/remember their partners. Even if they do so, they may be unwilling to identify or notify them.

10. Linkages with community or outreach programmes

Many health-care providers operate independently of projects and programmes reaching out to or working with adolescents in the community. Not surprisingly, they are generally used only by a small number of adolescents. In order to reach larger numbers of adolescents, more active means need to be used to reach out with services. Also, staff with a special interest in working with adolescents should be identified and encouraged to work with outside agencies in order to establish referral mechanisms and communication channels that will raise awareness of the availability of the service, and its utilization by adolescents.

In addition, easy access to condoms in the community is essential, especially for those adolescent males who are less likely to go to a clinic. This can be achieved through social marketing programmes which help to ensure that condoms are available in public places – either free or at a low cost.

SUMMARY

Sexually transmitted infections are an important public health problem. Health-care providers should give special consideration to STIs in adolescents because:

- Adolescents run special risks of exposure to STIs, with adolescent girls being especially vulnerable;
- The consequences of infection and disease contracted during adolescence are more severe than those in adults;
- Diagnosis of STIs during adolescence can be more problematic;
- Effective treatment of STIs in adolescents faces a number of constraints.

Given the above, health-care providers should make every effort to manage their adolescent patients more effectively and with greater sensitivity, as outlined in this handout.

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Annex 1

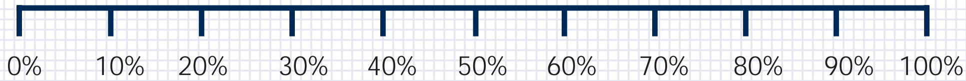
Spot checks

Session 1: ACTIVITY 1-2

SPOT CHECK 1

What percentage of all new STI infections in the world each year are among young people under age 25?

please mark your estimate with a spot anywhere along the line



0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

SPOT CHECK 2

What should health-care providers do with regard to STI prevention among adolescents?

please tick three of the most important reasons

- Stress to all adolescents that they should abstain from sex until marriage ○
- Stress faithfulness to sexually active adolescents ○
- Give condoms and information on how to use them to those who have more than one partner ○
- Make STI services adolescent-friendly ○
- Ensure that all adolescent patients know about STIs and all the ways of avoiding them ○
- Make condoms and information on how to use them available to all adolescents ○

SPOT CHECK 3

Are boys more vulnerable to STIs than girls, in your country?

please mark your answer with a spot anywhere along the line

boys are much more vulnerable — about the same for boys and girls — girls are much more vulnerable

SPOT CHECK 4

Why are adolescent girls more susceptible to STIs than adult women?

please fill in the blank spaces

SPOT CHECK 5

Factors that hinder adolescents from seeking prompt STIs treatment

please tick three of the most important factors

- STIs are often asymptomatic
- The do not have information about existing services
- The do not have money to pay for services
- Concerns about confidentiality
- Fear of stigma and embarrassment
- Afraid of being scolded by health-care workers

Annex 2

Scenarios

Session 6: ACTIVITY 6-2

SCENARIO 1

A 16-year old boy is brought to a clinic by his mother. She says that he told her that he had been injured in his groin, playing football with his friends. When taking the history, the doctor notices that the boy is silent, and does not interrupt his mother, or add to anything that she says. The doctor listens to her for a while, and then leads the boy to the examination room. After shutting the door and settling the boy on the table for examination, the doctor asks him to say what the problem is, in his own words. The boy is silent. After a few minutes, the doctor gently probes once again. He replies in a low voice and asks the doctor to promise not to repeat anything he says to his mother....

Question to pose: How would you deal with this situation?

SCENARIO 2

A 16-year old young woman has come to the clinic in the district hospital of a semi-urban area because she has a vaginal discharge and some painful sores around the vagina. She is received by the duty nurse who has briefly examined the young girl and asked her a few questions. She then calls in a junior female doctor who has recently joined the hospital. The doctor is appalled by the nurse's brusque manner and harsh words to the young woman. As the nurse moves around the examination room, slamming drawers and banging metal trays, she mutters quite audibly: "Shameless woman, stealing husbands, deserves her punishment...". The patient remains silent and starts weeping silently. The doctor takes her aside, completes the examination, gives her the appropriate medication, and asks her to come back for review in a week. She is gentle and courteous with the young woman which appears to inflame the nurse further.

Question to pose: If you were the junior doctor, how would you deal with this situation?

SCENARIO 3

A 19-year old man presents at a rural health centre with a urethral discharge. He tells the duty doctor 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. He says that he has had similar episodes in the past after visits to prostitutes in the nearby town. He is rather open about this and says that all his friends do the same. On enquiry, the doctor learns that the young man is married and has a wife who is 16 years old. The doctor explains that it would be important for both partners to be treated. The young man shakes his head, saying that it would be out of the question....

Question to pose: If you were the doctor, how would you deal with this situation?

SCENARIO 4

An 11-year old girl is brought to a peri-urban clinic by her mother because she has noticed that her daughter has genital sores. No meaningful history could be obtained from the mother or from the child on how and when the sores started. The girl was examined behind a screen while her mother sat in the same room. Examination revealed that the child had florid vulval condylomata strongly suggestive of syphilis. The nurse in charge, a mature and experienced woman, took the child into another room and probed the matter gently. After several minutes of gentle but persistent probing, the girl told the nurse that her uncle had been “playing” with her, and had warned her that if she told anyone he would kill her.

Question to pose: If you were faced with such a situation in this setting, how would you deal with it?

Annex 3

Role plays

Session 7: ACTIVITY 7-2

ROLE PLAY 1

You are a doctor working in a busy municipal clinic, in an urban area. You have had a demanding morning, running the outpatient clinic. The 18-year old young man, who is seated in front of you, is your 40th "new patient", today. You have diagnosed him with gonorrhoea, and handed him a prescription to take to the pharmacy in the clinic. He thanks you and rises to leave. You realise that you have not discussed STIs prevention with him, and tell him to sit down...

Roles: Doctor and 18-year old male patient.

ROLE PLAY 2

You are a woman in your mid-40s. You are a doctor and run a private practice in a middle-class locality in a big city. Your practice is well-established, and you are well-known by the local residents. In fact, you are the "family doctor" for many families in the area. The young woman seated in front of you is someone whom you have known for over 10 years. She is now 17 years old, a college student, and is stylishly dressed. She is still single. She has come to ask you for help with her pimples. You have dealt with that, and as she is about to leave, you realize that you have not kept a promise that you made some time ago to her mother, about talking to her about the risks and consequences of "unsafe sexual activity". You decide to try to do so now...

Roles: Doctor and 17-year old female patient.

Handout for

Module H

Care of adolescent pregnancy and childbirth

This handout presents background information to complement the material in module H entitled *Care of adolescent pregnancy and childbirth*. The facilitator may refer to the text in this handout during the sessions and you may be asked to read some extracts.

THIS HANDOUT PROVIDES INFORMATION ON THE FOLLOWING:

1. The scope of adolescent pregnancy, childbirth and maternal mortality H-5

2. Factors that influence adolescent pregnancy and childbirth H-6

3. Risks associated with pregnancy and childbirth in adolescence, and how they differ from those in adults H-7

4. Care of adolescents during pregnancy, childbirth and the postnatal period H-11

5. References H-14

Annex 1. Spot checks. Session 1– Activity 1-2 H-15

Annex 2. Case study. Session 6 – Activity 6-1 H-19

Annex 3. Role plays. Session 6 – Activity 6-2 H-23

1. The scope of adolescent pregnancy, childbirth and maternal mortality

It is estimated that 15 million births occur every year to adolescents. This represents about 11% of all births each year (*1*). The global average rate of births per 1000 females aged 15-19 years is 65. There are however wide regional variations – see Table 1.

TABLE 1

Rate of births per 1000 females aged 15-19 years

Region	Rate	Range
Africa	143/1000	Range: from 45 in Mauritius to 229 in Guinea
Middle East	56/1000	Range: from 18 in Tunisia to 122 in Oman
South-East Asia	56/1000	Range: from 4 in Japan to 115 in Bangladesh
Latin America	78/1000	Range: from 56 in Chile to 149 in Nicaragua
Europe	25/1000	Range: from 4 in Switzerland to 57 in Bulgaria
North America	42/1000	Range: from 24 in Canada to 60 in USA

Source: References (2,3,4).

Declines in adolescent pregnancy and birth rates have occurred in most developed countries and also in a wide range of developing ones (*5*). Significant delays in the age of first marriage and accompanying declines in early childbearing have occurred in North Africa and Asia. However, the proportion of women who give birth as adolescents is still very high in Sub-Saharan Africa. Further, the proportion of adolescent births to unmarried women is increasing in some countries, and can be expected to continue to do so if contraceptive use among unmarried, sexually active young women does not increase rapidly (*6*).

For those adolescents who do give birth every effort is required to make motherhood safe. The statistics show that this is not currently the case. Pregnancy-related complications are the main cause of deaths for 15-19-year old girls worldwide (*7*). In some developing countries, maternal mortality among adolescent girls under 18 years is 2-5 times higher than in those aged 18-25 years (*8*).

Children born to adolescent mothers often experience higher risks of death during the first five years of life. A comparative study of Demographic and Health Surveys data from 20 countries showed that the risk of death by age five was 28% higher for children born to adolescent mothers than those born to women aged 20-29 years. (*9*)

An important contributory factor to maternal morbidity and mortality among adolescents is their higher recourse to unsafe abortion. In countries with reliable statistics, 40-60% of adolescent pregnancies end in induced abortion (*10*). Another contributory factor of growing importance, both to maternal mortality and to childhood mortality, is HIV/AIDS (*11)*.

2. Factors that influence adolescent pregnancy and childbirth

A range of social, cultural, biological and service delivery factors contribute to the high levels of adolescent pregnancy and childbirth. These factors are shown in Box 1.

BOX 1

Factors contributing to adolescent pregnancy and childbirth

Declining age of menarche – The age of menarche has declined in developed countries and in the urban areas of many developing countries from +/- 15 years to +/- 12.5 years.

Longer periods of education and delayed marriage for some adolescents, and early marriage and pressure to have children for others – A growing number of adolescent girls stay on in school for longer periods and marry late as a result. For many other adolescent girls, female status is equated with marriage and motherhood. They are required to marry early, and face immediate pressure to prove that they are fertile.

Initiation of sexual activity during adolescence – In many parts of the world, adolescents become sexually active whether or not they are married. Sexual activity among unmarried adolescents is increasing in many parts of the world. However, it must be noted that the age of first sexual debut has increased or remained unchanged in a number of countries, notably in Asia and Latin America.

Sexual coercion and rape – Adolescent girls may be coerced into having sex, often by adults and peers in their social circle. Pregnancies can result from such assaults. Girls who are subject to sexual abuse and rape can suffer serious, life-long physical and psychological consequences.

Education levels – This strongly influences adolescent childbearing as seen in many countries in which women with no education give birth before the age of 20 years, whereas women with even some secondary schooling, are less likely to do so.

Socio-economic factors – Economic hardships can force young girls to leave home and seek a living elsewhere. Sexual exploitation and prostitution are sometimes the consequences of this. Through ignorance of contraception, inability to access contraceptive services, and inability to insist on condom use, the young girl may soon find herself pregnant.

Other risk behaviours – The use of alcohol and other substances may be associated with unprotected sexual activity, leading to unwanted pregnancies.

Lack of knowledge – Sexual and reproductive health information and education programmes are underway in many places. This has contributed to increases in knowledge and understanding. However, adolescents in many places continue to have significant knowledge gaps and misconceptions about sexuality and reproduction.

Lack of access to services – In many places, a range of barriers hinder the abilities of adolescents to obtain the contraceptive services they need[1]. Further, termination of pregnancy is illegal in many parts of the world. Even where it is legal, it is often inaccessible to adolescents.

Source: References (12,13,14,15,16).

[1] Adolescent pregnancies tend to be highest in regions with the lowest contraceptive prevalence. Moreover in many developing countries recent gains in contraceptive prevalence have been almost exclusively among older, married women and not adolescents.

3. RISKS ASSOCIATED WITH PREGNANCY AND CHILDBIRTH IN ADOLESCENCE, AND HOW THEY DIFFER FROM THOSE IN ADULTS

Pregnancy and childbirth in adolescence carry a greater risk to the health of both mother and baby, than in adult women. This is attributable to both biology and the social environment. A young maternal age, when combined with low social status and inadequate access to health care, contribute to the high maternal mortality in adolescents reported in many developing countries. The risks are high during the antenatal period, during labour and in the postpartum period (Box 2). Babies born to adolescent mothers also have a higher risk of being of low birthweight, and of higher rates of mortality and morbidity.

BOX 2

Pregnancy complications occurring more commonly in adolescents than in adults

- 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 birthweight
- Perinatal and neonatal mortality
- Inadequate child care and breastfeeding practices

Problems in the antenatal period *(17)*

Pregnancy-induced hypertension

There are conflicting reports on the incidence of hypertensive diseases of pregnancy in adolescents. However, studies report an increased incidence of the condition in young adolescents, when compared with women aged 30-34 years.

Anaemia

Results from a meta-analysis of studies show an increased risk of anaemia in adolescents from developing countries, compared with women over 20 years of age. Anaemia in pregnancy is often caused by nutritional deficiencies, especially of iron and folic acid, and by malaria and intestinal parasites. Vitamin A deficiency and HIV infection may also play a role in its causation.

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

Malaria is one of the most important causes of anaemia during pregnancy. First-time pregnant women (which includes many adolescents) are more likely to be infected with malaria than women who have been pregnant before. They are also more likely to suffer its more severe forms. This puts them at risk. It also puts their foetuses at risk of intra-uterine death or low birthweight.

Problems during labour and delivery

Pre-term birth[1]

A meta-analysis using data from developed and developing countries showed that, compared to women over twenty years of age, adolescents are at increased risk for pre-term delivery. A likely cause of this is the immaturity of the genital organs of young women. However, social factors such as poverty, behavioural factors such as psycho-active substance abuse, and lack of optimal antenatal care also have a negative influence on pregnancy outcome.

Obstructed labour

In young girls (below 15 years of age), cephalo-pelvic disproportion is more likely to occur than in older adolescents, and in adult women. This is due to the immaturity of the pelvic bones, and the small size of the birth canal. In such circumstances, lack of access to medical – and surgical – care can result in obstructed labour with all the attendant implications. Prolonged obstructed labour can result in vesico-vaginal and recto-vaginal fistulae, which if left untreated can have serious social repercussions for the young woman.

Problems in the postpartum period

Anaemia

Adolescents are more at risk of anaemia in the postpartum period due to pre-existing anaemia during pregnancy. This may be further aggravated by blood loss during labour and delivery and may increase the risk of puerperal infection.

Pre-eclampsia

Several studies report that pre-eclampsia occurs more often in young adolescents. The symptoms may become worse during the first postpartum days, and occasionally the first symptoms are recognized postpartum.

Postpartum depression

Adolescent women are also more likely to suffer from postpartum depression, or other mental health problems.

Too early repeat pregnancies

In many countries unmarried adolescents face considerable barriers in obtaining reliable contraception, because of barriers to the provision of services to them. Unprotected intercourse and repeat pregnancy have been found to occur in as many as 50% of these young women, within 24 months of delivery.

[1] Gynaecological age is defined as the chronological age less the age at menarche. A value of less than two years is associated with a higher risk of pre-term labour, and possibly cephalo-pelvic disproportion and consequent obstructed labour.

Problems affecting the baby

Low birthweight

A number of clinical studies in developing countries, and some from developed countries, have showed a higher incidence of low birthweight (weight <2500 grams) among infants of adolescent mothers.

Perinatal and neonatal mortality

Clinical studies in both developing and developed countries have found increased perinatal and neonatal mortality rates in infants of adolescent mothers, compared with infants of older mothers.

Inadequate child care and breastfeeding practices

Young mothers, especially those who are single and in difficult socio-economic situations, may find it hard to provide their children with the care they need. This is reflected in their poor child-feeding, including breastfeeding, practices.

Why are these complications worse in adolescents than in adults?

The complications described above are by no means limited to adolescents. Older women also suffer from similar complications. Also, the situation of adolescents varies depending on their marital status and the support available for them during pregnancy and childbirth. Social and cultural norms may hinder the ability of adolescents (married and unmarried) to obtain information and access antenatal, delivery, and post natal services. There are, however, several reasons why the complications have a worse outcome in adolescents.

1. Biologically, young adolescents are not mature enough for the strain imposed on them by pregnancy. Firstly, in physical terms, their pelvic bones are not fully mature, and as a result, cephalo-pelvic disproportion could potentially occur. Secondly, young adolescents may continue to grow during pregnancy. What this means is that there is a potential for competition between the mother and the foetus for the nutrients required for growth and development. If the adolescent's growth and development have been hindered by under-nutrition during childhood, she would then be entering pregnancy with nutritional deficiencies as well as impaired growth and development, further increasing the risk of negative outcomes. Thirdly, young adolescents may also not be psychologically prepared for motherhood. This could result in mental health problems such as depression.

2. Compared to older women, adolescents are less empowered to make decisions about matters affecting their health (as well as other matters). If married, the husband is likely to be older, better educated and the principal family wage-earner. In some cultures, the husband's mother and sister (s) are likely to have a greater say in decision-making in matters concerning the household than his young wife. If single, the shame of the pre-marital pregnancy may leave her voiceless and even as a family outcast. In some cultures, single pregnant adolescents are sent away to distant relatives until after delivery. In such circumstances, the adolescent is unlikely to get the psychological and practical support that she needs.

3. Adolescents are more likely to enrol later and to make fewer health-facility visits for antenatal care. Clearly, socio-economic factors have a major influence on antenatal care utilization. The stigma associated with premarital pregnancy is another critical factor contributing to this. In many places, unmarried adolescents hide their pregnancies for as long as they can. On the other hand, married adolescents may not even know of the value of antenatal care, and even if they do, may be unable to obtain it. What this means is that adolescents are deprived of a service that has been shown to contribute to positive pregnancy outcomes.

4. In many places, adolescents deliver at home. They come to - or are brought to - hospital only as a last resort, often with serious complications. The factors that contribute to this include:

   - Social and cultural norms may dictate that they deliver at home;
   - They may be afraid of hospitals;
   - They may have heard discouraging stories about mistreatment by hospital staff (and especially labour room staff);
   - They may be unable to bear the hospital charges, or even for the cost of private transport to get there.

   What this means is that a problem that could be prevented or promptly managed in a hospital could potentially get out of hand during delivery at home.

5. In many places, pregnant adolescents – especially unmarried ones – are treated with scant respect by medical and nursing staff, as well as clerical and other staff. Further, many health-care workers are not conversant with the issues that need to be borne in mind when providing care during pregnancy to adolescents. As a result, antenatal visits and the delivery experience can be unpleasant for the young person, and in addition inadequate in terms of technical quality.

4. Care of adolescents during pregnancy, childbirth and the postnatal period

There is much that can be done to reduce the occurrence of problems, and to improve the health of the mother and the (unborn) baby. This includes early diagnosis of pregnancy, effective antenatal care, effective care in labour and delivery, and effective postpartum care.

Early diagnosis of pregnancy

The early diagnosis of pregnancy is an important first step in drawing the adolescent into antenatal care. Health-care providers and other adults in more regular contact with the adolescent, including family members, have the shared responsibility of creating a supportive environment in which she feels able to share information about her situation. Health-care providers need to be aware that a young adolescent may not know that she is pregnant. This may be because she may not remember the dates of her last menstrual period, or because her periods are not regular. Another issue to be aware of is that if the adolescent is unmarried, she may want to hide her pregnancy or even to terminate it. Being aware of these issues, and being on the lookout for telltale signs of early pregnancy (such as nausea) will help ensure that an early diagnosis of pregnancy is made and that the adolescent receives the care and support she needs.

Antenatal care

Repeated contacts with the health-care system provide a useful opportunity for the detection and treatment of problems that commonly affect pregnant adolescents. Pregnancy-induced hypertension can easily be detected. Uncomplicated hypertension can be managed on an outpatient basis. In case of complications (such as pre-eclampsia, eclampsia, and abruption placentae), referral to a hospital is indicated. Anaemia and malaria too can be detected and treated during routine antenatal care. Antenatal visits also provide a valuable opportunity to screen for STIs such as syphilis and to provide the required treatment, when needed. They also provide an opportunity for the provision of food supplements, in case under-nutrition is detected. It is worth noting that there is only limited evidence of the value of food supplementation on increasing birthweight. Finally, antenatal visits could help identify those adolescents – especially very young adolescents – at risk of pre-term labour, though interventions to address this are limited *(17)*.

Antenatal care should go much further than the detection and treatment of problems. It provides a valuable opportunity for the provision of information and counselling support that adolescents need. WHO recommends a minimum of four antenatal visits for all pregnant women *(18)*. This is especially important in the case of adolescents – especially unmarried ones – because of their greater need for support.

Antenatal care also provides an entry-point for the identification and provision of social support services. The waiver of user-fees, and the provision of medicines such as anti-malarials, and food supplements free-of-charge will help ensure that they do in fact benefit from antenatal care.

Counselling during pregnancy

As indicated above, health-care providers should seek to understand the situation that their adolescent patients are in, and to provide them with the information and counselling support that meet their needs (listed below). In addition, pregnant adolescents may have questions and concerns of their own. They must be given an opportunity to raise and discuss these issues.

- The life situation of the adolescent including her marital status and socio-economic situation, and the support available to her from her husband/partner, family members, friends and others;
- The options available to her in terms of the pregnancy (e.g. in some places discreet arrangements are available for handing the child over for adoption soon after birth);
- The support that she needs, and the social support services for which she is eligible;
- Her access to health services for routine antenatal care and in case of emergency;
- Her plans for the delivery;
- Her plans for the care of the baby;
- Her plans for continuing with her education or work after the delivery.

Counselling should also include health issues that are relevant to the person. These include good nutrition, malaria prevention and smoking (and other psychoactive substance use) cessation. Another important issue is HIV/AIDS. As indicated above, adolescents are at an increased risk of contracting HIV infection, and of transmitting the infection to their infants. In a growing number of countries, voluntary counselling and testing services, as well as anti-retroviral therapies to prevent mother-to-child transmission, and to safeguard the health of the mother, are becoming available. Adolescents should be encouraged to obtain HIV counselling and testing. In addition to opening the door to anti-retroviral therapy to prevent mother-to-child transmission, and to prevent/ reduce viral multiplication in her body, the knowledge of her HIV status will enable the HIV-infected adolescent to take the necessary steps to prevent transmission to others. For those who test HIV-negative, this provides an opportunity to reinforce the message of STI/HIV prevention.

Management of labour and delivery

If the pregnancy in an adolescent is uneventful, complications such as anaemia are treated adequately, labour starts at term, and the infant is in cephalic presentation, labour is not at increased risk. However, if the adolescent is severely anaemic, postpartum haemorrhage can be dangerous. In very young adolescents, pre-term labour as well as obstructed labour are more likely to occur. What this means is that although in general, labour is not necessarily more risky in adolescents than it is in adults, some adolescents clearly are a high risk for specific reasons.

As a general rule, if the labour is a potentially high-risk one, it is advisable to encourage hospital delivery. In some places, "waiting mothers" shelters have been established to help ensure that women who are likely to require institutional delivery do not find themselves stranded at home because there is no one around to accompany them to the hospital, or because transportation is not available/affordable.

Guidelines for the provision of care during normal labour have been developed by WHO *(19)*. Besides observing and monitoring, supporting the woman and her partner (or companion) is very important, especially in adolescents. Studies have shown that continuous empathetic support during labour, provided by a nurse or midwife results in many benefits both to the mother and the baby *(17)*.

Postpartum care

Postpartum care includes the prevention, early diagnosis and treatment of postnatal complications in the mother and the infant. It also includes the provision of information and counselling on breastfeeding, nutrition, contraception and care of the baby *(20)*. The adolescent mother will require support on how to care for herself and her baby. Since many adolescents – especially those in difficult social situations - do not receive adequate antenatal care, or the support of their partners/families, postpartum care is even more important for them.

Contraception

Many too-early repeat pregnancies are unplanned and as a result of absent or inadequate contraceptive efforts *(17)*. The postpartum period presents a good opportunity for taking concrete steps towards pregnancy prevention and for promoting dual protection by using condoms.

Nutrition of the mother

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

Breastfeeding

WHO has made recommendations concerning breastfeeding *(20)*. A young adolescent – especially one who is single – would require extra support in achieving breastfeeding successfully.

Between 5-20% of infants born to HIV-positive mothers may acquire HIV through breastfeeding depending on a range of factors. Every HIV-infected mother should receive counselling, which includes information about the risks and benefits of different infant feeding options, and specific guidance in selecting the option most suitable for her situation. The final decision should be the woman's, and she should be supported in her choice. When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended. Otherwise, exclusive breastfeeding is recommended during the first months of life, and should be discontinued when an alternative form of feeding becomes feasible (*21*).

The first weeks and months as a young mother

Many adolescents return with their babies to the love and support of their families. Many others are less fortunate. Their social circumstances are often distressing. If the adolescent mother is unmarried or without a partner, she may face problems with her family and community because they disapprove of her behaviour. In such circumstances, her health and well-being and that of the baby are at risk. Maintaining ongoing contact through home visits has been shown to be helpful in reducing rates of child abuse and maltreatment. In addition to support with baby-care, the adolescent will benefit from support for planning her future. Responding to this can be both rewarding and challenging.

SUMMARY

- Pregnancy in adolescents is not uncommon.
- Many factors contribute to adolescent pregnancy.
- Adolescents have higher maternal mortality than adults.
- Babies born to adolescents have a higher mortality too.
- Many of the complications arising 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 through pregnancy, labour, delivery and the postpartum period.
- Promoting safe pregnancy and childbearing in adolescence requires concerted actions beyond the health sector. Three key actions in relation to this are increasing girls' access to education and job opportunities, enhancing their status of women and girls in society, and improving their nutritional status.

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Annex 1

Spot checks

Session 1: ACTIVITY 1-2

SPOT CHECK 1

In developing countries, how does the rate of maternal mortality of pregnant girls under 18 years old compare with adults?

please mark your answer with a spot anywhere along the line

The rates are about the same	About twice as much as for adults	About three times as much	About four times as much	About five times as much

SPOT CHECK 2

Which factors could contribute to antenatal complications in pregnant young adolescents?

please write down one example each for married and unmarried adolescents

MARRIED

UNMARRIED

SPOT CHECK 3

What are the most common antenatal complications in young adolescents?

SPOT CHECK 4

In your opinion, what are the most important issues to raise in counselling sessions with pregnant adolescents?

please write down your answers

SPOT CHECK 5

What are the critical aspects in caring for the pregnant adolescent in the postpartum period?

please write down your answers

Annex 2

Case study

Session 6: ACTIVITY 6-1

CASE STUDY

Safina, a 15-year old adolescent girl was brought to the casualty department of a government hospital located in the a sprawling district of an East African country. The accompanying relatives told the doctor on duty that she had been in labour for three days, and was being cared for at home by a Traditional Birth Attendant (TBA).

This was Safina's first pregnancy. She had not attended any antenatal clinic for the entire duration of her pregnancy (which was at term). According to her relatives, labour had started three days earlier. The TBA who had been attending to her, gave her herbal potions to speed up the labour, to no avail.

Safina had complained of unbearable abdominal pain, had started bleeding from her vagina and had grown progressively weaker. That is why her relatives decided to bring her to hospital. Further enquiry revealed that Safina had been married a year ago to a man in his late fifties. She was his fourth wife.

Examination revealed a young woman with pregnancy at term. She was pale and dehydrated. Her abdomen was tender and firm. Foetal heart sounds could not be heard. There was moderate vaginal bleeding. Vaginal examination revealed a fully dilated cervix with marked caput. The foetal head was 3/5 and fixed.

A diagnosis of obstructed labour with intrauterine foetal death was made. Arrangements were made for emergency caesarean section.

At caesarean section, the foetus was found lodged in the abdominal cavity. It was evident that the uterus had ruptured at the fundus, extending to the left lateral side. There had been severe bleeding. The doctors considered uterine repair but decided against it. A sub-total hysterectomy was performed and the abdomen closed.

Safina had a stormy post-operation period. Her temperature remained high despite antibiotics and on day 5 she started to have urinary incontinence although a Foleys catheter had been left in place. Her fever settled after 10 days but the urinary incontinence continued. At the examination under anaesthesia three weeks later, the presence of a Vesico-Vaginal Fistula was confirmed. She was discharged and advised to return after three months for surgical repair of the fistula.

Annex 3

Role plays

Session 6: ACTIVITY 6-2

ROLE PLAY 1

A doctor, the nurse in-charge and two other nurses are conducting a ward round in the maternity ward of a government hospital. There are around 25 patients in the ward. About a third of them are adolescents. The team arrive at the bedside of a 14-year old girl who has been admitted with severe anaemia (complicating her pregnancy). Her haemoglobin is 7gm%.

As they reach the bed the nurse in-charge, starts berating the girl loudly. "You had no business to have sex before getting married, and no business getting pregnant. You play around and we all have to work to take care of you." The girl starts weeping silently. Her mother hangs her head in shame. The doctor is clearly embarrassed by this outburst. He gently tries to intervene…

Roles: Doctor, nurse-in-charge, 14-year old girl, mother.

ROLE PLAY 2

A woman in her mid-fifties has come in to the weekly antenatal clinic in a municipal health centre with her 15-year old daughter-in-law, who is pregnant (about 24 weeks). The doctor elicits information and carries out an examination. Her conjunctivae and nail beds are very pale, but apart from that, she appears to be well. He sends her for a quick check of the haemoglobin level. According to the report, it is 9 gm%. He sets about explaining the diagnosis and its implications for the health of the mother and her unborn baby, and what remedial action needs to be taken…

Roles: Doctor, 15-year old pregnant girl (24 weeks), mother-in-law.

ROLE PLAY 3

A teacher at a boarding school comes in to the casualty unit of a district hospital with a 16-year old school-girl (who is in school uniform). The teacher says that the girl has been complaining of severe lower abdominal pains, and wonders whether she has menstrual cramps.

On examination, the clinical officer on duty confirms a full-term pregnancy. The girl has concealed her pregnancy from her family and from teachers at school by binding her abdomen tightly.

The girl is in labour. Her cervix is 4 cms dilated. After sending the girl to the labour ward, the clinical officer sends for the doctor on call, to help explain matters to the teacher.

Roles: Doctor, clinical officer, teacher.

ROLE PLAY 4

A 15-year old girl who delivered a baby boy three days ago at a maternity hospital in a city, is now ready to go home. The nurse responsible for this is filling in the discharge slip and then turns to speak with her about follow-up care.

Roles: 15-year old girl, 3-day old baby (doll), nurse.

Handout for

Module I

Unsafe abortion in adolescents

This handout presents background information to complement the material in module I entitled *Unsafe abortion in adolescents*. The facilitator may refer to the text in this handout during the sessions and you may be asked to read some extracts.

THIS HANDOUT PROVIDES INFORMATION ON THE FOLLOWING:

1. The nature and scope of unsafe abortion I-5

2. Factors contributing to unsafe abortion in adolescents I-6

3. The consequences of unsafe abortion I-8

4. Diagnosing unsafe abortion I-9

5. Managing unsafe abortion I-10

6. Preventing unsafe abortion I-11

7. References I-13

Annex 1. Spot checks. Session 1 – Activity 1-2 I-15

Annex 2. Case studies. Session 4 – Activity 4-3 I-21

Annex 3. Role plays. Session 5 – Activity 5-3 I-27

Annex 4. Questions. Session 6 – Activity 6-1 I-31

1. The nature and scope of unsafe abortion

WHO estimates that about 25% of all pregnancies worldwide end in an induced abortion. Table 1 that follows presents global estimates relating to abortions for women of all ages (*1*). The vast majority of unsafe abortions take place in developing countries, and as can be expected, in countries in which abortion is restricted by law.

TABLE 1

Global estimates relating to abortions for women of all ages

	Estimated annual figure
Abortions performed globally	50 million
Abortions performed in developing countries	30 million
Unsafe abortions	20 million
Death from unsafe abortions	80,000

Source: Reference (1).

Unsafe abortion accounts for up to 13% of all maternal deaths (*1*). Some 80,000 women are estimated to die every year as a result of unsafe abortion. Many more women survive the experience only to suffer throughout the rest of their lives from chronic health problems, and in many cases infertility.

In many parts of the world, more adolescent girls than adult women will resort to abortion as a way of solving an unwanted pregnancy. A conservative estimate of the total number of abortions among adolescents in developing countries ranges from 2 million to 4.4 million annually. In many developing countries, hospital records of women treated for complications of abortion suggest that between 38% and 68% are less than 20 years old. A recent review of unmarried women aged 15-19 years who gave birth in the preceding five years showed that 32-93% of the births were unwanted or mistimed. Even among the married adolescents, up to 61% of the last births were unwanted or mistimed (*2,3*).

The choice to have an abortion is not an easy one. Adolescents often state a number of reasons for resorting to abortion (*4*):

- **Education:** Pregnant girls who fear expulsion from school or the interruption of their studies may believe that they have no choice but to terminate their pregnancy.
- **Economic factors:** Since adolescents have fewer economic resources to care for a child, it is not surprising to find economic pressures influencing their decision to seek an abortion.
- **Social condemnation:** In societies where a pregnancy before marriage is considered immoral, adolescent girls choose termination of pregnancy to avoid bringing shame and condemnation on themselves and their families.
- **Having no stable relationship:** This reason is encountered more commonly among adolescents than in adults.
- **Failed contraception:** Contraceptive use among adolescents is often low. Where they are used, this is often done so inconsistently and incorrectly. Also, less effective methods tend to be used.
- **Coerced sex (including rape and incest):** Cross-cultural data point to the fact that a larger percentage of rape and sex abuse incidents are perpetrated against adolescents than among adults.

Early studies on unsafe abortion, especially in developing countries, reported a higher prevalence in the urban and educated than in the rural areas. This may be as a consequence of greater access to information and wider availability of services in urban areas. In countries where abortion laws are restrictive, the rich are often able to obtain safe abortion from competent, well-trained providers at exorbitant fees. The rich are therefore less likely to suffer the consequences of unsafe abortion. On the other hand, the poor are forced to seek the services of clandestine, unqualified providers with all the attendant implications.

2. Factors contributing to unsafe abortion in adolescents

There are several factors which determine the magnitude and severity of unsafe abortion:

- Delays in seeking care
- Resorting to unskilled providers
- Use of dangerous methods
- Legal obstacles
- Service-delivery factors.

Delay in seeking abortion is the largest single factor in determining the risk of complications and death due to unsafe abortion among adolescents (*5*). Adolescents, like some adults, may delay seeking help even after complications develop. Adolescent women may delay seeking care because they may not know that they are pregnant, or may not want to admit it even if they are aware of their pregnancy. They may not know where to obtain help. Even if they do so, they may not be able to obtain help because factors such as cost may prevent them from doing so. Finally, even if they can obtain help, they may be unwilling to do so because of the attitudes and behaviours of health-care workers.

Adolescent girls are more likely than adult women to seek abortion from unskilled providers. The younger the adolescent, the more likely that her abortion will be self-induced or carried out by a non-medical person.

Adolescents are more likely than adults to use dangerous methods for abortion, such as inserting objects into the cervix, placing herbal preparations into the vagina, or taking various preparations from modern and traditional systems of medicine – orally or through injection.

Varying forms of legal barriers to the provision of abortion services exist in many countries. Even in countries where these laws are relatively liberal, various requirements that have been created make it harder for adolescents to have access to safe abortion. For example, in some countries the consent of the husband, parent or guardian is needed for the abortion if the woman is below a certain age. Generally speaking, abortion-related mortality is highest in countries where abortion is legally restricted and reproductive health service provisions are not widely available. It must be noted that even where laws and policies are not restrictive, societal views and the – real or perceived – attitudes of health-care workers act as obstacles to access (*6).*

The way in which service-delivery is organised affects the extent to which adolescents have access to sexual and reproductive health information and services, including safe abortion when needed. Later in this handout, we will describe what actions need to be taken in order to improve the diagnosis and management of unsafe abortion in adolescents. For information on how to overcome barriers to the provision and utilisation of health services to adolescents, please refer to the module D. *Adolescent-friendly health services*.

The magnitude and severity of problems related to unsafe abortion among adolescents vary from country to country, and within communities in the same country.

Factors determining magnitude and severity include the extent to which:

- Reproductive health information and services are available and accessible to adolescents;
- Safe abortion services are available and accessible;
- Health-care providers are helpful and non-judgemental in their dealing with adolescents;
- Community norms permit open and frank discussion about sexuality in adolescents;
- National laws and policies facilitate the provision of reproductive health information and services that adolescents need.

3. The consequences of unsafe abortion

While the risks of mortality and morbidity from unsafe abortion are high for women of all ages, they are especially high for adolescents. The consequences are multiple, and can be conveniently categorized as medical, psychological, social and economic.

Mortality

Information on mortality due to unsafe abortion for women of all ages was presented earlier in this handout. The available data clearly points to the fact that three groups of women run a heightened risk of mortality from unsafe abortion. These are women of young age, those who have not yet had children, and women of lower socio-economic status. The risk of mortality is clearly far greater for adolescents than for adult women.

Medical consequences

The major short-term complications are cervical or vaginal lacerations, sepsis, haemorrhage, perforation of the uterus or bowel, tetanus, pelvic infection or abscess, and intrauterine blood clots. Post-abortal sepsis can rapidly develop into septicaemia; haemorrhage is a common complication that leads to or aggravates pre-existing anaemia. Both septicaemia and anaemia are common causes of death, especially in developing countries where life-saving antibiotics and safe blood transfusion services are less available. Physical injuries may vary from small genital lacerations to major perforations involving not only the reproductive organs but also urinary and gastrointestinal systems.

In order to save the lives of these young women, major emergency surgical interventions are needed. Paradoxically such interventions are least available in developing countries, where young people are least able to prevent pregnancy. Where they are available, they are least accessible to those who require them most: poor adolescents in rural areas. Thus, adolescents who resort to unsafe abortion often pay with their lives.

The major long-term medical complications (more than a month after the procedure) include secondary infertility (a particularly heavy life-long burden, in societies where a woman's status depends on her ability to have children), spontaneous abortion in a subsequent pregnancy, and an increased likelihood of both ectopic pregnancy and pre-term labour.

Psychological consequences

These are less well-documented than physical consequences but are by no means insignificant. Long-term abortion-related psychological problems have been frequently reported, especially in young women pregnant for the first time. These include a sense of loss and reactions of grief. Some have also expressed guilt that extends beyond the abortion itself to guilt for having engaged in sexual relations, and for failing as a "real" woman by opting for abortion (*7*).

Social and economic consequences

The social and economic consequences of unsafe abortion are borne by the girl herself, her family, community and the society as a whole. The girls who survive may face a range of social problems. If it becomes known that they have undergone an unsafe abortion, they may have to leave school and face disapproving attitudes, even ostracism, from their community. Furthermore, they risk

being thrown out by their families. Girls who drop out of school, or are thrown out by the family, often marry early, get poorly paid jobs and are tempted or forced into prostitution. In short, the spiral of events stemming from their obtaining an unsafe abortion, greatly reduces their life chances.

In some countries where abortion is illegal, women – including adolescents – who have undergone an abortion illegally, may face imprisonment.

Throughout the developing world, the economic consequences of unsafe abortion are immense for both the community and the country. Treatment for the complications of unsafe abortion drains precious resources – often already in short supply – such as safe blood, other intravenous fluids, and antibiotics. Women recovering from unsafe abortion tend to stay in hospital three or four times longer than those recovering from safe abortion. Also, the long-term morbidity resulting from unsafe abortion incurs future health care and other costs. In addition, there are other significant costs. Investments made in education and training young women are lost. Human resources which could have contributed to the nation's development are lost. Unsafe abortion thus results in costs not only to individuals and families but to communities and societies.

4. Diagnosing unsafe abortion

In theory the diagnosis of unsafe abortion or its complications should not differ between adolescents and adult women. There is a history of a missed menstrual period(s) followed by an attempt to terminate the unwanted pregnancy, by oneself, with the assistance of a friend or a clandestine provider. In places where abortion is illegal, the illicit provider often merely induces bleeding and leaves it to the woman to go to a hospital for an evacuation later. In such circumstances, an adolescent may present with a history of vaginal bleeding and complications of sepsis and anaemia.

Unlike adult women, adolescents (particularly very young girls) are often not willing and sometimes not able to given 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 (*4*):

- Be unmarried and outside a stable relationship
- Be primi gravida
- Have a longer gestation up to the time of abortion
- Have used dangerous methods to terminate pregnancy
- Have resorted to illegal providers
- Delay seeking help
- Come to the health facility alone or with a friend, rather than with the partner
- Have ingested substances that interfere with treatment
- Have more entrenched complications.

It is important for health-care providers to bear in mind that unwanted pregnancy may be the real presenting problem, though other symptoms may be reported, and to observe the adolescent's demeanor 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.

5. Managing unsafe abortion

The clinical presentation will obviously depend the condition of the patient. In case infection has set in, the adolescent is likely to be feverish and dehydrated. 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, tender adnexae, and fullness in the pouch of Douglas. In case treatment has been delayed, the adolescent is likely to be in shock with impending respiratory and circulatory failure.

The management of the patient will depend on the history and the findings of the examination. It should be based on the following principles (*8*):

- *Emergency resuscitation* may be necessary as many adolescents present in shock. In primary level facilities, health-care workers will need to be prepared to make referrals and arrange for transport to a referral facility with effective treatment.

- *Evacuation of the uterus* is necessary to remove all the products of conception.

  For inevitable or incomplete abortion, uterine evacuation is necessary. The technique chosen will depend on the length of gestation, stage of the abortion, uterine size and availability of skilled staff and supplies. If there are signs of infection, abdominal injury, cervical or uterine perforation, evacuation should be carried out only after broad-spectrum antibiotics effective against gram-negative, gram-positive and anaerobic organisms, as well as chlamydia, have been started.

  In the first trimester, vacuum aspiration is the surgical procedure of choice. 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. Early second trimester (12-14 weeks) procedures can be done by vacuum aspiration using larger cannulae. Curettage is also sometimes required. The treatment of incomplete abortion in the late second trimester (more than 14 weeks), by dilation and curettage or by uterotonics, should be done by experienced health-care workers. In addition, intravenous fluids and oxytocics, blood transfusion and facilities to perform abdominal surgery must be available as a back-up.

- *Management and prevention of complications* such as infection and injury. It is unfortunately true that complications are more frequent and more severe in environments where self-induced or otherwise unsafe abortions are common and where reproductive health services in general are lacking.

- *Arrangements for post-abortion care* must be put in place because adolescents are more easily "lost to follow-up" than are adults. Establishing a good rapport with the adolescent patient will facilitate follow-up. In any case, patients 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. They must also be provided with information on sexuality and contraception for well-informed decision-making.

6. Preventing unsafe abortion

In many parts of the world, adolescent and adult women with unwanted pregnancies continue to resort to abortion, whether or not it is legal and safe. Prevention of such pregnancies must therefore be one of the key objectives in efforts to eliminate unsafe abortion. Communities, governments and health-care workers should endeavour to:

- Improve access to reproductive health information and services

  The need to improve adolescents' access to reproductive health information and services has been discussed in module C. *Adolescent sexual and reproductive health*. Specifically, there is an urgent need to expand the availability of a wide range of contraceptive methods to enable sexually active adolescents to choose the method that best suits their needs. The contribution that emergency contraception could make in preventing unsafe abortion needs to be clearly articulated. Adolescents need to know that this method is available, and where it could be obtained when needed. Information on ways and means of improving the accessibility and acceptability of health services is provided in module D. *Adolescent-friendly health services*. Further information on contraception is provided in module J. *Pregnancy prevention in adolescents.*

- Address laws and policies on access to safe abortion services and their application

  In many countries, legal barriers prevent adolescents from obtaining abortion services. It is important to press for legislative review and reform in these countries. Even in countries where abortion is legally available on demand, women experience difficulties in exercising their right to obtain these services. The reasons for this include local opposition or reluctance to applying national laws, and burdensome administrative requirements. These barriers are heightened when adolescents are involved. In such situations, it would be important for the relevant authorities to clarify the role that health-care providers are obliged to play in the provision of abortion services. This will help to ensure that available services are not withheld from adolescents who need them (*9*).

- Train health-care providers in comprehensive abortion care

  Health-care providers – both modern and traditional – need to be trained in comprehensive abortion care so that they can recognize the signs and symptoms of abortion-related complications and how to manage them effectively. They also need to be trained in post-abortion counselling. In this way, they can help adolescents deal with the many health and social issues that arise. In addition to building the knowledge and skills of health-care providers, it is important to help them examine their attitudes and beliefs, in order to prevent these factors from hindering the provision of care.

  The dilemma for service providers is often a complex one. On the one hand there are laws concerning the provision of abortion services, and on the other hand there are laws governing the treatment of minors. Both of these sets of laws can come together to pose barriers to the health and well-being of adolescents, especially young adolescents. The issuance of clear standard operating procedures and guidelines for the management of unsafe abortion, within the context of the prevailing laws and policies, will assist health-care providers in dealing with the legal and ethical dilemmas that they encounter.

- Involve communities in protecting and safe-guarding adolescents

  In addition to their role as service-providers, health-care workers have to play the important role as change-agents in their communities. They must work to involve communities in discussions on unwanted pregnancy, unsafe abortion and its consequences, and the contribution they could make to protecting and safe-guarding adolescents in the community (*10*).

SUMMARY

- Unsafe abortion is common among adolescents in many countries.
- By definition, it 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 obtain abortions for a broad range of reasons related to social, economic and cultural reasons.
- Adolescents undergoing unsafe abortions tend to be single, pregnant for the first time, and tend to 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 unsafe abortion should include post-abortion counselling, addressing contraception in addition to other issues.

8. References

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Annex 1

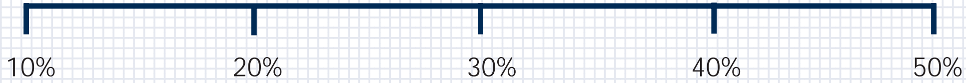
Spot checks

Session 1: ACTIVITY 1-2

SPOT CHECK 1

In the developing world, roughly what percentage of all maternal deaths are caused by unsafe abortion?

please mark your estimate with a spot anywhere along the line

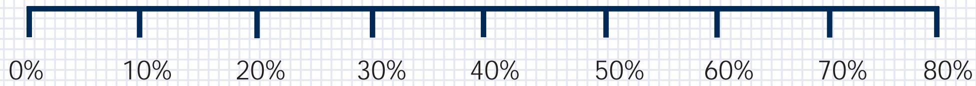


10% 20% 30% 40% 50%

SPOT CHECK 2

In the developing world, roughly what percentage of women who are hospitalized with abortion complications are under 20 years old?

please mark your estimate with a spot anywhere along the line

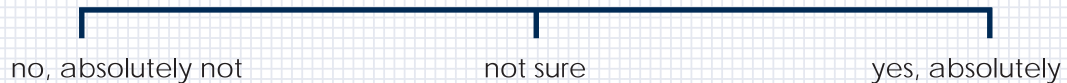


0% 10% 20% 30% 40% 50% 60% 70% 80%

SPOT CHECK 3

Some people say that if safe abortion services are made available and accessible to adolescents, it will encourage promiscuity. Do you agree with this?

please mark your answer with a spot anywhere along the line



no, absolutely not not sure yes, absolutely

SPOT CHECK 4

How confident do you feel about working with adolescents on the issue of abortion?

please mark your answer with a spot anywhere along the line

not very confident — ok — very confident

SPOT CHECK 5

A school-girl presents with complications due to unsafe abortion. Which of these best describes how you feel about her situation?

please answer with three spots

- I feel angry with her ○
- I feel angry with the boy or man who is responsible ○
- I feel pity for her ○
- I feel angry with the politicians for the restrictions on safe abortion ○
- I feel we have failed because she resorted to unsafe abortion ○
- I feel sadness that she didn't use safe abortion ○
- I feel pity for the life that has been aborted ○
- I feel angry with the person who did the abortion ○

SPOT CHECK 6

As health-care providers, what should we focus on to prevent unsafe abortion among adolescents?

please answer with three spots

- Train modern and traditional health-care providers in abortion care ○
- Support efforts to change the law to expand access to safe abortion ○
- Improve confidentiality for adolescents seeking abortion ○
- Improve access to safe abortion for adolescents ○
- Improve provision of contraception to all adolescents ○
- Encourage the authorities to stop untrained people carrying out abortions ○
- Emphasize abstinence from sex before marriage ○
- Encourage adolescents to go through with their pregnancies ○

SPOT CHECK 7

Realistically, is there more you could do with respect to unsafe abortion among adolescents?

please mark your answer with a spot anywhere along the line

no — perhaps — definitely

Annex 2

Case studies

Session 4: ACTIVITY 4-3

CASE STUDY 1

Nyako, a 14-year old school-girl, attended a boarding school on the outskirts of Kampala. One evening, she was admitted to Mulago Teaching Hospital with complaints of high fever and severe lower abdominal pain.

Nyako was brought to the hospital by one of her teachers. She had been found huddled up in bed and shivering in the school dormitory.

They were received by a nurse in casualty who asked Nyako a few questions about what had happened but did not get much information. Nyako was clearly very upset and mumbled or answered in monosyllables. The teacher, who appeared sympathetic to Nyako, told the nurse that another pupil had found Nyako very unwell in bed and that she had been terribly sick. She wondered if Nyako had eaten something and had a stomach upset.

The nurse thanked the teacher and asked her to wait while she took Nyako for an examination. Nyako was weeping while undressing and the nurse comforted her and asked if she would like to tell her a little bit about what had happened. Nyako confided that she had got pregnant, had had an abortion which had gone all wrong and, indicating the lower abdomen, said that her tummy hurt terribly.

The nurse called the doctor on duty and reported what Nyako had told her. On examination, the doctor found that her abdomen was tender with marked guarding. The uterus was bulky and there was a foul-smelling purulent discharge due to infected products of conception.

On further questioning, Nyako told the doctor that, seven days before, her best friend had taken her to an abortionist in a slum area of Kampala, who had inserted a rubber pipe deep into her vagina and instructed her to go to hospital when heavy bleeding started.

The doctor asked her about the date of her last period and how sure she was that she was pregnant. Nyako told him that her periods had started about two years ago but had always been irregular. She was having a love affair with a boy from a neighbouring school and they had started to have sex three months before. She was seven weeks late with her period and suspected she was pregnant. She did not do any test.

Following the abortion, bleeding had not, in fact been heavy but intermittent, with steadily increasing lower abdominal pain. The pipe dropped out after two days. Nyako had endured the pain and tried to keep going as best she could at school until that afternoon, when she could bear it no longer.

Despite the pain which was by then excruciating, the main concern Nyako expressed was that neither the school nor her parents should know about the pregnancy. She begged the doctor not to tell them. She also asked if she was going to die. The nurse reassured her, while the doctor went out to tell the teacher who had accompanied Nyako that she needed to be admitted to hospital for investigations.

She was admitted to the gynaecology ward with a diagnosis of septic incomplete abortion. She was started on parenteral antibiotics and taken to theatre for evacuation 12 hours later. Her temperature settled and she was put on haematinics. She was discharged after five days and given a return appointment to the gynaecology clinic a week later.

At the return visit she was given a cursory examination. She had apparently recovered completely; she was also extremely grateful to the doctor and nurse for not informing either the school or her parents except in vague terms about some abdominal disorder.

Questions for group discussion

1. Who do adolescents turn to for advice and help when they have an unwanted pregnancy?

   - In the case of a "botched" illegal abortion, with serious consequences, where do they go?
   - How promptly do they seek help when problems arise?

2. How are adolescents treated if/when they go to a government health facility; a private practitioner or an illegal abortionist?

   - From an adolescent's point of view, what are the pros and cons of going to each of these places?

3. When seeing an adolescent in such circumstances, how can you make her feel at ease and encourage her to confide in you?

4. What are the things you need to be aware of when carrying out a physical examination of a young woman in such a situation?

5. What is the best way to communicate facts about abortion, its possible consequences and its implications, to adolescents?

   - Which of the adolescents' concerns must you address?
   - In this situation, what are the rights of minors to privacy and confidentiality?
   - What are the rights of parents to be informed and make decisions?

6. Do health-care workers deal with the social and psychological aspects of abortion effectively? What do they need to consider in order to deal more sensitively with these aspects?

7. What follow-up actions need to be undertaken following unsafe abortion?

   - How to coordinate with related services for contraception and STI prevention?
   - How can vital education and information on prevention best be provided?

CASE STUDY 2

Yolanda, an 18-year old girl had just completed her secondary school education. She went to the outpatient department of the district hospital in the town in which she lived, because she suspected that she was pregnant.

After waiting for several hours in a long queue, she was seen by a middle-aged male doctor. She told the doctor that she suspected that she was pregnant and wanted to have the pregnancy terminated. The doctor sent her for a pregnancy test at the hospital laboratory and told her to come back in two days.

The test confirmed that she was pregnant. On the next visit, she was examined and found to have a bulky uterus and to be 8-10 weeks pregnant. Yolanda again stated that she wanted the pregnancy terminated. The doctor asked her to explain why she could not continue with the pregnancy.

She explained that she had just completed her secondary school leaving certificate the year before and was due to go to nursing school in four months. She was the first-born in a family of six, both parents were school teachers and the father was a lay preacher at the local church.

She pleaded with the doctor to help her. She felt very ashamed about the pregnancy and could not bear the thought of giving up or postponing her nursing training, which would ruin her own employment opportunities and let her family down.

The doctor told her that termination of pregnancy was illegal under any circumstances. However, he offered to assist her at his private clinic. Yolanda saw the doctor privately and was told that the termination of pregnancy could be performed the following day for a heavy fee – to be paid before the operation. She had no way of doing this and left very frustrated.

Two months later, she was brought to casualty. By chance the same doctor was on duty at that time. She was wheeled in on a stretcher by her parents. They told him that she had been behaving strangely for the past several weeks. She had gone to visit an aunt up country 10 days before and stayed away one week. She had been extremely unwell for the past three days. Her parents suspected malaria. Yolanda herself was too unwell to provide any further information.

Physical examination revealed a very sick girl with marked pallor, jaundice, temperature of 36 degrees, rapid and weak pulse, and blood pressure 80/50 mm; the abdomen was tender and distended. There was foul smelling discharge from the vagina. The diagnosis of septic incomplete abortion with a foreign body in the vagina, causing septicaemic shock was made.

Resuscitation was started and the patient was admitted to the surgical ward. Broad spectrum antibiotics were prescribed but were out of stock. Only penicillin was available. The parents rushed out to buy the prescription that they were given. A blood transfusion was ordered; and the drip started.

Six hours later, there was no improvement; a surgical evacuation under anaesthetic (EUA) was planned. At EUA, a stick was found in the vagina, perforating through the pouch of Douglas into the abdominal cavity. There appeared to be leakage of faecal matter into the abdomen. The doctors decided to do a laparotomy and an evacuation. At laparotomy, they found uterine perforation, partial necrosis of the posterior wall of the uterus and perforation of the gut. They also found fulminating peritonitis and a pelvic abcess. Gut resection, colostomy, and subtotal hysterectomy were performed. The patient was taken to the intensive care ward where her condition steadily worsened. She died five days later.

Questions for group discussion

1. What important issues pertaining to health services (availability and accessibility) are highlighted by this case study?

2. In your experience and practice, how often does this sort of event occur?

3. What do we need to do (as health-care providers) to prevent such tragedies from occurring?

4. What do you need to be aware of when carrying out a physical examination on a young woman in such a situation?

5. How frequently do basic supplies and other resources for resuscitation run out in your experience?

6. What could have been done differently to save the young woman's life after she presented at the hospital?

Annex 3

Role plays

Session 5: ACTIVITY 5-3

ROLE PLAY 1

A 14-year old girl, dressed in her school uniform, comes during school hours, to see the duty medical officer in the casualty department of a district hospital.

She explains to the doctor that she thinks she is pregnant and wants a termination. She does not want to talk about who the father might be, even on probing.

She tells him that she is the first-born in a family with six children. She attends a local Catholic secondary school and lives with an uncle who is her local guardian and is paying for her upkeep. Her parents are poor farmers living in a rural area.

The girl believes that her future education and her relationship with her family will be irrevocably damaged by carrying through with this pregnancy. She says that she depends on the support of the duty medical officer to find a solution...

The doctor seems willing to consider assisting her, but the nurse on duty is a staunch Christian who believes that abortion is murder.

Roles: Doctor, nurse, 14-year old girl.

ROLE PLAY 2

A young woman (18 years) has died in hospital from septic incomplete abortion (see Case study 2) in the care of a certain middle-aged male doctor.

Two months before her death, the woman had come to the hospital seeking an abortion. She had met with this doctor who had told her that he would be prepared to perform the procedure in his private clinic, on payment of a heavy fee (and had then refused to do so because she did not have the money required). This doctor now has to break the news of her death to the family, and he has in his office both her parents and her sister.

The sister breaks down sobbing and in anger reveals what had happened two months earlier when her sister came to the hospital for help.

The doctor wants to comfort the family but, of course, his own part in the affair makes this very difficult. He feels torn between his own guilt, genuine sympathy for the family and his real concerns about safeguarding his position...

Roles: Doctor, young woman's parents and 21-year old sister.

ROLE PLAY 3

A manual vacuum aspiration (MVA) programme has recently been introduced in the gynaecology ward of a busy regional hospital. This means that evacuations can now be performed in the treatment room rather than in the operating theatre.

The value of post-abortion counselling and contraception has been stressed during staff training.

Three girls of secondary-school age who have just undergone medical termination of pregnancy are in the office of the nurse in charge, waiting to be discharged. The nurse has only a few minutes to devote to them.

As she begins talking to them about preventing future pregnancy, one of the girls says that she does not want to take contraceptive pills as she is sure that her parents will find them. She and her family live in small 2-roomed quarters and she has no privacy. The other girls immediately nod in agreement.

Roles: Nurse, three girls of secondary-school age.

ROLE PLAY 4

At 8 a.m. on a Monday morning, a gynaecologist at a regional hospital is summoned to see the Hospital Superintendent urgently.

The Superintendent is not in a laughing mood! He accuses the gynaecologist of performing abortions in the hospital, abortions which he says are illegal. His accusations are based on reports from the nurse in charge of the gynaecology ward.

The Superintendent has ordered the confiscation of the MVA instruments and instructed that henceforth all evacuations are to be performed in theatre under general anaesthesia.

The nurse in charge of theatre has been instructed to release instruments only for sharp curettage if she herself has confirmed that they are to be used in cases of incomplete abortion.

The gynaecologist is very angry now too and threatens to resign. He tells the Superintendent that he has carried out only 10 terminations of pregnancy in the last 12 months, following assessment and recommendation by a psychiatrist. The psychiatrist's notes have been duly recorded in the case sheets. He points out that he receives 10 cases of incomplete abortion daily. Most of these are induced outside and have high rates of complications. He challenges the Superintendent to do something about that. He then realizes that angry words will not solve the problem...

Roles: Hospital superintendent, gynaecologist.

Annex 4

Questions

Session 6: ACTIVITY 6-1

1. Given societal norms, laws and policies, what can health-care workers do to prevent unsafe abortion?

Specifically, how can they:

- improve access to reproductive health information and services?
- create a climate conducive to contraceptive use for all sexually active adolescents?
- involve communities in discussions of the issues of unwanted pregnancy and the consequences of unsafe abortion, as well of their role in enabling adolescents to prevent these problems and to cope with them when they occur?

2. Given societal norms, laws and policies, what can health-care workers do to reduce the consequences of unsafe abortion when it occurs?

Specifically:

- how can a young person's confidentiality be respected in public hospitals where records and notes are difficult to protect from inquisitive eyes?
- if there are medical complications, under what circumstances should we inform parents or guardians?
- how should we build our own capacity to provide comprehensive abortion care including post abortion counselling and contraception?

3. What can health-care workers do to generate supportive norms and stimulate policy review and reform?

Specifically:

- to what extent should health-care workers conform to community beliefs and values if these conflict with principles such as availability and accessibility?
- how could you use existing legal avenues to expand access to safe abortion while pressing for review of existing laws?
- how could you involve communities in discussions of the issues of unwanted pregnancy and the consequences of unsafe abortion, as well of their role in enabling adolescents to prevent these problems and to cope with them when they occur?

Orientation Programme on Adolescent Health for Health-care Providers

Handout for

Module J

Pregnancy prevention in adolescents

This handout presents background information to complement the material in module J entitled *Pregnancy prevention in adolescents*. The facilitator may refer to the text in this handout during the sessions and you may be asked to read some extracts.

THIS HANDOUT PROVIDES INFORMATION ON THE FOLLOWING:

1. Why adolescents need pregnancy prevention methods J-5

2. Providing adolescents with information and education on sexuality and contraception J-6

3. Providing adolescents with contraceptive services J-7

4. References J-14

Annex 1. Spot checks. Session 1 – Activity 1-2 J-15

Annex 2. Role plays. Session 6 – Activity 6-2 J-19

1. Why adolescents need pregnancy prevention methods

Use of contraceptives among adolescents

Millions of individuals around the world begin their sexual activity during their adolescent years. They do so often without adequate knowledge about sexuality, and without using modern contraceptives or protection against STIs including HIV. For example, demographic and health survey data from sub-Saharan Africa reveal that, in a number of countries, 80% of women have had sexual intercourse before age 20 *(1)*. While these women may know of one or more contraceptive methods, in many sub-Saharan African countries fewer than 30% of sexually active women have ever used a contraceptive method *(1)*.

Few unmarried adolescents use contraception during their first sexual experience. For example, only 4% of sexually active women aged 15 to 24 in Ecuador reported using contraceptives, and the corresponding figure in Uganda was only 6%. In the developing world, with some notable exceptions – such as in Latin America – few young women use contraception between marriage and first pregnancy. Most women who marry young have at least one child before age 20 *(1)*. Sexually active young people are less likely to use contraception than adults even within marriage. Unmarried adolescents, who face additional barriers to obtaining contraceptives, are even less likely to use contraception than married adolescents.

Studies in the USA suggest that there tends to be a delay of one year, on average, between the initiation of sexual activity and the first use of modern contraceptives *(1)*. Thus premarital sexual activity often results in unintended pregnancy. In Mexico City, nearly two-thirds of women aged 18 to 19 with premarital sexual experience reported that they had been pregnant at least once. In Zimbabwe, 46 % of women aged between 11 and 19 who had been sexually active before marriage had been pregnant (*1*). Many unintended pregnancies occur within a year of first sexual intercourse.

Whether they are married or unmarried, adolescents can face potentially serious physical, psychological and social consequences from unprotected sexual relations. These include too-early and unwanted pregnancy and childbirth, unsafe abortion, and STIs including HIV/AIDS. These events can also limit educational and job opportunities and negatively affect social and cultural development, especially of adolescent girls *(2)*.

Barriers to contraceptive use among adolescents

Adolescents in general – and unmarried adolescents in particular – often find it difficult to obtain the contraceptives they need. The most important reasons that adolescents cite, in a variety of different settings, for not using contraceptive methods when they are sexually active are (*3*):

- The unexpected and unplanned nature of sexual activity
- Lack of information and knowledge about contraceptives and where to get them
- Embarrassment and fear of lack of confidentiality
- Fear of medical procedures
- Fear of judgemental attitudes and resistance from providers
- Inability to pay for services and transport
- Displacement – refugees, or political strife
- Fear of violence from partner or parents
- Pressure to have children.

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

In many parts of the world, laws and policies prohibit the provision of contraceptive information and services to adolescents. Restrictive societal norms add to this by hindering both their provision to and their utilization by adolescents. Working to reform these restrictive laws and policies, and to overcome societal resistance will help improve the availability and accessibility of contraceptive services to adolescents.

In many places, adolescents lack information about sexuality, and specifically about contraception. To add to this, health-care providers are often unaware of the special needs of adolescents, and further, contraceptive services are not geared to meeting the needs of adolescents. There is a pressing need to provide adolescents with the information they need. Alongside this, concerted efforts are required to help health-care providers understand and respond to the special needs of adolescents, and to reorient health services to meet those needs and preferences. In addition to the biomedical issues, it is important for health-care providers to be aware of the wider social issues, such as inequitable gender norms, that affect the adolescent's ability to obtain and use contraceptive services. Broader issues (such as gender norms and violence) often influence an adolescent's ability to access and effectively use contraception. Further, violence, either as a result of domestic abuse or political strife, can disproportionately affect the ability of women to access and use contraceptive services. In addition to their role as service providers, health-care workers should, where they can, contribute as change-agents, to the actions that are needed at the community and societal levels, to address these issues. These initiatives will help prevent the consequences of too-early and unprotected sexual activity in this important population group.

2. Providing adolescents with information and education on sexuality and contraception

For decades, education on sexuality and reproductive health for adolescents has been a controversial issue in developed and developing countries alike, because of concerns that knowledge would lead to earlier or increased sexual activity among unmarried adolescents. However, a review of studies from around the world which examined the impact of sex education programmes on adolescent knowledge and behaviour, found no support for this contention *(4).* If any effect is observed, almost without exception, it is in the direction of postponed initiation of sexual intercourse and/or effective use of contraception. The report stated that 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 (*4*).

Sexual and reproductive health education programmes need to tailor their messages to suit the needs of adolescents who have not begun sexual activity, and those who are already sexually active. Also, because some adolescents begin sexual activity during early adolescence, formal sex education programmes need to begin during this stage *(4*).

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[1]. Increasing awareness and understanding is only the first step in preventing unwanted pregnancy and STI/HIV. In addition, adolescents must know where to find services and be comfortable in using them. This important issue is addressed in this handout.

[1] A discussion on other issues that contribute to changes in behaviour, e.g. social norms, are beyond the scope of this paper.

3. Providing adolescents with contraceptive services

Dual protection provided by available contraceptive methods

Some adolescents may have temporary sexual relationships and multiple partners, which puts them at a high risk of STIs/HIV. Sexually active adolescents need to be aware of the importance of protection against both pregnancy and STIs/HIV. When used correctly and consistently, male condoms are the most effective method of preventing STIs including HIV/AIDS and can be highly effective in protecting against pregnancy as well. Another approach for simultaneous protection against pregnancy and STIs is the "dual use method", that is to use condoms in conjunction with another method that has more contraceptive typical-use failure rates 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 including HIV *(5).*

Medical eligibility for available contraceptive methods

WHO places a high priority on ensuring that adolescents and young people worldwide have access to safe and high-quality reproductive health and family planning services. The publication *Improving access to quality care in family planning: Medical eligibility criteria for contraceptive use (6)*, provides recommendations of an expert scientific working group for appropriate contraceptive use in the presence of various medical conditions. It provides essential information for the provision of contraceptives safely to adolescents, while at the same time ensuring that they are not denied access to contraception based on unfounded "contraindications".

A brief review of method-specific medical, service delivery and counselling considerations for adolescents is provided below in Table 2. This table covers issues that are most important when providing contraceptive methods to adolescents. For a more thorough discussion of the medical eligibility criteria, please refer to *Improving access to quality care in family planning: Medical eligibility criteria for contraceptive use*. For more information on methods, such as mechanism of action, correct use, management of problems and side effects, and contraceptive benefits, see *The essentials of contraceptive technology: A handbook for clinic staff (7).*

Healthy adolescents are medically eligible to use any of the methods of contraception that are currently available. Age alone does not constitute a medical reason for denying any method to adolescents. However, age is an important social factor to take into account when considering irreversible contraceptive methods, such as male or female sterilization. It is also true that some concerns exist regarding the use of certain other methods by adolescents (for example, progesterone-only pills), but this must be balanced with the advantages of avoiding pregnancy. Many of the method-specific eligibility criteria that apply to older clients also apply to young people. Some conditions such as circulatory system diseases, that may limit use of some methods in older women, will not often apply to young people, since these conditions are rare in this age group.

TABLE 1

Dual protection of available contraceptive methods

<table>
<tr><th rowspan="2">Method</th><th colspan="2">Effectiveness against pregnancy</th><th rowspan="2">Protection against STI/HIV</th><th rowspan="2">Comments and considerations</th></tr>
<tr><th>As commonly used</th><th>Used correctly and consistently</th></tr>
<tr><td>Abstinence and non-penetrative sex</td><td>Not effective</td><td>Very effective</td><td>Protective against STI/HIV</td><td>Most effective method for dual protection. Only provides dual protection when used correctly and consistently.</td></tr>
<tr><td>Male condom[1]</td><td>Somewhat effective</td><td>Effective</td><td>Protective against STI/HIV</td><td>Only provides dual protection when used correctly and consistently.</td></tr>
<tr><td>Female condom</td><td>Somewhat effective</td><td>Effective</td><td>Protective against STI/HIV, although data is limited</td><td>Only provides dual protection when used correctly and consistently.</td></tr>
<tr><td>Spermicide[2]</td><td>Somewhat effective</td><td>Effective</td><td>May protect against gonorrhoea and chlamydia, no protection against HIV</td><td>Only provides limited dual protection when used correctly and consistently.
Not recommended for use alone.
Not recommended for frequent use (may cause genital lesions).</td></tr>
<tr><td>Diaphragm with spermicide</td><td>Somewhat effective</td><td>Effective</td><td>May protect against gonorrhoea and chlamydia, no protection against HIV</td><td>It is not clear to what degree the diaphragm, when used with a spermicide provides protection against STIs.
Only provides limited dual protection when used correctly and consistently.
Spermicide not recommended for frequent use (may cause genital lesions).</td></tr>
<tr><td>Combined Oral Contraceptives (COCs)</td><td>Effective</td><td>Very effective</td><td>Not protective</td><td rowspan="2">Only protective against pregnancy when used correctly and consistently.
If at risk of STI/HIV, recommend switching to condoms or using condoms along with this method.</td></tr>
<tr><td>Progestin-Only Pills (POPs)</td><td colspan="2">Very effective (during breastfeeding)</td><td>Not protective</td></tr>
<tr><td>Long-Acting Hormonals:Injectables or Implants</td><td colspan="2">Very effective</td><td>Not protective</td><td>If at risk of STI/HIV, recommend switching to condoms or using condoms along with this method.</td></tr>
<tr><td>Copper Intra-uterine Device (IUD)</td><td colspan="2">Very effective</td><td>Not protective
Insertion of an IUD in a woman with an STI increases the risk of PID</td><td>Use of IUDs among women at risk of STI/HIV is generally not recommended (unless other, more appropriate methods are not available).
If an IUD user becomes at risk of STI/HIV, recommend switching to condoms or using condoms along with this method.</td></tr>
<tr><td>Fertility Awareness-Based Methods</td><td>Somewhat effective</td><td>Effective</td><td>Not protective</td><td rowspan="3">Only protective against pregnancy when used correctly and consistently.If at risk of STI/HIV, recommend switching to condoms or using condoms along with this method.</td></tr>
<tr><td>Lactational Amenorrhoea (LAM) during first 6 months postpartum</td><td>Effective</td><td>Very effective</td><td>Not protective</td></tr>
<tr><td>Withdrawal</td><td>Somewhat effective</td><td>Effective</td><td>Not protective</td></tr>
<tr><td>Male and Female Sterilization</td><td colspan="2">Very effective</td><td>Not protective</td><td>If at risk of STI/HIV, recommend using condoms along with this method.</td></tr>
</table>

[1] At present, dual protection applies only to condoms. The evidence for the effectiveness of condoms for STIs/HIV prevention is substantially greater for male condoms than it is for female condoms.

[2] Spermicides containing nor oxynol-2 do not appear to protect against chlamydia infection or gonorrhea.

TABLE 2

Medical, service delivery and counselling considerations for adolescents

Method	Dual protection	Age Restriction	Availability/ Accessibility	Side Effects	Other important counselling points for adolescents	Comments/ considerations
Abstinence and non-penetrative sex	Yes	No age restriction	Available at anytime to anyone	None	Can be used even by those who have already begun sexual activity To prevent pregnancy, avoid vaginal intercourse To prevent STI/HIV, also avoid anal intercourse and oral sex Examples of safe sexual activities: hand-holding, hugging, massaging, kissing, mutual masturbation Emphasize need to use condom or other method if penetrative sex is initiated	Most effective method for dual protection Requires high level of motivation and self-control Counselling can help with issues of motivation and peer pressure
Male condom	Yes	No age restriction	Easily available in most places	Usually no side effects (local irritation possible)	Explain and demonstrate correct use Requires partner communication / negotiation Requires supplies at home (fear of discovery may be an issue)	Important method because provides dual protection
Female condom	Yes (data limited)	No age restriction	Availability limited in many places High cost may be a constraint	Usually no side effects (local irritation possible)	Explain and demonstrate correct use Use can be controlled by woman Requires supplies at home (fear of discovery may be an issue)	Important method because provides dual protection
Spermicides	Yes (protective against some STIs, not HIV)	No age restriction	Easily available in many places	Usually no side effects (local irritation possible)	Explain and demonstrate correct use Recommend use with condom or diaphragm Requires supplies at home (fear of discovery may be an issue)	Not recommended for use alone Not recommended for frequent use (may cause genital lesions)
Diaphragm with spermicide	Yes (protective against some STIs, not HIV)	No age restriction	Requires a clinic visit for fitting Availability limited in many places	Usually no side effects (local irritation possible)	Explain and demonstrate correct use Requires supplies at home (fear of discovery may be an issue)	It is not clear to what degree the diaphragm, when used with a spermecide provides protection against STIs Spermicide not recommended for frequent use (may cause genital lesions)
Low Dose Combined Oral Contraceptives (COCs)	No	No age restriction	Requires clinic visit in many places May be available through community-based distribution	Side effects may include nausea or headache	Explain and demonstrate correct use Recommend also using condom if at risk of STI/HIV Requires daily regimen Requires supplies at home (fear of discovery may be an issue)	A widely-used method among adolescents, although correct and consistent use may be an issue

1 of 3

TABLE 2

Medical, service delivery and counselling considerations for adolescents

Method	Dual protection	Age Restriction	Availability/ Accessibility	Side Effects	Other important counselling points for adolescents	Comments/ considerations
Progestin-Only Pills (POPs)	No	No age restriction	Requires clinic visit in many places May be available through community-based distribution	Fewer side effects than COCs or long-acting hormonals (injectables and implants)	Explain and demonstrate correct use Recommend also using condom if at risk of STI/HIV Requires strict daily regimen Requires supplies at home (fear of discovery may be an issue)	Stricter regimen than COCs Good option for breastfeeding women after first 6 weeks postpartum
Emergency Contraceptive Pills (POPs or COCs)	No	No age restriction	Requires clinic visit in many places May be available over-the-counter or through community-based distribution	Side effects may include nausea and vomiting (much less likely with POP regimen)	Not meant for repeated use Discuss initiation of a regular method	Important method when intercourse may be unplanned, unprotected
Injectables: Depo medroxy progresterone acetate (DMPA) and Norethisterone Enanthate (NET-EN)	No	Not first method of choice for those under 18, as there is a theoretical concern that bone development in general	Requires clinic visit every 2 or 3 months May be available through community-based distribution	Side effects may include irregular bleeding, amenorrhoea, or weight gain	Recommend also using condom if at risk of STI/HIV Often delay in return to fertility No daily regimen required No supplies needed at home (can be private)	May be a good option for those desiring a hormonal method, without a daily regimen Side effects the main reason for discontinuation and if they occur, method cannot be quickly discontinued
Combined Injectables: Cyclofem and Mesigyna	No	No age restriction	Requires clinic visit every month May be available through community-based distribution	Side effects may include nausea or headache	Recommend also using condom if at risk of STI/HIV No daily regimen required No supplies needed at home (can be private)	May be a good option for those desiring a hormonal method, without a daily regimen
Norplant Implants	No	No age restriction	Clinic visit required for insertion and removal	Side effects may include irregular bleeding or amenorrhoea	Recommend also using condom if at risk of STI/HIV No delay in return to fertility No daily regimen required No supplies needed at home (can be private)	May be a good option for those desiring a hormonal method without a daily or monthly regimen

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TABLE 2

Medical, service delivery and counselling considerations for adolescents

Method	Dual protection	Age Restriction	Availability/ Accessibility	Side Effects	Other important counselling points for adolescents	Comments/ considerations
Copper Intra-uterine Device (IUD)	No	Not first method of choice for those under 20, as risk of expulsion may be great in younger, nulliparous women	Clinic visit required for insertion and removal	Sides effects may include excessive bleeding or pain during menses	Recommend also using condom if at risk of STI/HIV No delay in return to fertility No daily regimen required No supplies needed at home (can be private)	Not a good choice for those at risk of STI/HIV (more than one sexual partner or whose partner may have more than one partner) Nulliparous women may be at higher risk of expulsion
Fertility Awareness-Based Methods	No	No age restriction	Available at anytime to anyone	No side effects	Explain correct use Recommend also using condom if at risk of STI/HIV Requires partner communication/ negotiation	Important for adolescents to understand their fertility May not be as effective in younger women whose menstrual cycles are irregular May be difficult to use for couples who have sex infrequently
Lactational Amenorrhoea (LAM)	No	No age restriction	Can be used during first 6 months postpartum when exclusively breastfeeding and amenorrhoeic	No side effects	Explain and demonstrate correct use Recommend also using condom if at risk of STI/HIV	Important method option for breastfeeding women
Withdrawal	No	No age restriction	Available at anytime to anyone	No side effects	Explain correct use Requires partner communication/ negotiation important	Important method to discuss, as may be only method available in some places
Male and Female Sterilization	No	No age restriction However, age at sterilization is a key risk factor for regret for both women and men	Clinic visit required for procedure	Minimal side effects, local infection possible	Recommend also using condom if at risk of STI/HIV Permanent method No daily regimen required No supplies needed at home (can be private)	Consider only in special circumstances after thorough counselling

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Counselling on sexuality

Adolescence is a period when individuals may test limits set for them by adults, experiment with new behaviours, and struggle with issues of independence, acceptance, and peer group pressure. Thus, a supportive, encouraging, non-judgemental environment, where confidentiality is ensured, is essential

when counselling adolescents. Health-care providers and others may benefit from special training in sexuality and in counselling skills, to enable them to deal with the needs, concerns and problems of adolescents.

Developing a good rapport with adolescents is important, as is using language that they can understand and be comfortable with. Due to inexperience and possibly embarrassment, adolescents may be hesitant in expressing their needs. Providers need to be patient and take the necessary time when working with them.

Adolescents may have special information needs, such as a desire to understand the changes that are happening in their bodies as they mature, whether they are "normal" or not, and other information regarding sexuality and sexual function. Service providers who are not comfortable discussing these issues with issues with adolescents, should refer them to those who are. Also, parents should be encouraged – and given the necessary support – to communicate with their children/adolescents on sexuality.

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.

Counselling for contraceptive method choice

While adolescents may choose to use any one of the contraceptive methods available to them, some methods may be more appropriate for adolescents 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). The information provided should address the following issues:

- The effectiveness of the method
- Information on protection against STIs including HIV
- The common side-effects of the method
- The 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 which would necessitate a return to the clinic.

Proper education and counselling at the time of method selection can help adolescents address their specific problems and make well-informed, voluntary decisions. Further, expanding the number of method choices offered can lead to improved satisfaction, increased acceptance and higher contraceptive prevalence.

Special considerations

Married adolescents

It is important to remember that many adolescents seeking contraception services are married. Their contraceptive needs are similar to those of married adults, but they may have other special information needs.

In terms of counselling issues, married adolescents may be particularly concerned about their return to fertility after discontinuing use of a method. Those desiring a quick return to fertility may prefer to avoid injectables such as Depo Medroxy Progesterone Acetate (DMPA), which can delay return to fertility. Young married women may in some cases feel a pressure to have children, and thus may want to keep their contraceptive use private from their spouse or in-laws. They also may knowingly or unknowingly be in a relationship where they are at risk for STIs including HIV/AIDS. This is an important, yet often difficult issue to discuss, and must be done with sensitivity.

Unmarried adolescents

Unmarried adolescents may be less likely to seek contraceptive services at health facilities because of embarrassment at needing or wanting reproductive health services, and because of fears that the staff may be hostile or judgemental or that their parents might learn of their visit. Adolescents need to feel that they are respected, that their needs are taken seriously, and that they have the right to use contraception if they desire.

For unmarried adolescents 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 and self-control. Adolescents need support and encouragement to abstain from and/or delay the initiation or continuation of sexual intercourse.

For unmarried adolescents who want to have sexual intercourse, condoms – or condoms in combination with another method – are the best recommendation. For adolescents who are not in monogamous relationships, sexual activity may be sporadic and unplanned. In these circumstances, condoms are a good choice because they are widely available and can be used when needed.

Adolescents, especially those in monogamous relationships, may also desire to use other, longer-acting methods. Providers of contraceptives must support this decision. For these adolescents as well, the risk of STIs including HIV/AIDS must be discussed. Some of them may be at risk for STIs/HIV when they do not consider themselves to be, if their partner has other sexual partners.

Adolescents who have been coerced into having sex

In designing and providing services, it is crucial not to assume that clients are engaged in mutually consensual sexual relations. 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

- In many parts of the world, adolescents are entering their reproductive years ill-prepared to protect and safeguard their sexual and reproductive health.
- For all adolescents, but especially for those who are sexually active outside the context of marriage, access to appropriate information and services – and the assurance of confidentiality – are particularly important.
- To help ensure contraceptive use among sexually active adolescents, contraceptive information and services must be made readily available through a variety of delivery points, including community-based points and outreach services.
- By providing quality services that respect adolescents' rights and respond to their needs, reproductive health programmes will contribute to the overall health and well-being of their adolescent clients and to their communities and societies.

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Annex 1

Spot checks

Session 1: ACTIVITY 1-2

SPOT CHECK 1

Which contraceptive methods should not be used by adolescents?

please mark all unsuitable methods

- Abstinence ◯
- Male condom ◯
- Female condom ◯
- Spermicide ◯
- Diaphragm with spermicide ◯
- Combined oral pill ◯
- Progestin-only pill ◯
- Combined injectable ◯
- Progestin-only injectable ◯
- Progestin-only implant ◯
- Intra-Uterine Device ◯
- Fertility-awareness based methods ◯
- Lactational amenorrhoea ◯
- Withdrawal ◯
- Sterilization ◯

SPOT CHECK 2

Which contraceptive methods are protective against HIV/STI?

please write down two examples for each method

protective

not protective

SPOT CHECK 3

Which contraceptive methods are available in your local clinic?

please write down two examples

SPOT CHECK 4

Which contraceptive methods do not require the cooperation of the male partners?

please write down three examples

Annex 2

Role plays

Session 6: ACTIVITY 6-2

ROLE PLAY 1

You are a nurse-midwife in a district hospital. Along with the other members of your small Obstetrics-Gynaecology team, you run an antenatal outpatient clinic, twice a week (in the mornings). One Friday morning, as you walk into your clinic, you see two young women, in their late teens, huddled together in a corner of the waiting room. One of them is obviously crying, and the other appears to be trying to console her. You say to yourself that this is a sight you have seen several times before - yet another possible unintended, unwanted pregnancy… When it is their turn, your suspicions are proved right. The two young women are aged 15 and 16. They are students in a nearby secondary school. The one in tears tells you that her periods are delayed by four weeks, and she suspects that she is pregnant. On gentle questioning, she tells you that she had unprotected intercourse only once with a young man who is her neighbour. You carry out an examination and request a urine test for pregnancy. You ask them to wait for the results. An hour and a half later, a technician from the laboratory brings you the results: the urine test for pregnancy is negative. You call the two women into the room to share the news with them. Both of them start sobbing in relief.

Roles: Nurse-midwife, two adolescent girls 15 and 16 years old.

ROLE PLAY 2

You are a female doctor in your late 40s. Along with your husband, who is also a doctor, you run a private practice in a well-to-do suburb of a large city. Your clinic has been in operation for nearly 15 years and is a well-established one. Your husband and you are well-known in the neighbourhood, and in fact you live nearby. One evening, your nurse ushers in a young woman whom you have not seen before. The woman waits till the door is firmly shut and then leans forward to speak to you in a soft voice, which is almost a whisper. She says that she is 19 years old, just married and has moved into the neighbourhood to live with her husband and his extended family. She smiles when you congratulate her, and says that she is happy with her husband, but that she is under a lot of pressure from her in-laws to have a baby as soon as possible. She wants to wait for some time and asks for your advice. Apparently, her husband agrees but feels unable to resist the pressure of his parents…

Roles: Doctor, 19-years old young woman.

Orientation Programme on Adolescent Health for Health-care Providers

Handout for

Module K

Young people and psychoactive substance use

This Handout for the module on *Young people and psychoactive substance use* describes the common substances used by young people, the risk factors and protective factors, and the most common problems. The module also considers how health workers can assess young people's substance use and how they can respond to such problems in their clinic and in the community.

This handout provides information on the following:

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4. Stages of change K-26
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1. Young people and substance use

Rapid increases in global use of alcohol, tobacco and other psychoactive substances are contributing significantly to the global burden of disease. Alcohol and tobacco are major causes of mortality and disability in developing countries, and the impact of tobacco is expected to increase in other parts of the world. Alcohol consumption is the leading risk factor for disease burden in low mortality developing countries and the third largest risk factor in developed countries. Cigarette smoking is spreading rapidly in developing countries and among women. Among the ten leading risk factors in terms of avoidable disease burden, tobacco was fourth and alcohol was fifth in the year 2000. The burden of ill-health from use of psychoactive substances is substantial and the main global burden is due to legal rather than illegal substances.

Alcohol and tobacco are similar in that both are legal substances, both are widely available in most parts of the world, and both are marketed aggressively by transnational corporations that target young people through advertising and promotional campaigns. Despite increased law enforcement activities, illicit substances are widely available.

Around the world there is increasing concern about the use of psychoactive substances by young people. The onset of such use is occurring at younger ages in many countries and the range of substances is increasing. Substance use is more prevalent among young people than in older age groups. In some countries early tobacco use is the major issue; in others there is an alarming rise in the use of amphetamine-type stimulants among young people.

Health workers come in contact in a number of ways with young people who are having difficulties associated with substance use. A young person may come to the clinic with an issue related to substance use (e.g. a youth with a broken arm from a fight after drinking alcohol, or a young woman with mental health symptoms after taking psycho-stimulants at a party), or with an unrelated issue (e.g. a routine contraception visit, or concerns about their development). Whether related to the presenting problem or not, substance use should be discussed by the health worker routinely during every contact with young persons. Health workers have a role in preventing substance use among young people and to assist them to reduce or stop their use.

This module focuses on substance use by *young people* (rather than adolescents) because many of the issues discussed are also important for people aged 19-24 years. WHO defines "adolescents" as individuals aged 10-19 years and "youth" as aged 15-24 years. These age ranges are combined in the group of "young people", who are individuals aged 10-24 years.

What are the substances?

Psychoactive substances (or psychoactive drugs), both legal and illegal, are substances which when consumed can affect the way people see, hear, taste, smell, think, feel and behave. In this module, the term *substance* includes all legal and illegal psychoactive substances and psychoactive drugs.

Common substances can be divided into depressants, stimulants, opioids and hallucinogens. Some examples of these are:

- **Depressants**
  - Alcohol (wine, beer, spirits, home-brew)
  - Sedatives/hypnotics (sleeping pills containing benzodiazepines, methaqualone, barbiturates, chloral hydrate)

- Volatile solvents (aerosol sprays, butane gas, petrol/gasoline, glue, paint thinners, hair spray, nitrites, solvents, felt-tip-marker fluid)
- Date rape drugs (flunitrazepam, rohypnol, GHB, ketamines).

- **Stimulants**
  - Nicotine (cigarettes, cigars, pipes, chewing tobacco, snuff)
  - Cocaine (crack, crystal, coca products)
  - Amphetamines (methylenedioxymeth-amphetamine [MDMA or ecstasy], dextroamphetamines, methamphetamines)
  - Caffeine (coffee, tea, soft drinks)
  - Betel nut, kava, buri.

- **Opioids**
  - Heroin, morphine, opium, buprenorphine, methadone, pethidine
  - Cough syrup with codeine.

- **Hallucinogens**
  - Lysergic acid diethylamine (LSD)
  - Mescaline, psilocybin, peyote, tryptamines
  - Cannabis (marijuana, ganja, hashish, bhang, pot, grass).

Substances can be legal or illegal and can be found in the following products:

- Medicines (obtained with a prescription or over the counter)
- Drugs (obtained without a prescription)
- Tobacco products (e.g. cigarettes, chewing tobacco, cigars, bidis)
- Alcohol (e.g. spirits, beer, home brew)
- Chemical products (e.g. caffeine, glue, mouth wash with alcohol, aerosol)
- Other products which may be locally produced (e.g. khat, cocaine leaves, cannabis).

Although it is important to know whether the substances used by young people are legal or illegal, the action that health workers will take with young people may be the same. This is because the action is concerned with changing behaviour in order to reduce substance use, and with reducing the likelihood of harmful health outcomes from such use. The action may be the same regardless of the legality of the substance used; however, the ease by which the action is developed and implemented is often influenced by the legality or illegality of the substance.

Substances can be administered in many ways. They can be chewed, dissolved slowly in the mouth, or swallowed; smoked or inhaled; injected; rubbed into the skin or placed under the eyelid, or inserted in the anus or vagina. Some of the health risks of substance use (e.g. local or general infection, HIV transmission, hepatitis B and C, nasal sepsis, cancer of the airways, etc.) are related directly to the route of administration.

Regular substance use by young people is rarely confined to a single substance. Frequently they practise poly-pharmacy substance use or poly-substance use (i.e. combining several substances simultaneously or serially). One substance may be used to counteract the unpleasant effects of another, and may itself cause adverse health consequences.

Negative consequences of substance use by young people

The effect on the young substance user is shaped by four factors:

- The substance: the pharmacology or properties of the substance.
- The mode of use: the way it is taken (orally, by injection, sniffing etc.).
- The person taking it: the influences, personality, family situation etc. of the individual.
- The environment: the immediate environment in which the person takes the substance and the risk and protective factors of the wider environment in which the person lives.

The substance

Aspects of the substance that can affect the use and consequences of use include:

- Type of substance(s) used
- Pharmacological properties of the substance
- Use of other substances at the same time
- Immediate and longer-term effects of the substance
- Strength and purity of the substance
- Route of administration
- Social influence.

The person

Aspects of the young person that can affect the use and consequences of substance use include:

- His/her health and nutrition
- Other substances used by him/her
- Previous use of this or other substances
- Use of substances by the family, partner, peers
- Support available from the family, school, friends, peers.

The mode of use

Aspects of the mode of use that can affect the use and consequences of use include:

- Common mode of use among peers
- Availability of drugs that can be used in a particular mode
- For injectors, availability of needle-syringe programmes to reduce the risk of blood-borne infections.

The environment

Environmental aspects that can affect the use and consequences of use include:

- Mood of the occasion when the substance is taken
- The physical environment (safety, support, etc.)
- Whether the use is alone or in a group

- The expectations of the group (support, peer pressure, violence, etc.)
- The risk and protective factors of the wider environment in which the person lives.

These factors also directly contribute to the *negative* consequences of use, both physical and psychosocial.

Physical consequences

- Trauma while intoxicated (e.g. falls, road traffic accident, drowning), overdose, blackouts, unsafe sex, damage to organs (e.g. liver, lungs, nerves).
- Blood-borne infections (e.g. HIV, hepatitis) and local infections (e.g. abscesses, phlebitis).

  The harmful consequences can affect the health of others (e.g. from secondhand smoke, injury to passengers in road accidents caused by impaired drivers).

Psychosocial consequences

- Family dysfunction, social withdrawal, learning difficulties in school, loss of job and income, criminal behaviour, violence, crimes committed for money to buy substances.
- Anxiety, memory and concentration problems, psychotic episodes (fixed false ideas, hallucinations), depression, suicide.

The use of substances can lead to a wide range of acute and chronic health and social problems in young people, as with adults. Acute problems are more likely to occur among young persons because of the frequency and quantity of substance use and because:

- Although there may not be a long history of substance use, young people may use levels which put them at high risk of death and morbidity – e.g. from traffic accidents, falls, drowning, injuries, blackouts, or unprotected sexual activity.
- Young people are less experienced with substance use; they are less tolerant and can have an unexpected overdose (e.g. when using cocaine or heroin) or may have a mental crisis or "bad trip" (e.g. when using LSD or cannabis).
- Young people more commonly become involved in fights and aggressive behaviour, which are more likely to occur when they are intoxicated or under the influence of a substance.

These acute consequences are not, in themselves, predictive of dependence in later years. Nor do they necessarily indicate that the young person is already dependent, although the levels of substance use may be high at times. For the majority of young people, dependence does not follow sporadic episodes of heavy use or intoxication.

It is important, therefore, to understand the relationship between hazardous substance use, harmful use and dependence. Simply asking whether a person has used or is using a substance does not give information on how much he/she is using, or if such use has caused or is causing any problems, or whether the person is dependent.

For example, the immediate risks with alcohol intoxication relate to injuries, aggressive behaviour, homicides and traffic accidents. Repeated use of alcohol over several days can lead to gastritis, acute hepatitis and other health problems. Heavy consumption over a period of years is related to many more health problems and dependence is likely to occur.

In general, young people may feel less threatened and will be more responsive to discuss their current problems and concerns if the health worker did not focus too much on the long-term consequences after 20 or more years in the future (such as cancers, liver cirrhosis).

TABLE 1

Physical effects of different substances

Substances	Desired effects	Undesirable/problematic effects
Depressants Alcohol Sedatives/ hypnotics Volatile solvents	Pleasant relaxation, reduced inhibition, reduced anxiety	Drowsiness, slurred speech, headaches, impairment of judgment, memory and coordination. Hangovers, 'blackouts', acute intoxication, respiratory depression, gastritis, pancreatitis, worsening of existing diabetes or epilepsy, unconsciousness, severe dependence, death from intoxication.
Date rape drugs		Sexual assault by a predator with little or no memory of the attack.
Stimulants Nicotine Cocaine Amphetamines Caffeine Betel nut, kava, buri	Exhilaration, reduced tiredness, sedation, stimulation, sexual arousal, loss of appetite, weight loss	Increased pulse and blood pressure, irritability, insomnia, tremor, paranoia, hyperactivity, exhaustion, weight loss, cardiac arrest, impaired judgment. Psychotic experiences, worsening aggressive and violent behaviour, personality changes, irreversible CNS damage, intra-cerebral haemorrhage, muscle breakdown, nasal septum infection/perforation, organ dysfunction (CNS, liver, renal).
Opioids Heroin Morphine Opium, Buprenorphine Methadone Pethidine Cough syrup with codeine	Pain relief, euphoria, relaxation, reduced hunger	Irritability, drowsiness, nausea, impaired judgment, aggressive paranoia, respiratory depression, myocardial infarction, seizures, cardiac irregularities and sudden death.
Hallucinogens Lysergic acid diethylamine (LSD) Mescaline, psilocybin, peyote, tryptamines, phencyclidine Cannabis	Perceptual distortions, other-worldliness Relaxation, reduced anxiety.	Increased blood pressure, tremor, long-term psychiatric effects, panic attacks, paranoia, auditory and visual hallucinations, impaired judgment, increased appetite, memory and cognitive impairment, amenorrhea (stopping of menstrual periods), reduced sperm production, bronchitis.

Some signs of specific substance use

- *Depressants*. Drowsiness, confusion, lack of coordination, tremors, slurred speech, depressed pulse rate, shallow respiration, dilated pupils.
- *Alcohol*. Slurred speech, impaired judgement and motor skills, lack of coordination, confusion, tremors, drowsiness, agitation, nausea and vomiting, respiratory ailments, depression.
- *Volatile solvents*. Slurred speech, lack of coordination, nausea, vomiting, slow breathing.

- *Stimulants*. Excitability, tremors, insomnia, sweating, dry mouth and lips, bad breath, dilated pupils, weight loss, paranoia, hallucinations.

- *Tobacco*. Smell of smoke in hair, clothes and breath; yellowing of teeth; cough; increased asthma attacks; shortness of breath and poorer athletic performance. After only a few weeks, tobacco chewers can develop cracked lips, white spots, sores, and bleeding in the mouth.

- *Cocaine*. Excitability, euphoria, talkativeness, anxiety, increased pulse rate, dilated pupils, paranoia, agitation, hallucinations.

- *Opioids*. Lethargy, drowsiness, euphoria, nausea, constipation, constricted pupils, slow breathing.

- *Hallucinogens*. Trance-like state, excitation, euphoria, increased pulse rate, insomnia, hallucinations.

- *Cannabis*. Mood swings, euphoria, slow thinking and reflexes, dilated pupils, increased appetite, dryness of mouth, increased pulse rate, delusions, hallucinations.

Drug testing of urine or blood should only be undertaken if needed for diagnostic or therapeutic purposes, or in an emergency situation. Testing must never be carried out without the informed consent of the individual. These tests are expensive and are unlikely to be available in the primary healthcare setting.

BOX 1

Pregnancy and substance use

All substances taken by the mother during pregnancy can reach the unborn baby. These substances can cause serious health effects on the mother, the unborn baby and the newborn.

Effects on the mother

- Safe levels of alcohol intake during pregnancy have not been established
- Drinking alcohol during pregnancy can lead to miscarriage
- LSD can increase the chance of miscarriage and complications during pregnancy
- If the mother stops using opioids suddenly, she can experience withdrawal problems.

Effects on the unborn baby and newborn

- There is a possibility of physical deformities
- Drinking alcohol during pregnancy can cause slower development in the fetus and mental disability in the newborn (fetal alcohol syndrome)
- Smoking during pregnancy can reduce the amount of oxygen available to the fetus and may affect growth and development before birth (low birth weight) and after birth
- If a mother who is pregnant or breastfeeding suddenly stops using opioids, the baby may experience withdrawal. Withdrawal in a newborn is a serious problem.

Reasons why young people use substances

Some reasons why young people may use substances are discussed below.

- *Urge for discovery and experimentation*

  Young people have the urge for discovery of themselves and others, which leads them to experiment with adult behaviours and to question social norms. But often they lack knowledge

and understanding of the risks. Behaviour at this stage can be seen by the young person as a rite of passage of puberty, from childhood to adulthood. Substance use can be considered as proof of reaching "maturity".

Most young people, after experimenting with substance use, will not continue and will not develop any significant problems. However, it is important to remember that the younger a person starts using any substance, it follows that:

- he/she is at greater risk of developing problems later in life;
- dependence, if it occurs, is more severe;
- the toxic consequences are greater;
- there is more resistance to treatment.

■ *Young people may copy other people's use of substances*

There are several developmental factors that help account for young people's attraction to substance use. During transition from childhood to adulthood, adolescents adopt many of the behaviours and attitudes of the adults in the world around them. Thus in the process of establishing their own identity, young people often imitate adult behaviours and attitudes. They observe adults using legal and illegal substances, the conditions under which they are used and the effects they bring about. Parents, other adults, peers, TV personalities and sports stars who use substances can all serve as models for young people's experimentation and regular use.

■ *Marketing of substance use*

People with commercial interests are all too aware of the need, during adolescence and youth, to encourage the use of substances available for adults. Alcohol and tobacco use are supported by mass marketing strategies which target young people through the portrayal of these substances as "cool" to use. In some cultures, drinking to intoxication is portrayed as "macho".

Marketing strategies for substance use show images of wealth, glamour, adulthood and independence which attract young people. This is especially evident in the marketing of alcoholic beverages and tobacco, which is increasing in the developing countries. Marketing activities play a critical role by targeting young people, who are increasingly using alcohol and tobacco. Television programmes and films also frequently portray substance use without showing the adverse consequences.

■ *Easy access to substances*

When substances are easily available and affordable to young people, substance use will increase.

■ *Other immediate reasons*

The reasons why young people use substances are many and include:

- For excitement, enjoyment, or courage.
- To stay awake or to sleep.
- To reduce pain (physical and emotional).

However, like anyone else, young people may use substances in certain situations spontaneously, or only when the opportunity arises.

BOX 2

Young girls and substance use

In the past, not many girls used substances. However, this trend is now changing in most parts of the world as more young girls use different types of substance. It is important to pay equal attention to both boys and girls for preventing, assessing and treating substance use. In this way it is possible to reduce and eventually eliminate their vulnerability to substance use. Young girls using substances are more vulnerable to nutritional deficiencies, prostitution and sexual abuse. This can lead to an increase in unplanned and high-risk pregnancies and an increased risk of sexually transmitted diseases, including HIV.

The relationship between young people and substance use is complex, and the pattern and context of use can change rapidly. In different places and at different times, young people may use a variety of substances, often those that are easily accessible and inexpensive. For example, street children frequently use inhalants like glue, which is cheap and easy to get.

Risk factors and protective factors

As discussed above (see 1.2), the effect and impact of any young person's substance use is a result of four interacting factors:

- the substance;
- the person;
- the mode of use;
- the environment.

Any discussion of the effect and impact of substance use needs to consider these factors and also the risk and protective factors.

Risk and protective factors take into account "who you are, where you live, and what you do", which determine many behaviours, including substance use.

- Risk factors include individual and contextual influences that either encourage or are associated with one or more behaviours that might lead to negative health outcomes, or might discourage behaviours that might prevent a negative health outcome.
- Protective factors include individual and contextual influences that discourage one or more behaviours that lead to negative health outcomes or that encourage behaviours that prevent negative health outcomes. Protective factors can also lessen the likelihood of negative consequences from risk factors.

Protective factors function by:

- providing personal or social controls against problem behaviour;
- promoting activities which are an alternative and incompatible with problem behaviour;
- strengthening orientation and commitment to conventional social institutions such as the family, religious institutions or school.

For example, if a young woman has parents who smoke, this is a risk factor that may encourage her to smoke. However, if she has peers who disapprove of smoking, this is a protective factor. Their disapproval may not stop her from smoking, but it may make her smoke fewer cigarettes (i.e. lessen the negative effects) or play a role in her stopping to smoke (i.e. work against the effects of the risk factor, smoking by her parents).

Protective factors play an independent role in influencing young people's behaviours, which can enable them to resist or reduce substance use.

Risk and protective factors can occur in five areas. The following is a list of some risk and protective factors for young people and substance use in each of these areas.

The individual

Although there is no indication of specific mental disorders that are predictive of harmful substance use, people with mental health disorders may be more likely to use substances and substance use can often exacerbate any existing mental health difficulties. Emotional feelings of distress and vulnerability, and stressful situations such as death of a parent, serious accidents, war, physical and sexual assaults, abuse and suicide attempts may cause a young person to turn to substance use as a way to ease the pain or to help them adjust to changes.

- *Risk factors*
  - Low personal expectations and low self-esteem;
  - Personal stress, feelings of hopelessness, distress, depression;
  - Abuse as a child;
  - Expected positive outcomes of substance use.

- *Protective factors*
  - No tolerance for unacceptable behaviour;
  - Positive attitude towards health;
  - Practise a religious belief or have a sense of spirituality;
  - Positive orientation to school by attending school and engaging in community activities;
  - Expected negative outcomes of substance use.

The family

A close relationship with the family is a protective factor for the challenges, including substance use, that confront adolescents. The ability of parents to maintain a mutual close relationship with their children may be compromised by the economic and social problems they face. Parenting skills alone will not be sufficient if there is no available support from child care, health care, social services, adult education, employment opportunities, minimum living conditions, housing facilities, etc.

Young people want to establish their independence from the family, to gain a sense of self-determination, to choose an occupation and to develop their own personal values. In an attempt to achieve these, they may separate from and be rebellious towards their family.

- *Risk factors*
  - Models in the family for risk behaviour;
  - Availability of substances in the home;
  - Tension or violence in the family;
  - Poverty.

- *Protective factors*
  - Parents provide models for conventional and healthy behaviour;
  - Parents provide boundaries, controls and rules for behaviour;
  - Parental expectations for academic achievement;
  - Parental presence and support in the home.

Peer group

Adolescents and young people have a developmental need to strengthen social connections (with friends, peer groups, gangs, etc.), which means that role models can have positive or negative consequences, depending on their behaviour and social connections. Most of the risk-related characteristics of young people have to do with identity-seeking. As young people mature, they enter into new social roles and there is pressure to establish a new social identity, to seek new role models and not miss out on opportunities for new experiences. Young people may identify with certain role models or peer groups in their search for their new social identity, models or groups which may lead them directly or indirectly to substance use.

- *Risk factors*
  - Friends and peers as models for problem behaviour;
  - Influence of friends greater than that of parents.

- *Protective factors*
  - Peer models for conventional and healthy behaviour;
  - Peer disapproval of problem behaviour;
  - Peer controls against risk behaviour.

The school

The school environment and educational social policies are important tools in the prevention of substance use and in the early detection of substance use by young people.

- *Risk factors*
  - School provides models for problem behaviour;
  - Harassment by other students;
  - Stress and poor safety at school.

- *Protective factors*
  - Student-peer disapproval of problem behaviour;
  - School regulatory controls;
  - Perceived teacher expectations for school behaviour;
  - Perceived student norms for school behaviour;
  - Perceived availability of and participation in school activities;
  - Perceived parental involvement in school.

The community

The availability of substances in the community is an important factor related to their use among young people. Ease of access to both legal and illegal substances (e.g. prices, laws and law enforcement, and the community's cultural norms) has a direct relationship with the possibility for young people to experiment with and repeat the use of any substance.

Many young people live in instability and uncertainty (e.g. as migrants, refugees, street children). A disorganized community is likely to be less supportive of young people, offers few alternative activities after school, and may either not care about substance use or be too strict, thus marginalizing substance

users as the source of the community's problems. Selling substances may be an important source of income for young people (and their families) struggling for economic viability.

- Risk factors
  - Advertising and promotion of legal substances;
  - Sponsorship of events by the tobacco and alcohol industry;
  - Availability of illegal substances in the community;
  - Community gang activities that normalize or promote substance use;
  - Poverty and poor safety in the community.

- Protective factors
  - Community's disapproval of problem behaviour;
  - Social controls in the community;
  - Community resources for young people (sports, recreation and creative activities, etc.).

Not all risk and protective factors are equal; some are much more influential than others. For example, having friends who use drugs has been shown to be a very significant factor that influences an adolescent to start using drugs. It is a much stronger risk factor than having substances available in the community. The relative importance of each risk and protective factor must be recognized because it helps in prioritizing action by the health worker. This action aims to support the protective factors, decrease the risk factors for young people, and focus on specific actions for those who are most at risk.

2. Patterns of substance use

The patterns of substance use provide a guide to the different ways that individuals use substances, based on the frequency and amount of the substance used. In this module we discuss three patterns of substance use:

- Hazardous use
- Harmful use
- Dependence.

Understanding an individual's pattern of substance use is a critical part of the assessment. However, individuals and especially young people can move back and forth between patterns in their use of different substances over a period of time. For example, a young person might be dependent on tobacco and simultaneously be experimenting with cannabis.

It is important for health workers to understand the patterns of substance use so that in their approach to assessment and management of a young person they will take into account how that individual is using a substance. Simply asking if a young person ever uses a substance does not give any insight into how much is being used, the frequency of use, and whether there are any problems associated with the use.

Hazardous use

Hazardous use is a pattern of substance use that increases the risk of harmful consequences for the user. Some definitions limit the consequences to physical and mental health (as in harmful use); some would also include social consequences. In contrast to harmful use, hazardous use refers to patters of use that are of public health significance despite the absence of any current disorder in the individual user. The term hazardous use is used currently by WHO but is not a diagnostic term in ICD-10.

Hazardous (or potentially hazardous use) is the most common pattern of substance use by young people. Substance use usually begins with experimental use, which is when a young person tries a substance out of curiosity or the desire for a new experience. However, experimental use can only describe the first one or two occasions of using a substance. After this, the use becomes potentially hazardous.

Most young people who experiment with legal or illegal substances do not become dependent and do not continue to use them when they become adults. However, there is evidence that the younger the age at first experimentation, the more likely that a problem or serious dependence will develop. The majority of adult smokers of tobacco products start in their teens. Also, even short-term experimental substance use can have a negative effect on progress in school. It can impair judgement and increase the likelihood of engaging in other risky behaviour, such as unprotected sex or driving under the influence of substances. Some young people have serious adverse reactions to a substance or a mix of substances the first time they are used. There is no guarantee of "safe use".

Hazardous use can include functional use, which is where the substance has a specific purpose in an individual's life (e.g. the substance enables them to get to work). Functional use is not common among young people. They may use a substance for certain occasions (e.g. for recreation, or to stay awake, or to assist in sleeping) and other aspects of their life are often still intact (e.g. they are still able to attend school, go to work). They may know their substance well and, in the case of illegal substance use, they may have a regular source.

During hazardous use the young person only sees the benefits of their substance use and not the problems. Often there is no motivation to stop because they do not experience or do not perceive any problems with their use.

Harmful use

Harmful use is defined as a pattern of substance use that causes damage to health. The damage may be physical (e.g. hepatitis following injection of drugs) or mental (e.g. depressive episodes secondary to heavy alcohol intake). Harmful substance use often causes adverse social consequences (e.g. loss of job), but the social consequences alone are not sufficient to justify a diagnosis of harmful use. Substance use can have an impact on personal relationships (e.g. fights or arguments with others) and on schooling, work or training (e.g. expulsion from school, periods out of work, or interruptions in training).

Harmful use is prevalent among young people. Brief interventions have proved to work, especially for tobacco and alcohol, and may be effective for other substances. Risky behaviours related to such substance use, including sharing of needles and unprotected sexual activity, may be responsive to brief counselling and outreach programmes.

Harm from substance use can result from:

- Intoxication;
- Mode of administration (e.g. blood-borne infection from sharing of injection equipment, local infection);
- Depleted support from friends and family (e.g. due to alienation);
- Exacerbation of other health issues – physical health (e.g. chronic health problems) or mental health (e.g. depression).

Dependence

Dependence is defined as a cluster of behavioural, cognitive (related to thinking or memory), and physiological experiences that may develop after repeated substance use. This occurs when the individual using the substance has a strong desire to take it and cannot control the desire or the use.

Substance dependence, especially with alcohol and tobacco, is prevalent among young people. If there is indication that dependence already exists, an assessment is needed and referral to specialist services is required (when available).

The following are the criteria for substance use dependence in the International Classification of Diseases (ICD-10).

- A strong desire or sense of compulsion to take the substance;
- Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use;
- A physiological withdrawal state when substance use had ceased or been reduced;
- Evidence of tolerance (a need for more of the substance to achieve the same effect);
- Progressive neglect of other activities or obligations;
- Persisting with substance use despite clear evidence of harmful consequences.

Diagnosis of a dependence syndrome is made if three or more of the above six phenomena occur within a year. The dependence syndrome may relate to a specific substance (e.g. tobacco, alcohol), a class of substances (e.g. opioids), or a wider range of pharmacologically different substances.

Dependent users are the most visible and controversial group of substance users. They require a more precise diagnosis and they experience a greater range of disabilities and a higher mortality rate. However, the largest group of substance users, many of whom are young people, are not yet dependent users.

All people with a history of injecting should be offered counselling and testing for HIV. They should be assessed, supported and counselled on the risks of hepatitis B and C and other health problems, how to reduce their risk, and how to change to non-injecting practices.

"Dependence" as opposed to "Addiction"

The term "dependence" is better than "addiction". Dependence is less emotive than addiction; it also more appropriately conveys the relationship between the young person and the substance. Like any close relationship, the individual experiences an intense desire to be with the "other" and this involves certain benefits as well as certain costs. In this way the young person's substance may be likened to a "best friend".

A best friend is usually there to celebrate with us when things go well, and to commiserate when things go bad. Similarly, there is great sadness and loss felt when our best friend is no longer around even if we were annoyed and angry with our friend sometimes. It is the same for young people who make a decision to change their substance use, and this needs to be acknowledged with them. They are going to lose something they enjoy and which they will miss. Often instead of acknowledging this, we ask young people who have changed their substance use how much "better" they feel for the change.

3. Assessment of young people's substance use and related difficulties

Substance use is common among young people and early recognition and appropriate actions can prevent the development of many problems, including dependence. Assessment is an ongoing process and continues during each contact with the young person.

It is important for health workers to consider – when writing the health records - the possible repercussions that a written record of substance use can have on the future of a young person.

The HEADS approach

The HEADS approach can be used as an aid for eliciting a young person's psychosocial history. The purpose of this is to explore the factors that might be influencing substance use.

The initial letters, HEEADSSS (or HEADS), remind the health worker of the steps to take during the interview. Not all the questions need to be asked at the first visit.

At the initial assessment, it may not be possible or appropriate to discuss sensitive issues in depth. As trust develops between the young person and the health worker it should be possible to deal with issues of concern. This can offer an opportunity to prevent young people who are not using substances from beginning to use them, to advise and assist those who are using substances to stop or reduce their use, and to agree on and arrange ways to reduce the harmful effects for young people who do not stop using substances.

BOX 3

The HEADS approach

H Home
E Education
E Eating
A Activities
D Drugs
S Sexuality
S Suicide and depression
S Safety

H – Home

The home environment is an essential part of the young person's life and is a natural and unthreatening place to begin the interview. This can begin with an open-ended question (e.g. "Who lives with you at home?"). This will help the health worker to understand the family situation or if any family members are missing and whether there is extended family support.

E – Education

The school, college and university environment and peer influences are important factors that influence behaviour. The health worker should ask questions that will help them to understand the young person's school performance, attitude to school, involvement in school activities and relationship with teachers. If the young person is working, the questions can focus on their work. A question to begin the discussion could b, "How is school this year compared to last year?" "What do you do on a typical school/work day?"

E – Eating

The health worker should screen the young person regarding unhealthy eating habits. An open-question could be, "What do you think about your weight?" This opening can then lead to questions on the young person's eating habits.

A – Activities

Asking about what the young person enjoys doing for fun can give a picture of their behaviour. They may respond, "Hanging out with my friends". Asking about the friends and what they do together for fun can lead to further questions regarding risky behaviour.

D – Drugs

The health worker should routinely ask all young people some general questions about substance use. This is an opportunity to begin discussions that can prevent young people from beginning to use substances. A closed question, e.g. "Have you ever smoked cigarettes?", can begin the assessment.

S – Sexuality

This is one of the most intimate parts of the interview. Concerns about sexual development, sexuality and sexual abuse are all sensitive topics and need to be approached in a careful and supportive manner.

The discussion could begin with a statement and a question, e.g. "There are many changes that happen in the bodies and minds of young people of your age. Are there any questions that you would like to ask me, any questions about changes that you may have noticed?"

S – Suicide and depression

Asking the young person about their moods, as well as signs and symptoms of depression is important. Signs of irritability and sleep disturbances may be presenting symptoms of depression in young people. When asking about suicide, the questions should be asked in an accepting manner with no blame on the patient who may have thought about it.

This question could be framed as follows: "Sometimes things get very rough for young people and the pain is so unbearable that they wish they could end it all. Have you ever had such thoughts?"

S – Safety

The health worker should ask about safety issues at home, at work and in school, including questions regarding bullying and violence. Discussion on issues of safety can begin with a question such as "What situations make you feel afraid?" When a person comes to the clinic with an acute substance use problem (e.g. overdose), safety issues are the immediate concern.

Effective listening skills

When the health worker is talking with the young person about their substance use there are three goals in assisting them:

- self-exploration: assist them in examining how they are using substances and how their substance use affects their life.
- self-understanding: assist the young person in understanding how they feel about using substances.
- decision-making with consequent action: assist the young person in coming to a decision on the changes they choose to make and how they can take responsibility and action to make the changes happen.

There are counselling techniques that can help the young person to achieve these goals, by talking and exploring his or her feelings, as well as discovering the facts and circumstances of their situation. These techniques include effective listening skills, such as:

Eye contact and body language

The health worker should maintain appropriate eye contact, so that the young person knows you are paying attention. Eye contact should be natural (not staring) and kept within cultural norms. How we communicate with our body is very significant. Ensure your body language shows you are listening. Communication depends on body language in all cultures.

Remain attentive, show empathy

Remain attentive, do not interrupt, and be genuine. By showing empathy the young person will feel you understand his/her situation. Empathy is when you are able to feel the other person's position and understand their point of view. Young people may not expect empathy from an adult.

In the following examples, consider how the young person may feel about each of the two responses.

Young person:	"My father hit me last night."	
Health worker:	"What did you do to make him angry?"	(no empathy)
	"Did he hurt you?"	(showing empathy)
Young person:	"I don't have any money for cigarettes but I really need a smoke."	
Health worker:	"It's better for your health if you don't smoke."	(no empathy)
	"How does that make you feel?"	(showing empathy)

"Encouragers"

Every culture has "encouragers". These are the small signals (nods of the head), noises (mm hm) and small words ("I see" or "Go on"), which indicate to the young person that you are listening and interested.

Use encouragers that are commonly used in your culture.

Reflecting

Reflecting is repeating what the young person has said using your own words, to confirm that you have understood. Reflecting can be about facts (something that happened) or feelings (how a situation made the young person feel). This can be a useful technique to encourage someone to keep talking. It is important that the health worker is accurate in reflecting what the young person has said. Do not change the meaning. Use simple language.

Affirmations

Affirmations are when the health worker recognizes the effort that the young person has already made. This is particularly important with substance use and with helping a young person reduce or stop his/her substance use.

Examples: "Well done, it must have been hard to walk away from the party without having a drink", "I'm impressed that you were able to refuse to smoke cannabis with your friends". Be sure to be genuine and sincere.

Summarizing

Summarizing is similar to reflecting but can cover more of what the young person has said. It is a useful way to close a topic and change the subject in the least disruptive way. It is shorter than what the young person said, but includes all the important points.

Asking questions

Open-ended questions are ones that cannot be answered with "yes" or "no" or briefly. They are useful to explore the opinions and the feelings of the client. These questions are usually more effective in determining what the client needs. They often start with: What? Could? Would? How?

Closed questions are usually answered by a very short response, often one word. They are useful for determining the client's condition and medical history at the start of the interview.

TABLE 2

Examples of closed questions and open-ended questions

Closed question	Open-ended question
Do you play football?	How do you spend your leisure time?
Do you get on well with your family?	Would you like to tell me about your family?
Have you ever drunk so much that you vomited?	Could you tell me about the worst experience you have had with drinking too much?
Do you use cocaine because your friends do?	What do you like about using cocaine?
Do you know that smoking is bad for your health?	What effects do you think smoking has on your body?

Specific question about substance use

There are some specific questions the health worker can ask when discussing substance use with young people. When the assessment indicates that a young person is using a substance, these questions can help the young person to think about changing their substance use behaviour. Change can happen when the client sees a conflict between their current predicament and the situation that the client wishes in their life.

- **Good things/Perceived benefits of substance use**

  Explore the what the young person sees as the "good things"

  "What are the things you like about smoking cigarettes?

  "What are the things that you get out of smoking cigarettes?

- **Less good/Not so good things about substance use**

  Explore the young person's concerns about the "less good things"

  "What are the 'not so good things' about smoking cigarettes?

  "Can you give me some examples of that?"

  Have the young person argue for change by asking such questions as:

  "But aren't you used to having no money because you spend it on cigarettes?"

- **Cost of change**

  Explore what would be different for them if they gave up or reduced their substance use

  "What would be different in your life if you stopped/cut down on your smoking?"

The GATHER approach

The GATHER approach can be used to interview young people.

BOX 4

The GATHER approach

G Greet
A Assess
T Tell
H Help
E Explain
R Return visit/Refer

G – Greet

- Greet the client and offer a seat
- Introduce yourself
- Ensure confidentiality and privacy.

This step appears simple, but it is crucial because this is the step when the health worker starts to establish a rapport with the young person.

Confidentiality is essential to establish a trusting and professional relationship. The health worker needs to tell the young person that they will not reveal to others what is said in this interview. If possible, have a quiet and private space where you can talk with the young person without being disturbed, as discussed in the *Adolescent Friendly Health Services* module.

A – Assess

- Ask the client what you can do for him/her.
- Obtain personal information.
- Assess whether the young person is using substances.
- Assess the pattern of substance use and the feelings/concerns about use.

During the first visit, use open-ended questions and general enquiries to begin talking about substances. The first question can be, "Have you ever used a substance (e.g. alcohol)?" Other questions can be more specific about the timing and the quantity the substance(s) used. Remember that the health worker should not criticize the young person's use of substances, but can assess his/her feelings, opinions, knowledge, concerns and difficulties associated with substance use.

During a follow-up visit with the young substance user, ask about:

- Any changes in situation.
- Any other concerns/difficulties.

T - Tell

- Ask permission to give information.
- Discuss the dangers and problems with substance use.
- Give information on preventing/reducing/stopping substance use.
- Respond to the concerns and questions.

The health worker, having determined in the assessment whether the young person is or is not using substances, the following actions are valuable for both groups - users and non-users. The specifics of the information provided will be different.

- The health worker asks the young person for permission to give him/her information on substance use.
- It is important to discuss the dangers and problems with substance use in general and with the specific substances and modes of use that the young person is using or may use.
- The health worker gives the young person information on preventing, reducing or stopping substance use and responds to his/her concerns and questions. The information needs to be given in a factual and non-judgemental manner, using plain language.

H – Help

- Help the young person decide what to do about substance use.
- Encourage him/her to identify possible options.
- Discuss the possible outcomes of the options.
- Help the young person to make a decision on action.

The health worker helps the young person to find out what he or she wants to do about their substance use. If they are not substance users, the health worker can reinforce and encourage behaviour that will prevent them from starting.

Encourage the young person to identify the available options to reduce or stop substance use. Discuss the possible positive and negative outcomes of each option. It is for him/her to make a decision on what action to take. Young people need to feel ready for change and be willing to take responsibility to make the change happen. Reinforce the fact that whatever action they decide to take, they will have the health worker's support. Young people will not respond well to being lectured or told what to do.

E - Explain

- Identify other possible options.
- Explain the young person's responsibility to make action happen.
- Identify other sources of support.
- Provide supplies or services.

The health worker can identify other options that have not come up. It is important to explain that it is the young person's responsibility to make the action happen. The health worker can encourage them to feel confident that they are able to make the change happen. They may feel afraid of how their life will change if they stop using substances.

It is possible for the health worker and the young substance user, working together, to identify people who can support the young person to make the action happen. The health worker can provide supplies (e.g. condoms, needles and syringes) and services (e.g. STI management, contraception).

R - Return Visit/Refer

- Schedule a return visit.
- Refer for other services.
- End the session with a positive message.

It is important to schedule a return visit and write it down for the young person. If required, refer him/her for other services (e.g. peer support, STI, community outreach services).

End the session by thanking the young person for coming; acknowledge the progress made during the session and review the plan.

4. Stages of change

BOX 5

The Stages of Change

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse

The Stages of Change model describes the process of change which all people may go through for any behaviour change, not just in giving up substance use.

The idea behind the Stages of Change Model is that behaviour change does not happen in one step. People usually progress, at their own pace, through different stages on their way to successful change. People have to feel ready for change and be willing to take responsibility to make the change happen.

As an example, consider a young man who is overweight and what he may feel or do in the different stages.

- *Pre-contemplation*. He does not yet acknowledge that there is a problem with his weight and he makes excuses.
- *Contemplation*. At this stage he acknowledges that there is a problem with his weight, but he is not yet ready or sure that he wants to make a change.
- *Preparation*. He starts to get ready to change and he may tell some people of his plan.
- *Action*. He begins to carry out his plan: eating less, eating well, exercising.
- *Maintenance*. He stays with his diet for many weeks even though it is sometimes hard.
- *Relapse*. One weekend he attends a family wedding and eats too much rich food. The next morning he feels bad and regrets that he broke his diet. This type of incident can happen at any stage. At this point he may go back to any stage of change; he may be so discouraged that he returns to his former eating habits and abandons his diet (pre-contemplation), or he may spend some days thinking that he really should get back to his diet (contemplation), or he may make plans to return to his diet on Monday (preparation/action), or he may get straight back to his diet (maintenance stage).

The stages of change can be applied to many situations. It is a useful way of determining where an individual is in his/her readiness for change. However, it is only a model and may not always provide an accurate assessment of individuals and their stage of substance use.

The key to understanding the Stages of Change model is that there needs to be a match between the stage of change of the young person and the action proposed by the health worker. For example, if young persons are at the "pre-contemplation" stage, then it may be useless for a health worker to give them a referral to a counselling service, because they do not feel they have a problem or the desire to change their behaviour.

See Annex 3 for an individual exercise on the process of change.

5. ACTION BY HEALTH WORKERS WITH YOUNG SUBSTANCE USERS

Health workers have an important role to play in dealing with the issues of substance use in the communities they serve. However, they cannot work alone and there is a need for the community to help them on substance use by young people. Community action includes:

- Providing information on substance use that specifically targets young people and their families, especially young people most at risk for substance use.
- Strengthening the support given to young people by their families and communities.
- Developing social activities for and with young people to replace their substance use.
- Providing young people with educational opportunities to build intellectual, social and vocational skills which could lead to productive and purposeful activities in society.
- Offering counselling and psychiatric interventions to deal with any psychological problems young people may have.

The aims of health worker action with young substance users are to:

- Prevent young people (who are not substance users) from starting to use them.
- Advise and assist young substance users to stop or reduce their use.
- Arrange ways to reduce the harmful effects for young people who do not stop substance use.

Actions at each stage of change

Health workers are an important source of information and advice about substance use for all people in their community. They should be prepared and willing to discuss substance use with their young clients, parents, families and community members with the aim of motivating them to reduce or help reduce substance use.

The following examples are actions that the health worker can take when assisting young substance users at each of the four stages of change.

Stage 1: Pre-contemplation

Young persons usually feel that what is enjoyed (or "positive") in their substance use far outweighs any perceived costs, so that there is no desire to change their behaviour. A health worker encountering such a person may consider action to:

- Raise his/her awareness of the risks; routine assessment provides an important opportunity to identify substance use in the early stages.
- Provide information (factual, professional and non-judgemental) using plain language.
- Discuss ways of reducing the risks and potential harm of substance use (e.g. by eating something before taking alcohol, or smoking only half a cigarette, and not injecting the drug).

Lectures and sermons do not "raise awareness" and do not assist in the engagement process. If young persons decide to change or to think about changing their substance use behaviour, they are less likely to discuss or act on their decision with someone who lectures to them.

Stage 2: Contemplation

A young person who is starting to think about change is filled with mixed feelings. Contemplation is often induced by someone or something external (parents, school, juvenile justice, etc.). A health worker encountering a young person at this stage may consider the following actions:

- Continue to raise awareness of the risks of substance use.
- Assist the young person in making informed choices.
- Listen to what young persons say about why they like using the substance and what they see as the problem with stopping. This will give important information on how to assist them towards change.
- Avoid too much focus on 'action', e.g. by not telling them too soon what to do. If they make the decision to change by themselves, they will be more likely to succeed.
- Aim to tip the balance in favour of change by recalling the points they made earlier in support of change.

Stage 3: Preparation and action

In this stage, the young person's attitude moves towards change and he/she decides to begin with changing their pattern or level of use. A plan is made and implemented. The health worker may:

- Decide that an assessment is now appropriate, using a national assessment tool for *substance use or the WHO assessment tool (*see *The WHO ASSIST Substance Use Assessment Tool* (www.who.int), even if not yet validated for use with young people***).***
- Advise the young person on the options that have been identified during the GATHER assessment.
- Assist the young person in making a plan and help him/her in developing skills and strategies to support the plan.
- Assist the young person in maintaining motivation.
- Prepare the young person for the possibility of a relapse. If not prepared for this, they may feel very disappointed and discouraged by their return to substance use. The disappointment may cause them to feel all is lost, but if they had been told about a relapse, they can see this as a single lapse and maintain their progress towards behaviour change. It is therefore important for the health worker to prepare young persons for the possibility of a relapse before it occurs.

Stage 4: Maintenance

During this stage the young person maintains his/her changed behaviour and works to avoid a relapse. The health worker's action may be to:

- Provide reinforcement to deal with any difficulties and assist young persons to maintain their new status.
- Teach them to recognize their own strengths and draw on the positive experiences they had in maintaining their behaviour change.
- Monitor relapse prevention by reminding them that a relapse may happen and by not making them feel bad when or if this occurs.
- Teach them self-monitoring skills and help them to take responsibility for their behaviour by raising awareness of early detection of their feelings and of situations which may lead to a relapse. For example, ask them: "What makes you feel you want a drink?" or "How can you plan in advance to avoid such a situation?"

- Link them with other community resources. Self-help groups and peer support may be useful because the experience of peers may reflect their own situation.

Stage 5: Relapse

In this stage, the individual may relapse just once or return to continued substance use. Owing to the tendency for relapses with substance use this is the most likely initial outcome. As it is important for young persons to know about relapses in advance, explain that while this may occur, it does not mean that all they have gained in behaviour change is lost. The health worker can help them to learn from this experience and to overcome any harm from a relapse.

The health worker's actions may include:

- Support for young persons to renew their decision to change.
- Support for them to identify and try different strategies (e.g. strategies to reduce the risk of getting into situations where substances are commonly used, or to help them deal with peer pressure to use substances, or to find peer support for their changed behaviour).

Important issues when working with young substance users

The attitudes and values of the health worker on substance use

It is important for health workers to examine and understand their own values and attitudes to substances so that they could work effectively with the people who come to their clinics with substance-related problems. It is also important for them to examine their personal substance-use behaviour.

Our attitudes and values are formed over a period of time by the circumstances in which we are born and live, by the situations and people we encounter, and by the experiences from which we learn. The attitudes and values that we hold influence our view of other people's behaviour and our ability to provide professional and nonjudgemental care and support. In previous modules, this has been discussed in relation to many important and sensitive issues (adolescence, sexuality, adolescent-friendly health services). Substance use and substance users are another important area where health workers need to assess their own attitudes and values. This will enable them to provide the best possible care and to challenge the stigma and discrimination which substance users frequently have to deal with in society and in healthcare settings. The exercise in Annex 7 can assist the health worker in exploring their attitudes and values.

The health workers own substance use is important both as a basis for their attitude and as a role model in the community. Young people will be aware of the hypocrisy of health workers who give a client information and advice which they do not practise themselves.

Establishing a trusting relationship is important for the effective assessment and treatment of problems with young substance users. Young people are usually honest with their health worker once trust is established. It is very important that the health worker is also honest and respectful of the young person, since young people will sense if the health worker is insincere, disrespectful or judgemental. Most young people do not like to be told what they should do and not do. It is important to give factual information, to be supportive, friendly and non-judgemental, and to act in a professional manner. Health workers need to be themselves and not try to talk or behave like the young people to whom they are providing a professional service. Using street names for drugs or activities may be important to ensure understanding; however, health workers should avoid exaggerating this and

trying to speak and act like a young person. Maintaining a professional, respectful and understanding attitude will help build a relationship of trust.

One way to establish trust is to listen to young people with genuine respect, and to be attentive to their emotional needs. Young substance users may be guarded and suspicious at first – they may have had past experiences with professionals who "preached" to them about their substance use, or who stigmatized them as "addicts" or "delinquents". In order to be effective, the health worker must approach the young person in a frank, open, non-threatening manner. Expressions of shock or disapproval are not helpful. Trust is increased when health workers express sympathy and understanding for the young person's situation and when he/she is allowed to express him or herself openly.

When speaking to young people, health workers should use simple words and plain concepts. Personal responsibility should be encouraged and it should be emphasized that all final decisions are in the young person's hands.

Helping young people to express their feelings

Young people may have a limited vocabulary for identifying and expressing their feelings. For example, they may not be able to distinguish differences between anger, jealousy, or annoyance. For this reason, it can be difficult for them to express their feelings to a health worker during clinical interviews. Frustration can result for both the young person and the health worker.

When working with young people, health workers can help them to label their feelings. For example, if a young person starts crying, the health worker can say, "You look sad." This helps the young person to learn to give words to their feelings, and also to feel understood. Through listening skills and open questions, the health worker can assist young people to explore their feelings about their substance use and their readiness for change.

Health workers can also encourage young people to use other media to express their feelings, such as making drawings of situations related to substance use. These drawings can be reviewed together and the health worker can help the young person to identify the feelings they had when making the drawing.

Coping strategies for young people

Young people can be encouraged to use strategies that can reduce or stop their use of substances, and reduce the negative consequences of substance use. For example:

- plan ahead if they are going to use a substance and decide how much they will use;
- plan how they will negotiate not using or reducing their use of a substance;
- practise what to say if they are pressured by others to use more than they planned;
- eat some food before they use the substance;
- slow down their rate of consumption;
- avoid combining two or more substances.

They can also take precautions against secondary consequences of substance use by, for example, not driving a car while intoxicated and not accepting a ride from someone who is intoxicated. To help avoid substances altogether, young people can get involved with non-substance-related activities, especially activities that may be incompatible with substance use (e.g. smoking and exercise). They

can prepare and practise how to resist social or peer pressures to use substances. Role playing is a useful method for developing confidence to face these encounters: it helps young people to find the right words to say, and increases their ability to challenge the social norm.

Relapse prevention

When reducing substance use, a backward 'slip' into earlier behaviour is common (e.g. a young person who has stopped smoking takes one cigarette at a party). When slips occur, it is important for the substance user to view them as temporary and surmountable, and not to view them as evidence that he or she will never be able to overcome their substance use.

Relapse prevention is a set of skills that the health workers have to counsel young people in advance, so that they will be less likely to 'relapse' into former substance use patterns once a slip occurs. Young people are taught to view slips as temporary and surmountable experiences, and to determine what went wrong and make changes accordingly for the future. Young people are also taught how to avoid situations that could lead them towards relapse (e.g. social events where the consumption of substances is likely), and how to manage their urges and pressures from others to use substances.

This approach focuses on three main areas for relapse:

- *Intra-personal* (e.g. feelings and moods that are likely to lead to relapse);
- *Inter-personal* (e.g. relationships that are likely to lead to relapse);
- *Situations/cues* (e.g. places and times that are likely to lead to relapse).

Some approaches that attempt to address these different areas can include:

- Individual or group work focused on the identification and management of negative or positive affect (emotions) associated with the use of particular substances.
- Individual, group or family interventions focused on inter-personal issues (e.g. family conflict, relationship difficulties).
- Individual and possibly group interventions which target cues and situations (e.g. cue exposure, developing social networks and alternative leisure pursuits).

Developing these approaches assists young people to consider the following statement: I am more likely to use X, when I feel Y*, and/or* when I am with Z*, and/or* when I am at W.

When health workers recognize these triggers, they will be able to look for alternative actions. To develop statements like these and then to effectively address some of the triggers, the following must be offered to the young person:

- accurate and unbiased information;
- attention to personal variables that may be associated with increased vulnerability to negative peer influence for some individuals or groups;
- decision-making skills and skills associated with resistance to negative influences;
- assistance in improving communication between young persons and their parents, teachers, adults and peers;
- harm reduction strategies (e.g. techniques of safer use) when appropriate, and exposure of users to satisfying and acceptable alternatives to substance use;
- long-term support.

Parents and young people: towards a better relationship

National laws govern issues of consent and confidentiality about young people and their parents' rights to give consent and to know about their treatment. It is important for health workers to understand the laws of the community in which they work. In some areas, professionals are required to tell parents if minors are using substances, while in other areas this information can remain confidential. Health workers should take into account the best interests of the young person and their evolving capacities. All health discussions with minors should be kept confidential – unless unlawful.

Regardless of the law, involving the family is usually important, because parents and other family members may be part of the problem and may be able to help the young person to reduce his or her substance use. However, involving the family must be dealt with sensitively, because the young person may not want to involve them at all. Similarly, parents may feel blamed or defensive about substance use and about their family and may not want to participate in treatment with the young person. The health worker should recognize these potential problems, assist everyone to feel less defensive, and encourage the family to work together to solve its problems.

Community action for young substance users

Raise family and community awareness of a young person's substance use by talking with the parents, community members and young people about the situation locally.

Raising awareness of substance use in the community can enhance the protective factors and minimize the risk factors for young people.

In the enhancement of protective factors the involvement of parents is vital. Parents typically have concerns about their children's substance use. It is important to provide them with accurate information about the substances and their effects, as well as additional sources of information on treatment in the community. Parents, teachers, community leaders and peer counsellors can be educated about:

- prevalence of substance use among young people;
- typical reasons why young people use substances;
- effective strategies that can be used to discourage young people from substance use;
- effective strategies that can be used to encourage young people to reduce harmful use.

They also need to be aware of the problems related to more commonly used and legal substances (such as alcohol and tobacco), which often cause more health problems than the illicit ones but are overlooked by parents and the community.

Involve the community in planning and implementing community prevention programmes. This will mean that the target community will have ownership of the programme, which is a key ingredient to the success of any initiative. Programmes should make use of existing links and networks between community organizations, both governmental and nongovernmental.

Contribute to prevention programmes that aim to reduce supply and demand. Health workers can work with the community to examine and promote change in the supply and availability of illegal and legal drugs in the community. Also, contribute to school education campaigns and community action (e.g. no-smoking areas and venues, regulation of availability).

Media promotion of substance use, especially tobacco and alcohol advertising, is often aimed at young people. Health workers can encourage young people to look at how, in such advertising, they are being manipulated by companies that aim to promote their products.

Provide community links which can provide young people with support services within the community. Provide young persons with connections and encourage them to seek support, especially from peer counsellors and peer support groups. If appropriate, encourage them to ask their family, relations and friends for help. Give them information about community resources, peer support groups, referral services, etc.

Encourage community recreational activities as well as vocational and educational pursuits.

Support harm reduction strategies which aim to reduce the negative consequences of drug use rather than to stop or reduce drug use. These strategies focus on the most immediate and achievable changes that can reduce the threat to the health and wellbeing of the user and of society (e.g. a needle-syringe programme for injectors who do not stop injecting can prevent the transmission of HIV and hepatitis C, and providing safe injecting rooms and sterile equipment can prevent abscesses).

There is evidence to prove that harm reduction is a sound public health strategy. Health workers have a role in raising public awareness of the importance and benefits of harm reduction for individuals and communities. Harm reduction strategies are often opposed by community members who think this will encourage substance use.

6. Approaches to acute problems with young substance users

The signs and symptoms of intoxication and withdrawal from various substances often overlap. So when faced with an acute problem from substance use, it is appropriate for the health worker to focus on the individual's presenting symptoms in order to take immediate action. After dealing with any life-threatening situation, the health worker must assess the substance use patterns and problems and identify (if not already known) the main substance which caused the acute problem before proceeding to establish a long-term plan for the patient.

TABLE 3

Immediate cction in ccute substance use problems

Presenting symptom	Immediate action
Anxiety, agitation and/or panic	Approach the patient calmly and confidently, move and speak without hurrying, and keep to a minimum the number of staff attending him/her. Reduce stimulation by keeping the environment quiet, and frequently reassure and calm the patient. Explain the interventions and protect him/her from accidental harm.
Confusion, disorientation	Provide frequent orientation by reminding them where they are and what is happening, remove unnecessary equipment, and use or display object(s) familiar to the patient (e.g. own clothing, personal objects, etc.). Ensure frequent supervision and accompany the patient to/from locations.
Altered perception, hallucinations	Explain errors or misunderstandings they may have, create a simple and uncluttered environment, and provide care in well lit surroundings to avoid perceptual ambiguities and uncertainties about what they think is happening. Protect the patient from harm, use antipsychotic medication if necessary.
Anger, aggression	Keep space to protect yourself and touch the patient with care, keep your own emotions in check, speak calmly and reassuringly, and use his/her name when speaking to them. Let the patient talk about his/her feelings, listen attentively, determine the source of the patient's anger and be reasonably flexible.

Substances affect cognition, emotions and behaviour. Some substance can cause sudden confusion, disorientation, perceptual disturbance, euphoria, agitation, panic, emotional liability, repetitious behaviour and aggression. Withdrawal from these substances also can affect mental functioning, causing hallucinations, paranoia, agitation, or depression. Information on the time of the last dose, as well as the quantity and frequency of regular use, can help in the assessment process.

During an examination of their mental state, it is important to assess the following areas:

- levels of consciousness;
- orientation (to person, time and place);
- memory (recent and remote);
- judgement (e.g. are the patient's responses rational, do his/her ideas make sense?);

- affect (e.g. are the young person's emotion, grooming, posture, and facial expression appropriate?);
- speech (manner of speech, speech pattern, possible disorders, e.g. aphasia, dysphasia);
- language comprehension (understanding verbal instructions), particularly during emergency treatment.

Care must be taken not to overlook conditions that mimic some of the features of intoxication or withdrawal (e.g. metabolic disorders, cerebral disease and endocrine disorders).

Intoxication with depressants

Alcohol

Drinking alcohol is common among young people, but intake to the point of intoxication can lead to death (due to overdose). Alcohol is a central nervous system depressant. In sufficient doses, it can suppress respiration, gag reflex, and cough reflex. It also affects heart function, leading to irregular cardiac rhythms. Young people often 'binge' drink (defined as having 5 or more drinks in a row in males and 3 or more in females), which may result in blacking out.

In gross intoxication, respiration can be depressed and the person may choke on food, fluid or vomit. This can present a major problem in semiconscious or unconscious patients. Care should be taken to maintain a clear airway and prevent aspiration. Although rare, hypoglycaemia can occur and in these cases the administration of glucose is necessary.

Conditions other than alcohol intoxication should be ruled out (e.g. head injury, other drug overdose, psychosis, hypoglycaemia, severe liver disease). The patient should be kept for observation and vital signs should be monitored if the level of intoxication poses a threat to life, health or safety. In addition, you should follow these guidelines:

- orientate the patient;
- introduce yourself;
- provide a quiet place or room for the patient;
- speak slowly, using short sentences and repeating information if necessary;
- avoid emotional topics or discussions;
- maintain eye contact and use the patient's name.

Alcohol dependence takes some years to develop. It can occur with young people who have a history of long and heavy alcohol intake. Several psychological problems, adjustment problems and heavy alcohol use are conditions often found in young people.

Volatile solvents

Although the effects of individual components of compounds can be different, the overall action of most solvents is depression of the central nervous system. If high doses are inhaled, they can cause coma and death. Onset of solvent action is very quick; central nervous system impairment generally clears within a few hours after inhalation. The effects include initial exhilaration and euphoria followed by:

- slurred speech;
- ataxia (involuntary movements);

- drowsiness, dizziness;
- increased salivation, nausea, vomiting;
- confusion, disorientation, perceptual distortions.

In some cases, these symptoms are accompanied by hallucinations and delusions. Very high doses can result in convulsions, solvent-induced respiratory depression and cardiac arrhythmias, which can be fatal. Patients who sniff petrol may also present with lead poisoning.

If the solvent user presents with chest pain, difficulty in breathing or strange behaviour (including violent and aggressive behaviour), stay calm and keep him/her calm. If the user is unconscious, make sure that the airways are free. Lay him/her on the side (not flat on the back or front) so that if vomiting occurs, there is no aspiration of vomit, and observe the vital signs. Solvent intoxication may be suspected from the patient's history or from the odour on the clothing or breath.

Barbiturates

Barbiturates are central nervous system depressants which can be taken in a suicide attempt or in combination with alcohol. They produce cardiopulmonary depression, which can be life-threatening. They are more dangerous in overdose than benzodiazepines. Effects in some individuals may be atypical, with excitement instead of sedation in smaller doses. Intoxication symptoms and signs vary according to dose, ranging from euphoria in small doses to:

- impaired memory and attention;
- inability to walk;
- slurred speech, rapid eye movements;
- drowsiness;
- slow heart beat, hypotension;
- depression of respiratory drive and rhythm;
- coma.

Intoxication with stimulants

The stimulants considered here include amphetamine, dexamphetamine, methylphenidate, cocaine, crack and ecstasy (MDMA). High doses of stimulants can induce chest pain, hypertension and cardiac arrhythmias. Hyperthermia and convulsions also may be present. Following stimulation of the central nervous system, depression of higher nervous centres may occur, which may lead to death due to overdose. Panic can cause irrational behaviour causing harm to themselves and others. People suffering delusions that they are being persecuted may react with hostility and violent behaviour.

It is therefore important to observe the vital signs and to approach the patient calmly and confidently. Move and speak without hurrying, and keep to a minimum the number of staff attending him/her. Reduce stimulation by providing a quiet environment and frequently reassure and calm the patient. Explain the interventions and protect him/her from accidental harm.

Intoxication with opioids

Opiates have a depressant effect on the central nervous system. They are powerful analgesics and suppress cough and diarrhoea. Acute effects include analgesia, euphoria, tranquillity, constipation,

orthostatic hypotension, respiratory depression and decreased level of consciousness. An overdose may lead to respiratory depression without major effects on the cardiovascular system.

Withdrawal

This term is used to describe the physical and psychological symptoms associated with cessation or reduction of a substance.

The severity of the withdrawal depends on a number of factors:

- Type of substance(s) being used;
- Method and levels of use;
- Length of time used;
- Young person's experience of previous withdrawal(s);
- Use of other substances;
- Physical health of the young person;
- Environment of the young person (supportive versus unsupportive).

Most young people, because of their age and limited access to substances, generally do not develop a severe dependency as found in older individuals. Consequently, they may not experience a serious or difficult withdrawal; most will need safety, calm, rest, sleep, good food and to be off the streets or away from substance-using peers. There are few conditions where the use of medication is warranted to assist with withdrawal, but it is important to avoid over-medication.

Acute situations of substance use by a young person, which require medication, include the use of naloxone or naltrexone for opioid overdose and flumazenil for benzodiazepine overdose. In cases where there are hallucinations, care should be taken when administering antipsychotics because they lower the seizure threshold and may increase the risk of a convulsion.

The signs of withdrawal are different for the various categories of substances used. Often withdrawal is the opposite of the effect of intoxication. So, after heroin use, where one generally becomes relaxed, content, quiet, constipated, and pain-free, withdrawal usually results in restlessness, inability to sleep, diarrhoea, and feelings of pain (especially in the back and legs). Use of amphetamines makes one alert and energetic, and withdrawal can result in depression, lethargy and tiredness (often associated with a "crash", a long unsettled sleep).

Withdrawal is not a pleasant experience, no matter what the substance. Ensuring the young person is in a safe, supportive environment can assist them during this difficult time. In the knowledge that this may not be their last withdrawal, it is important to ensure that it is as painless as possible for the young person.

The most severe withdrawal occurs in those dependent on hypno-sedatives and alcohol. Withdrawal from either of these can be serious and, in some cases, life-threatening. For this reason it is important that withdrawal from these substances should be handled under medical supervision. For other substances withdrawal is less hazardous, but it is still good practice to encourage and assist the young person in accessing appropriate medical support as necessary.

Overdose

In dealing with young people who use different substances there is always the chance that they could "overdose". Overdose is the general term applied when a person has taken a substantial amount of a substance and poisoning has occurred. Overdose can occur accidentally or intentionally. Signs to look for with overdose are specific to each substance taken, but generally can include:

- decreased level of consciousness;
- difficulty in breathing;
- abnormal pulse (fast/slow/irregular);
- seizures, fits, convulsions;
- hallucinations, anxiety, depression;
- nausea, vomiting;
- slurred speech, drowsiness.

Some guidelines in managing a young person with an overdose are:

- If you suspect that an overdose has occurred, act immediately.
- If the young person is conscious, ask about the substance (how many, when and how it was taken), and look for signs of use.
- If unconscious, place him/her in the recovery position (side position, with the head on one side), and call for emergency medical assistance.
- If the young person begins to have a fit, do NOT restrain but move the furniture etc. to prevent injury.
- **Never leave the young person alone**.

7. Key messages

- Most substance use begins during adolescence.
- Substance use by young people is common.
- Family relationships and peer associations are important determining factors which can promote or protect young people from substance use.
- Early detection and intervention can prevent harmful use and dependence.
- The three patterns of substance use among young people (hazardous, harmful and dependent) indicate how the young person uses a substance. Understanding an individual's pattern of use is a critical part of the initial assessment for appropriate action.
- Understanding the stages of change can assist the health worker to assess a young person's readiness for change.
- Actions by the health worker aim to prevent young people from starting to use substances, to stop (or reduce) the use of substances by young people, and to reduce the harmful effects of substance use for young people who do not stop.
- Health workers have an important role with young people and substance use, both in the clinic and in the community.

8. Glossary

Abstinence. This refers to refraining from substance use, usually alcoholic beverages or illicit drugs, as a matter of principle or for other reasons.

Alcohol. Refers to a large group of organic compounds derived from hydrocarbons. Ethanol or ethyl alcohol, the main psychoactive ingredient in alcoholic beverages, results from the fermentation of sugar by yeast. The term "alcohol" is used, by extension, for alcoholic beverages. Alcohol is a sedative/ hypnotic (a substance that reduces the functioning of the central nervous system with the capacity of relieving anxiety and inducing calmness and sleep).

Amphetamines. A class of synthetic substances which have a powerful stimulant effect on the central nervous system. Commonly used amphetamines include amphetamine, dextroamphetamine (or dexedrine), and methamphetamine (or methedrine). On the street, these substances are all often referred to as "speed". A more potent chemical form of methamphetamine, commonly known as "crystal" methamphetamine (also known as jib, ice, crystal, crank), has become more commonly available on the street in the last ten years.

Antidepressants. These are psychoactive agents which are prescribed for the treatment of depressive disorders. Three common types of antidepressants are 1) monoamine-oxidase inhibitors (MAO-inhibitors), 2) tricyclics, and 3) selective serotonin reuptake inhibitors (SSRIs) such as Prozac, Paxil and Zoloft. These are also used for certain other conditions such as panic disorder.

Barbiturates. A group of central nervous system depressants, they are used to treat epilepsy and as anaesthetics, sedatives, hypnotics, and (less commonly) anti-anxiety medication.

Binge drinking. A pattern of heavy alcohol drinking that occurs in a limited period of time (usually defined as 5 or more standard drinks in a single session for men, 3 or more standard drinks in a single session for women). One standard drink is a can (350 ml) of beer, a glass (150 ml) of wine, or a shot (40 ml) of spirits.

Brief intervention. A treatment strategy in which structured therapy of short duration (typically 5-30 minutes) is offered with the aim of assisting an individual to stop or reduce the use of a psychoactive substance. It is designed for primary healthcare workers and is used mainly to assist in cessation of smoking and harmful use of alcohol.

Cannabis. Refers to all psychoactive substances derived from plants of the cannabis genus, which include marijuana leaf, hashish (dried sticky resin), and hashish oil (made by purifying hashish with a solvent). Cannabis products contain a number of psychoactive compounds known as cannabinoids, the best known of which is THC (delta-9-tetrahydrocannabinol).

Club drugs. Refers to substances associated with use by young people at dance clubs and parties. Although alcohol, tobacco, and cannabis are the most commonly used drugs in these settings, "club drugs" usually mean substances such as ecstasy, amphetamines, GHB, and ketamine.

Cocaine. This is a powerful central nervous system stimulant which is used non-medically to produce euphoria and wakefulness. Cocaine hydrochloride is a white powder which can be sniffed or dissolved in liquid and ingested orally or injected. Cocaine has a long history of use by many indigenous peoples of South America and is produced by processing the leaves of the coca plant (*Erythroxylum coca*). See also "crack".

Crack. This is a form of cocaine, produced by heating cocaine powder with baking soda. "Crack" refers to the crackling sound made when it is heated and smoked. It may also be injected. This form of cocaine produces a quicker and more intense "high", but the effects last only a short time (5-7 minutes).

Date-rape drug. See Rohypnol

Demand reduction. A general term to describe policies or programmes directed at reducing consumer demand for substances. It is applied primarily to illicit drugs, particularly with reference to educational, treatment, and rehabilitation strategies.

Dependence. Defined as a cluster of behavioural, cognitive (i.e. related to thinking or memory) and physiological experiences that may develop after repeated substance use. Dependence occurs when the individual taking the substance has a strong desire to take the substance and cannot control the desire or the use.

Early intervention. A strategy that combines early detection of problematic substance use and (if necessary) treatment of the individual. This pro-active approach is initiated by the health worker rather than the patient. As it aims to engage individuals before they develop physical dependence or major psychosocial problems, the treatment is often offered or provided before they are aware that their substance use may cause a problem. There is evidence that early and brief interventions, especially in primary healthcare settings, are effective in changing harmful alcohol use.

Ecstasy. This is the common street name for methylenedioxymethamphetamine (MDMA). It is a synthetic, psychoactive drug that is popular at raves and all-night dance parties for its mood-boosting and stimulating effect. It can cause feelings of empathy, wellbeing and euphoria along with some stimulatory effects and side-effects similar to amphetamines.

Harm reduction. A public health strategy that makes the reduction of potential harm the highest priority. It supports policies and practices aimed at addressing risky substance use behaviours without requiring abstinence. As it is impossible to keep people from engaging in certain risky behaviours, harm reduction seeks to ensure that individuals are fully informed and provided with the means to make safer choices. Policies and practices are measured according to their actual impact in preventing and reducing harm. Success is not reflected primarily through a change in use rates but rather by a change in the rates of death, disease, crime, and suffering.

Harmful use. This refers to a pattern of substance use that causes damage to health, even with no dependence. The damage may be physical or mental. Social consequences alone are not sufficient to justify a diagnosis of harmful use.

Hazardous use. This refers to a pattern of substance use that increases the risk of harmful consequences for the user. The harm may be to physical and/or mental health. In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user. The term is used currently by WHO but is not a diagnostic term in ICD-10. This is the most common pattern of substance use by young people.

Heroin. This was a brand name given to diacetylmorphine, a semi-synthetic opiate derived from morphine which is a constituent of the dried milk of the opium poppy plant. Heroin depresses the central nervous system, including reflex functions such as coughing, respiration, and heart rate. It also dilates the blood vessels (giving a feeling of warmth) and depresses bowel activity (resulting in constipation). Overdose can lead to coma and possible respiratory failure and is more likely if other depressant drugs, like alcohol, are used at the same time. There is an increased risk of hepatitis and HIV infection when heroin is used with unsterilized needles.

HIV (human immunodeficiency virus). The virus that causes AIDS (acquired immune deficiency syndrome). HIV is a lifelong infection. A positive HIV test does not mean a person has AIDS, but that HIV antibodies have been detected in their blood.

Inhalants. Volatile substances (i.e. they vaporize at room temperatures) which are inhaled for psychoactive effects.

LSD (lysergic acid diethylamide). This is a powerful hallucinogen. Although some psychologists and psychiatrists believe it may have therapeutic value, scientific research has been discontinued.

Methadone. This is a long-acting, synthetic (man-made) opiate which is used in the treatment of dependence on opioids.

Opiates. The group of substances derived from the opium poppy. The term opiate excludes synthetic opioids.

Opioids. A general term that includes all the substances derived from the opium poppy and all synthetically prepared opioid substances. Opiates and opioids are all central nervous system depressants and have the capacity to relieve pain, produce a sense of wellbeing, and (at higher doses) cause stupor, coma, and respiratory depression.

Overdose. The use of any drug in an amount that precipitates a crisis with adverse physical or mental effects. Deliberate overdose is a common means of suicide or attempted suicide, especially among young people. Accidental overdose occurs with injecting drug use, especially with young inexperienced injectors.

Polydrug use. This refers to the use of more than one psychoactive substance by an individual, all at the same time or sequentially, usually with the intention of enhancing the effect or counteracting the undesired effects of another substance.

Prevention. Action aimed at eradicating, eliminating, or minimizing the impact of disease and disability, or if these are not feasible, slowing the progress of disease and disability. There are four levels: 1) Primordial prevention - inhibiting the situations that increase the risk of substance use (e.g. by improving housing conditions, reducing child poverty); 2) Primary prevention - helping individuals and communities to take health-promoting actions and deal with the risks (e.g. training in effective socialization and decision-making skills, programmes to strengthen links to family, school and community); 3) Secondary prevention, which involves early detection and prompt intervention to prevent or minimize the impact of substance use (including early detection by school counsellors or home care workers); and 4) Tertiary prevention, which seeks to eliminate or reduce impairment, disability and harm (e.g. methadone replacement therapy).

Psychoactive substance use. The use of any substance that affects the way people see, hear, taste, smell, think, feel and behave. The use of psychoactive substances is an almost universal human cultural behaviour, and has been practised since the beginning of human history.

Rohypnol. The trade name for flunitrazepam, a benzodiazepine like valium (a central nervous system depressant with sedative-hypnotic effects that can be lethal when mixed with other depressants like alcohol). Much of the concern surrounding this drug is its use in drug-facilitated sexual assault, or “date-rape”. Rohypnol is a tasteless and odourless drug, and can be dissolved in drinks which mask its presence.

Second-hand smoke. This refers to a combination of two types of smoke: "mainstream" smoke which is exhaled by the person who smokes, and "sidestream" smoke which is released from the burning tobacco. Mainstream cigarette smoke is a mixture of over 4000 substances, 40 of which are known or suspected to be cancer-causing agents (carcinogens) in humans. Sidestream smoke contains all these same carcinogens, many of which are more concentrated because the lower temperature of a smouldering cigarette burns up fewer carcinogens. Cannabis, consumed in smoke form, also produces second-hand smoke, although it has not been studied as well.

Stimulants. A class of psychoactive substances that activates, enhances, or increases the activity of the central nervous system. Common stimulants include caffeine, nicotine, cocaine, amphetamines, and synthetic appetite suppressants.

Substitution programmes, replacement or maintenance therapy. The treatment of drug dependence by prescribing a dose of the drug or a substitute drug that suppresses withdrawal symptoms. The goals are to eliminate or reduce the use of a particular substance (especially if it is illegal), to reduce harm from a particular method of administration (such as injecting), or to reduce the health dangers and social consequences of drug use. Substitution programmes often offer other services, such as counselling and long-term follow-up.

Supply reduction. This is a general term to describe policies or programmes that aim to prevent production and intercept distribution of drugs, particularly by law enforcement strategies for reducing the supply of controlled substances.

Tolerance. Refers to a situation where a person requires a higher dose of a substance to get the same effect originally produced by a smaller dose. Different substances have different levels of tolerance attached to them. Tolerance develops for most substances - rapidly for some substances (e.g. heroin and associated substances) and less quickly for others (e.g. alcohol and benzodiazepines).

A complete list of alcohol and drug terms can be found at:
http://www.who.int/substance_abuse/terminology/who_lexicon/en/index.html

9. References

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Annex 1

Module schedule

Activities that are marked with * are optional activities which are not included in the 180 minutes planned for this module. The facilitators' decision to include the optional activities depends on the available time and whether these activities are covered in other modules in this workshop.

Sessions and activities	Time
Session 1 **Module introduction**	10 min
ACTIVITY 1-1 Module objectives ACTIVITY 1-2 Spot checks	
Session 2 **Young people and substance use**	50 min
ACTIVITY 2-1 Mini lecture: Meaning of "substance" ACTIVITY 2-2 Brainstorming: Locally used substances ACTIVITY 2-3	
Mini lecture by guest presenter: Local situation with young people and substance use *	10 min *
ACTIVITY 2-4 Mini lecture and brainstorming: Negative consequences of substance use for young people ACTIVITY 2-5 Group work: Reasons why young people use substances ACTIVITY 2-6 Mini lecture: Risk and protective factors ACTIVITY 2-7	
Group work: Risk and protective factors *	20 min *
ACTIVITY 2-8 Mini lecture: Patterns of substance use	
Session 3 **Assessment of young people for substance use and related difficulties**	30 min
ACTIVITY 3-1 Mini lecture: Assessment of young people for substance use ACTIVITY 3-2	
Group work: Listening skills and the health worker *	10 min *
ACTIVITY 3-3 Mini lecture: Listening skills and asking questions ACTIVITY 3-4 Mini lecture: The GATHER approach ACTIVITY 3-5 Role play: Using effective listening skills and GA(THER)	
Role play demonstration *	10 min *
ACTIVITY 3-6	
Individual exercise: Explore health worker attitudes and values on substance use *	20 min *

Sessions and activities	Time
Session 4 **The Stages of Change model**	30 min
ACTIVITY 4-1 Mini lecture: Stages of change	
ACTIVITY 4-2 Individual exercise: Understanding the process of change *	15 min *
ACTIVITY 4-3 Group work: Stages of change	
Session 5 **Health worker action with young substance users**	50 min
ACTIVITY 5-1 Mini lecture: The aims of health worker action	
ACTIVITY 5-2 Mini lecture: The (GA)THER approach	
ACTIVITY 5-3 Mini lecture: Action matched to each stage of change	
ACTIVITY 5-4 Role play: Action in the clinic using GATHER	
ACTIVITY 5-5 Mini lecture: Action in the community	
ACTIVITY 5-6 Mini lecture by guest presenter: Local substance use programmes for young people *	10 min *
Session 6 **Approaches to acute problems for young substance users ***	25 min *
ACTIVITY 6-1 Brainstorming: Acute problems *	
ACTIVITY 6-2 Individual and group work: Addressing the immediate needs of young people with acute problems *	10 min
Session 7 **Module review**	
ACTIVITY 7-1 Review of objectives	
ACTIVITY 7-2 Review of spot checks and Matters Arising Board	
ACTIVITY 7-3 OPPD	
ACTIVITY 7-4 Key messages from Module and closure	
180 min	**optional 120 min**

Annex 2

Spot checks

Sessions 1 and 7

SPOT CHECK 1

Name three protective and three risk factors for young people and substance use

Protective factors

Risk factors

SPOT CHECK 2

What are the three patterns of substance use for young people?

SPOT CHECK 3

What are the stages of change?

SPOT CHECK 4

What are the aims of health workers' actions with young substance users?

SPOT CHECK 5

Read each statement and tick the box that reflects your point of view

Statement	I agree	I disagree
There is no way of stopping young people from getting drunk - it is part of their growing up	○	○
As a health worker, I should ask all young people about the substances they use	○	○
Scaring young people is a good way to stop them from using substances	○	○
It is acceptable for boys to smoke cigarettes	○	○
It is acceptable for girls to smoke cigarettes	○	○
A drug addict is anyone who has ever injected drugs	○	○
Our health services should not waste money on treating young people who inject drugs	○	○
Girls and boys need to have information on substances so that they can make sensible choices	○	○
If I spend 5 minutes talking with a young person about substance use, I may make a difference	○	○
If a boy of 15 years came to me with an alcohol problem, I would need to tell his parents	○	○
Talking about substance use makes me uncomfortable	○	○
If I thought I had a problem with substance use, I would never discuss this with anyone	○	○

Annex 3

Understanding the process of change

Individual exercise

Session 4: ACTIVITY 4-2

The following exercise is to help you understand the process of change.

Through thinking of personal experiences, you will individually look at the phases of behaviour change and your needs at each stage.

The sequence of the questions can help you to understand the difficulty in changing and maintaining the outcome, and the reasons behind our refusing help at certain stages.

Questions 1 to 5 are about the stages of change and question 6 is about relapse.

Read through the questions individually, consider your feelings about the behaviour and briefly write down your responses. You will have 5 minutes to do this. Then there will be a short plenary discussion. Participants will not be asked to reveal the personal behaviour that they have considered (unless they wish to tell), but only their thoughts, reactions and feelings to the questions.

1) Think of something in your behaviour (e.g. eating, smoking, exercising, etc.) which people around you have asked you to change, but you don't think is important to change.
   a) What do you think of those who asked you to change?
   b) How do you react to them?

2) Think of something in your behaviour that you know you should change or that people are asking you to change, but you have not yet taken any steps towards change.
   a) Have you told anyone that you intend to change? Who?
   b) What do you think of those who ask you to change?
   c) How do you react to them?
   d) Why haven't you changed?

3) Think of something in your behaviour that you have decided to change but have not yet done so, or have not decided when you will do it.
   a) Have you told anyone that you intend to change? Who?
   b) What do you think of those who ask you to change?
   c) How do you react to them?
   d) What would make you move towards the change?

4) Think of something in your behaviour that you are now in the process of changing or have changed just recently.
   a) What is it that primarily made you change?
   b) How do you feel about the change?
   c) How easy is it to maintain the change?
   d) What challenges are there to maintaining the change?

5) Think of something in your behaviour that you have changed some time ago.
   a) How do you feel about the change?
   b) How easy is it to maintain the change?
   c) What are the challenges to maintaining the change?
   d) How do you cope with the change?

6) Think of something in your behaviour that you recently changed, but later something caused you to return to the previous behaviour.
   a) How do you feel about returning to the previous behaviour?
   b) What made you return to the previous behaviour?
   c) Did you try to resist?
   d) What were you thinking about at the moment you were returning to that behaviour?
   e) How did people who have known you before and after the change react? And how did you react to them?

Annex 4

Role play

Session 3: ACTIVITY 3-5

The purpose of this exercise is to use the following scenarios to practise effective listening skills and the G (Greet) and A (Assess) part of the GATHER approach in a role play situation.

You will be separated (counting 1, 2, 3) into groups of three (triads). All the 1s will be the young person, the 2s will be the health worker, and the 3s will be the observer. Each triad will be allocated a scenario.

The young person and the observer (1 and 3) should read the scenario that has been allocated to them.

The health workers (2) should not read the scenario but will find out the situation with their young person as the client, using listening and assessment skills. In this exercise, do not spend time discussing the presenting condition. Focus on Greeting and Assessment of the young person.

Stop the interview when you have completed the Greet and Assess parts.

The observer will watch and make notes. At the end of the exercise the three of you will discuss together what happened during the scenario.

Remember to come out of the roles at the end of the role play.

You have 2 minutes to prepare, 5 minutes for the interview, and 3 minutes to report back in your triad.

ROLE PLAY 1

Benni

You are a young man of 16 years living at home with your family. Your mother asked you to go to the health centre because you often complain of headaches before going to school.

If the health worker asks you, you say that you like to smoke cannabis with your friends and at the weekend you drink alcohol at parties. You were badly scared last weekend when you got drunk and had sex at a party with a girl in your class. You are concerned that you did not feel in control of what you did and are worried about what you may do another time. You also feel embarrassed to see the girl as you do not particularly like her. You did use a condom.

ROLE PLAY 2

Mohamoud

You are a young man of 18 years. You have come to the health centre because you have had a gash on your leg for two weeks that will not heal. Tell the health worker that the orderly has dressed the wound and does not think you need antibiotics. The orderly has sent you to see the health worker to check that this is the correct treatment.

If the health worker asks you, you can say that you ran away from home a year ago; since then, you have been living on the street with a group of friends. You find work as a casual labourer and are able to make enough money to support yourself. You snort (inhale) cocaine daily, you smoke cigarettes and cannabis, and you drink alcohol when you can afford it. Sometimes you cannot work because you are too slow and sleepy. If you don't use cocaine every day you feel bad. You injured your leg when you were high and have noticed that you are falling at work more often. You like sharing the pleasure of drugs with your friends but you dream of owning something one day (e.g. a cycle rickshaw or a motorbike or something else you can choose). At the moment you do not save any money but you would like to save some of the money that you spend on drugs. You did stop using cocaine for a month but it was hard.

ROLE PLAY 3

Chekkie

You are a young person (boy or girl) of 12 years. You have come to the health centre because you have had a cough for the last three weeks and you find it hard to breathe at night.

If the health worker asks you, you say that you have been smoking cigarettes for the last one year. You mostly take them from home where both your parents smoke. You think smoking makes you look cool and feel grown-up. You have friends who smoke. You do not have a boy/girl friend. You used to be good at sports (you choose which one) and wish you had continued. Now you find that you get too breathless.

ROLE PLAY 4

Shasta

You are a 15-year-old girl. You have come to the health centre because you feel that your breasts are too big. You think people are always looking at them and are hoping there is some medicine or operation you can have to make them smaller.

If the health worker asks you, you say that you have a boyfriend, Freddo who belongs to a gang. They all smoke cigarettes and cannabis, drink alcohol and hang out together. Freddo wants you to join in but you are afraid that smoking cannabis or drinking will make you crazy or want to have sex or something.

Your parents and your girl friends do not like Freddo or his gang.

Annex 5

Scenarios

Session 4: ACTIVITY 4-3

Session 5: ACTIVITY 5-4

Session 4: Activity 4-4

Group work: Stages of Change

In your group, look at your scenario and consider the following for presentation in plenary:

- Give a brief summary of the scenario.
- What is the pattern of use for each substance for this young person?
- What stage of change do you believe the young person is at with each substance?

You have 10 minutes to work in your group, and then one of you will give a 3-minute presentation.

Session 5: Activity 5-4

Role play: Action in the clinic

Interview using GATHER.

Sit in your group of three persons. Decide who will be the observer, the young person, and the health worker. If there is a participant who has not taken the role of a health worker, please give them this opportunity now.

You will be allocated a scenario. Go through the interview in your role play using the GATHER approach. Focus less on the G and A components this time, and more on the THER in identifying actions for this young person.

You have 2 minutes to prepare, 5 minutes for the interview, and 3 minutes to report back in your group. Remember to come out of your roles.

SCENARIO 1

Yasmine

Yasmine, an 18-year-old woman, has come to the health facility for a follow-up contraception visit. After discussing and meeting her contraceptive needs, you ask her about her family, her friends and work. She tells you that she has recently lost her job. After some discussion she tells you that she is often drunk or feels too ill to go to work. She also frequently injures herself or has arguments with her boyfriend when she is drunk.

She also complains of gastric pain most mornings, which prevents her from eating regular meals. She has recently realized that her alcohol use is a problem and she has been trying to reduce the amount and frequency of her drinking.

On further discussion, you find that she has been inhaling (snorting) cocaine at parties. In the morning after cocaine use she has often felt very ill and she says she wants to stop using it. She also tells you that she has been smoking about 30 cigarettes a day for about 2 years. She says she needs to smoke this number of cigarettes and does not see smoking as a problem.

SCENARIO 2

Hoang

Hoang, a 17-year-old man, comes to you with a genital ulcer and urethral discharge. As you begin to examine him closely, you realize that his eyes are bloodshot and he smells of cigarette smoke. When you have given him the treatment for his STI, he tells you that he smokes cannabis and tobacco. When you ask him about his cannabis use, he states that he smokes every weekend with his friends and has done so for over a year. However, he is thinking about giving it up because he had a bad fright the last time he was high. He thinks it would be hard to stop because getting high is something he likes to do with his friends.

He used to have a job after leaving school and could afford to smoke a pack of cigarettes a day. At that time he often had a bad cough. Now he cannot afford to buy cigarettes and he only smokes when they are given to him (about 3 a day). He has taken methamphetamine a couple of times with his friends. He liked the feeling and sees no problem with trying new substances occasionally.

SCENARIO 3

Samir

It is late in the evening and you are working in your hospital's casualty department. A young man is brought in with minor cuts on his face and arms. You attend to his cuts.

After a few questions you realize that he seems sleepy and his pupils are dilated. After some discussion, he tells you that he has been using heroin for about three years and smokes it every day. He got hurt earlier that evening when he was in a fight with some men over a drug deal. He says his family are very worried about his substance use and the troubles he gets into, but he says he has no desire to stop using heroin.

He said that a year ago he was drinking alcohol most evenings until he passed out once. After he lost his job, he managed to stop drinking. Now he has another job and wants to keep it. He says that now he only drinks alcohol with his friends at parties about once every few months.

Annex 6

Case studies

Session 6: ACTIVITY 6-2

SCENARIO 1

Tung

Tung, a 19-year old client whom you know well, staggers into your health centre. He smells very strongly of alcohol and is bleeding from a cut above his eye. You know him to be a pleasant young man who has been diagnosed with depression; however, he can become aggressive when intoxicated.

What would your immediate responses be?

SCENARIO 2

Nhat

Nhat, a 15-year old boy, comes running into your health centre. He starts screaming in the waiting room, “You are all out to kill me”, “I know that the cameras are in my head taking pictures”. He seems to be breathing fast and is very jittery, wide-eyed and staring. Because of this behaviour you believe you believe that he is possibly under the influence of methamphetamines. You have seen him in the centre once or two twice before. There is currently no one else in the room. As you approach him he picks up a chair and holds it above his head threatening you.

How would you respond?

SCENARIO 3

Ravi

The young people from your health centre are participating in a festival at a local park where there are ball games, activities and food. You notice that four of the young people have gone missing. You walk down to the river where you find them inhaling from a plastic bag. Three of the young people seem a little bit intoxicated but manageable; however, the fourth young person, Ravi, is quite unsteady on his feet and yells something about you spying on them and that he is going for a swim.

What would your immediate responses be?

SCENARIO 4

Young woman

You come across a young woman who is lying unconscious in the street near your health centre. There is a syringe beside her.

What would your immediate responses be?

Annex 7

Exploring your own attitudes and values on substance use

Our attitudes and values can be affected by many things - some are professional and some personal. Whatever you can do to clarify your values on substance use issues will help you to work with young substance users.

There are no objective data that can help you to assess your own attitudes and values regarding substance use. It is, however, important to review your thoughts on this topic because of the potential problems a lack of understanding in this area can create.

Our attitudes and values are formed over a period of time by the circumstances in which we are born and live, by the situations and people we encounter, and by the experiences from which we learn. The attitudes and values that we hold influence our view of other people's behaviour and our ability to provide professional and nonjudgemental care and support.

Health workers need to assess their own attitudes and values. This will enable them to provide the best possible care and to challenge the stigma and discrimination that substance users frequently have to deal with in society and in healthcare settings.

The following questions can help you explore your own attitudes and values on substance use. You can periodically ask yourself these questions to help clarify your thoughts on this subject.

Professional

- How important is it to ask your patients about their alcohol, smoking and substance use behaviours during a routine visit to the health centre?
- How much drinking is too much from your point of view?
- Is there really anything wrong with a 25-year-old using a little marijuana from time to time?
- How serious is smoking cigarettes for the health of a 17-year-old woman?
- How serious is smoking cigarettes for a pregnant woman?
- If a female patient drinks more than one drink a day, what health concerns would you have?
- How confident are you that you can help your young patient to change his/her substance use behaviour?
- How important is it for you to know all the street terms and all the characteristics of street drugs used by young people in order to really help a young substance user in your health centre?
- How important to your work with young people is personal contact with referral sources in your community?
- How serious a problem is substance use for young people in your community?

Personal

- What is different about the way you think about alcohol, tobacco, and other drugs compared to your parents?
- What effect do you think your childhood experiences have had on your current substance use patterns?
- How many drinks a day can you consume without creating health or social difficulties?
- How much can you smoke without creating health difficulties?
- Is it possible to use substances without causing harm to yourself, either socially or to your health?
- Do you have any personal alcohol, tobacco, or other substance-related behaviours that you would like to change?
- If the answer to the above question is yes, do you feel you know how to get help in your efforts to change?
- Would the fear of repercussions (professional, social, etc.) keep you from seeking help?
- If you had a colleague who was in trouble with alcohol or other substances, what would you do to help?
- How important an issue is substance use to you and your family?
- What is the worst thing that could happen to you in relation to your alcohol, tobacco or other drug use?
- What is the best thing that could happen to you in relation to your alcohol, tobacco or other substance use?

There are no “correct” answers to the above questions. If answered honestly, the answers reflect what is true for you. When you find that your opinion is out of step with the information presented in this module or with commonly accepted medical or social positions on substance use, it would be worthwhile to review the information and data concerning these issues.

We sometimes hold opinions that come from events in our lives, but these opinions may not be evidence-based and may involve a great deal of generalization. Challenging these opinions can have an enormous influence on our attitudes and values on these issues.

It takes courage to question and change an attitude that we have held for years, but these attitudes can hold us back from providing the best possible professional care and support. Through challenging our beliefs, we can stay open to current, correct and enlightened ideas.

Handout for

Module N

Young people and HIV

This Handout for participants provides information that complements the material on *Young people and HIV*. The facilitator will ask you to refer to this Handout during the sessions.

This handout provides information on the following:

1. HIV and AIDS N-5
2. The situation of HIV among young people N-7
3. How HIV affects young people N-10
4. HIV prevention and young people N-17
5. HIV testing and counselling among young people N-22
6. Management of HIV in young people N-26
7. Publications on HIV and young people N-38
8. Definition of terms N-39

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Annex 6. Case studies N-65

1. HIV and AIDS

HIV (Human Immunodeficiency Virus) is the virus that causes AIDS, which is a lifelong infection. A *positive HIV test* does not mean a person is ill with AIDS; it means that he/she is infected with the virus (HIV) and that HIV antibodies are detectable in that person's blood.

AIDS stands for Acquired Immune Deficiency Syndrome, "acquired" referring to the fact that the virus was caught; "immune deficiency" means that the person's immune system is weakened against infectious and non-infectious diseases. The word "syndrome" describes a group of symptoms indicating a particular disorder. The syndrome in AIDS is a set of infections or illnesses that occur because HIV has damaged the immune system.

Correct understanding of the terms HIV and AIDS and their different meanings is important. This module uses the term HIV – and occasionally AIDS – to describe all stages of HIV infection, including AIDS. The expression "people living with HIV" (PLHIV) is used for people living with all stages of HIV infection, including people living with AIDS.

When a person gets infected with HIV, the body tries to fight the infection by producing antibodies. Testing *positive* for HIV means that the individual has been infected with the virus and the body has produced antibodies against HIV. An *HIV test* measures the presence or absence of HIV antibodies in the blood; it does not measure the virus.

BOX 1

The window period

After a person becomes infected with HIV, it takes an average of six weeks for him/her to test positive (by seroconversion) because this is the time needed for antibodies to develop to levels where they can be detected in the blood. During this "window period" or time before antibodies can be detected, the person can transmit HIV to others as the virus is already in his/her body fluids.

In situations where exposure to HIV may have been only hours or days before (e.g. following condom breakage, rape), the health worker needs to be aware that the person may be in the window period (i.e. when HIV antibodies are not yet detectable). The person should be counselled and asked to return for HIV testing six weeks after the date of possible exposure and to use precautions to prevent transmission to others during this period.

However, if the person is going to receive Post-Exposure Prophylaxis (PEP), this must begin less than 72 hours after unprotected sex. For information on Post-Exposure Prophylaxis, see Box 7.

WHO has developed a system of clinical staging, with four well-defined stages of HIV illness:

- WHO Clinical Stage I : asymptomatic
- WHO Clinical Stage II : mild disease
- WHO Clinical Stage III : moderate disease
- WHO Clinical Stage IV : severe disease (AIDS).

Staging is helpful for making decisions on when to begin treatment, especially in situations when the only laboratory test available is an HIV test. The signs and symptoms that are used in clinical staging can be found in *Chronic HIV Care with ARV Therapy*, Integrated Management of Adolescent and Adult Illness (IMAI), WHO. There are IMAI training courses to prepare health workers for chronic HIV care, including ARV therapy.

Most individuals infected with HIV look and feel healthy and lead normal lives for many years before experiencing HIV-related symptoms. Worldwide, the majority of *people living with HIV* (PLHIV) do not know they are infected. However, anyone who is infected with HIV can transmit the virus to others.

HIV and AIDS raise many difficult issues that can challenge moral and societal values. When working with HIV, it is important to be able to talk openly about sensitive issues, in particular

about sex. Health workers need to be able to talk about these issues with young people and feel confident that they have the knowledge to discuss the behaviours that carry a high risk for HIV transmission.

These behaviours, and the people who practise them, may provoke strong feelings. As health workers, it is important to maintain a professional and respectful manner, without using blame, stigma or personal values to judge a situation.

Transmission routes for HIV

The blood, vaginal fluid, semen and breastmilk of persons infected with HIV have the potential to transmit HIV to others. Exchange of these body fluids can cause transmission of HIV.

HIV is transmitted through four different infection routes:

- Sexual intercourse
- Blood and blood products
- Needles and other skin-piercing instruments
- Mother-to-child-transmission (MTCT) from an HIV-infected woman during pregnancy, during childbirth or through breastfeeding.

Globally, sexual intercourse is the most common transmission route for HIV. In some regions, nearly 90% of all HIV transmissions are through heterosexual (man and woman) intercourse. For young people, sexual intercourse and injecting drugs are the most common transmission routes.

There are no documented cases of HIV being transmitted by tears or saliva. HIV is not transmitted via toilet seats, shared towels, mosquito bites, hugging, holding hands or any casual contact with a person living with HIV.

Natural history of HIV infection

The progression of HIV infection and AIDS can vary greatly from individual to individual.

Over the course of time, the virus slowly wears down and damages the immune system, allowing infectious agents that are usually harmless to make the individual very ill. These illnesses include opportunistic infections, neurological conditions, and particular forms of tumours. In many countries tuberculosis is the most common opportunistic infection. AIDS is the end-stage of HIV illness, when the immune system is severely damaged.

There is no cure for AIDS and there is no way of removing all the HIV from the body of an infected person. There are, however, highly effective and life-saving drugs that reduce the rate at which the virus can multiply and that can be used to treat infections and conditions caused by the virus.
Globally, there is a commitment and recognition of the importance of addressing HIV and young people. At the United Nations General Assembly Meeting on AIDS (June 2006), Declaration number 26 states:

“[We] commit ourselves to addressing the rising rates of HIV infection among young people to ensure an HIV-free future generation through the implementation of comprehensive, evidence-based prevention strategies, responsible sexual behaviour, including the use of condoms, evidence- and skills-based, youth-specific HIV education, mass media interventions and the provision of youth-friendly health services”. (*www.un.org/ga/aidsmeeting2006/declaration.htm*)

2. The situation of HIV among young people

Estimates of HIV are figures indicating approximately the number of people living with HIV at the end of a stated year. Estimates are not an exact number and that is why ranges are used. The main sources of data for calculating HIV estimates are:

- Sentinel surveillance systems: periodic surveys among specific population groups (e.g. antenatal women, drug users, sex workers and others).
- National population-based surveys with HIV testing: HIV information is collected from the general population as a whole. The data might underestimate the true prevalence because of greater risk factors among the non-responders (persons refusing or absent). Only a few countries have implemented such surveys.
- Case reporting from health facilities.

The UNAIDS/WHO HIV Surveillance Working Group collaborates with governments to produce regular HIV and AIDS estimates at country, regional and global levels. The summary in the Table below shows estimates published in the 2006 Report on the Global AIDS Epidemic.

TABLE 1

Global summary of the AIDS epidemic in 2005

No. of people living with HIV in 2005	38.6 million (range: 33.4 to 46.0 million)
No. of people newly infected with HIV in 2005	4.1 million (range: 3.4 to 6.2 million)
No. of AIDS deaths, 2005	2.8 million (range: 2.4 to 3.3 million)

Source: UNAIDS/WHO December 2006.

Global situation of HIV among young people

An estimated 39 million people are currently living with HIV worldwide. Of the estimated 4 million new HIV infections annually, almost 50% are women and over 40% are young people aged 15-24 years (UNAIDS/UNICEF/WHO, 2006).

Global data show that young people are central to the HIV epidemic. Some data do not give a breakdown by age groups, making it difficult to separately identify young people in the statistics. In countries with high HIV prevalence rates, young people and especially young women are at particular risk of contracting the virus as soon as they become sexually active.

There are more than 13 million drug injectors worldwide; more than 50% of them in some countries are living with HIV. Sharing of injecting equipment is a highly efficient way of transmitting HIV, and injecting drug use plays a major role in the HIV epidemic in some regions. There have been dramatic increases in the number of young people who inject drugs in some countries (UNAIDS 2004).

Regionally there are differences in the prevalence rates of HIV among young people (15-24 years).

TABLE 2

The global HIV prevalence rate estimates of young people living with HIV by region in 2005

	Women (15-24 years)	Men (15-24 years)
Sub-Saharan Africa	4.3%	1.5%
East Asia	<1.0%	0.1%
South and South East Asia	0.4%	0.6%
Caribbean	1.6%	0.7%
Latin America	0.3%	0.5%
Eastern Europe and Central Asia	0.5%	0.9%
North Africa and Middle East	0.2%	0.1%

Source: UNAIDS/UNICEF/WHO 2006.

The 2006 Report on the Global Aids Epidemic shows that important progress has been made in country AIDS responses, including increases in funding and access to treatment, and decreases in HIV prevalence among young people in some countries over the past five years. It also shows that young people and children are increasingly affected by the epidemic, and efforts to protect these and other vulnerable groups are not keeping pace with the epidemic's impact.

On HIV prevention, the report documents behaviour changes including delaying the first sexual experience, increasing use of condoms by young people, and resulting decreases in HIV prevalence in young people in some sub-Saharan countries.

Young people are a key population group on which to focus prevention, care and support because they represent such a high proportion of the new infections. As with adults, the vast majority of young people who are HIV-positive do not know that they are infected, and few young people who are engaging in sex know the HIV status of their partners.

Diversity of HIV epidemics

The world is now facing a multitude of HIV epidemics which are different in their time sequences, extent and affected populations. An accurate picture of the HIV epidemic in a country is vital for directing national and local responses.

The information in Box 2 is purely to illustrate the different epidemics and is not intended to point fingers at any country or region, or sexual behaviour between consenting partners.

HIV epidemics are dynamic and diverse. They do not start in the same way in all countries and the epidemic within a country can change over time. The course of an HIV epidemic depends on the people's pattern of behaviour which can increase or reduce their risk of HIV, as well as on the local political, economic and social situation. There may also be differences in the epidemic within a country - between regions and between rural and urban areas.

- *Generalized* epidemics are those where HIV prevalence is over 1% in the general population.
- *Concentrated* epidemics are those where HIV prevalence is over 5% in a sub-population at higher risk of infection, but where the prevalence in the general population remains below 1%.
- *Low-level* epidemics are those where relatively little HIV is detected in any group in the population.
- *Young people* are at the centre of transmission in both generalized and concentrated epidemics.

BOX 2

Examples to illustrate the global diversity of the HIV epidemic

- In many Southern African countries – with some of the highest reported HIV prevalence rates in the world – the epidemic is generalized and HIV transmission occurs mainly heterosexually within the population as a whole.
- In some settings in Eastern Europe, HIV began as a concentrated epidemic, primarily through needle sharing among drug injectors; recently HIV infections have moved into the wider community through sexual transmission.
- The high number of single male migrant workers moving to urban areas in Asia and their contact with sex workers has led to increased HIV infection levels. These men then act as a bridge population and sexually transmit HIV to their partners when they return to their rural areas.
- In other countries in Asia, the HIV epidemic began as a number of serious localized epidemics caused by injecting drug use and unsafe blood donations, but sexual transmission of HIV is now increasing.
- In many industrialized countries, men having sex with men continues to be a major cause of the epidemic.
- Drug injecting is also important for HIV transmission. In 2002, IDU accounted for more than 10% of all reported HIV infections in Western Europe and for 25% of HIV infections in North America.
- In some Latin American countries the epidemic was concentrated among drug injectors and men who have sex with men, before moving to the general population.
- In countries with conflicts, HIV can spread rapidly among internally displaced people due to violence associated with war (rape, breakdown of family structure and societal norms).

As young people are at the centre of transmission in both generalized and concentrated epidemics, HIV prevention among young people is the key to slow down the epidemic.

Worldwide the HIV epidemic affects the young, the poor and disadvantaged people. Even when the epidemic is generalized in a country, some groups within the population remain highly vulnerable and deserve specially focused attention. Among 15-24-year-olds, young women are 2-4 times more likely to become newly infected than men. The reason for this is that young women may be less able than men to avoid non-consensual sexual relations (i.e. unable to refuse to have sex or to avoid forced sex).

Fortunately, most young people are not infected with HIV. In fact, during early adolescence HIV rates are the lowest of any period during the life cycle. The challenge is to keep them this way. Focusing on young people is likely to be the most effective approach to confronting the epidemic, particularly in high prevalence countries.

3. How HIV affects young people

There are two groups of young people living with HIV: those who were infected around birth and survived into adolescence and those who became infected during adolescence (usually due to unprotected sex or through injecting drug use). This infection history has an impact on many features of how HIV affects a young person, including their HIV care and management (e.g. progression of HIV disease, treatment with ARV drugs, knowledge and disclosure of HIV status, access to care), and on prevention strategies.

Sexual activity begins in adolescence for the majority of people. In most countries the mean age of sexual debut is 17-18 years. This means that 50% have had sex by that age. In addition, in many countries unmarried girls and boys become sexually active even before the age of fifteen. Studies from many parts of the world have shown that the vast majority of young people have no idea of how HIV is transmitted or how to protect themselves. Surveys in Africa, Asia, the Caribbean and South America showed that fewer than half of adolescent girls aged 15-19 knew about the three main ways of avoiding HIV infection (delaying sex initiation, reducing the number of partners, and using condoms consistently and correctly). More than half the girls of this age did not know that someone who looks healthy may be infected with HIV.

Sharing injecting equipment carries a high risk of HIV transmission and plays a major role in the HIV epidemic in some regions of the world. Globally, injecting often commences during adolescence, the most common age for initiation being 15-19 years. In some countries there has been a dramatic increase in the number of young people who inject drugs. In general, compared to older injectors, young drug injectors have little knowledge about HIV, a lower perception of HIV risk through both drug injecting and sex, and are less likely to identify themselves as being an injecting drug user. Young injectors are more likely to be intermittent users and are less likely to be drug dependent. In their sexual behaviour, young injectors are more sexually active, have more partners and experiment with different sexual practices more than many older injectors. Young injecting drug users are also less likely to use the health services for prevention and treatment. In addition, there are issues of social stigma and illegal use of drugs. Working on HIV prevention with young injecting drug users is an important strategy to reduce the HIV epidemic. This is addressed in detail in the module *Young people and injecting drug use*.

Risk factors and protective factors

There are factors in every society that have an effect on how people behave. Some of these factors relate to the person as an individual (e.g. age, sex, knowledge, attitude, behaviour and practice {KABP}). Other factors, known as contextual factors, relate to the social and environmental context or situation in which the individual lives. Contextual influences include peers, teachers, family and community, as well as poverty, civil unrest, the legal system, and the values and norms in the broader society. Most risk and protective factors are a mix of individual and contextual influences.

- Risk factors include individual and contextual influences that either encourage or are associated with one or more behaviours that may lead to negative health outcomes or may discourage behaviours that could prevent a negative health outcome.
- Protective factors include individual and contextual influences that discourage one or more behaviours leading to negative health outcomes or that encourage behaviours that prevent negative health outcomes. Protective factors can also lessen the likelihood of negative consequences from risk factors.

Scientific studies in adolescents show that the following risk factors are associated with an increase in the risk of becoming infected with HIV (Adapted from *Risk and Protective Factors affecting Adolescent Reproductive Health in Developing Countries.* WHO, 2004):

- Increased age
- Commercial sex work
- Early age at becoming a commercial sex worker
- Commercial sex work in a brothel
- High numbers of sexual partners
- Current or past history of genital ulcer
- Unprotected anal sex
- Current or past history of STI
- Early age of sexual debut.

Protective factors that are statistically significant in avoiding HIV infection are:

- Regular use of condoms
- Usual partner circumcised
- Reduced number of sexual partners.

Other studies have identified protective factors that help adolescents avoid behaviours that put them at risk of HIV (*Young People and HIV/AIDS: Opportunity in Crisis*. UNICEF/UNAIDS/WHO, New York, 2002). These include:

- Positive relationships with parents, teachers and other adults in the community
- Feeling valued
- Positive school environments
- Exposure to positive values, rules and expectations
- Having spiritual beliefs
- Having a sense of hope for the future.

The term "risk groups" is no longer used because it can give the impression that these groups are to blame for HIV. Also "risk groups" often do not have a clear identity; for example, men who have sex with men (MSM) may not identify them selves as homosexual, or persons who occasionally use intravenous drugs may not identify themselves as an injector.

Vulnerability to HIV

Even when HIV infection rates are generalized in a country, some groups within the population remain highly vulnerable. The concept of vulnerability recognizes that they may not have a choice as to whether they engage in behaviour that puts them at risk of acquiring HIV.

BOX 3

Vulnerability to HIV

For most young people, the important messages that will protect them from the risk of HIV are: delaying sexual debut, reducing the number of sexual partners, and using condoms correctly and consistently. Vulnerability is a measure of an individual's or community's inability to control their risk of HIV infection. Vulnerability recognizes that they may not have a choice as to whether they engage in behaviour that puts them at risk of acquiring HIV.

Vulnerability increases the likelihood of negative health outcomes. There are social and contextual risk factors that make many young people vulnerable to HIV infection. These include: gender norms, relations between different age groups, race and other social and cultural norms and value systems, location, and economic status.

Behaviour or situations that put young people at risk of HIV include:

- Having sex with older men
- Injecting drugs
- Being sexually violated
- Working in the sex trade
- Living on the street
- For men, having sex with men
- Being a migrant worker
- Living without parental support
- Being orphaned as a child or affected by HIV
- Being caught in armed conflict.

Young people represent a large proportion of these highly vulnerable people and they may need special HIV strategies to be reached.

Studies show that many young people do not believe that HIV is a threat to them, and many others do not know how to protect themselves from HIV. They are vulnerable because they often do not know how HIV is transmitted or what they can do to protect themselves. Surveys from 40 countries indicate that more than 50% of young people have serious misconceptions about how HIV is transmitted. Many adolescents do not go to school, and do not have access to information about AIDS, or do not have the opportunities to develop the life skills that they need to turn this information into action. Frequently they do not have access to prevention services that take their specific needs into consideration. (*Young People and HIV/AIDS: Opportunity in Crisis.* UNICEF/UNAIDS/WHO. 2002).

There is need to pay particular attention to preventing HIV infection of girls and young women, who, in some regions, are almost three times more likely to be infected than young men of the same age. The difference in infection levels between men and women is even greater among young people.

BOX 4 - part 1

Gender and HIV

Gender can be understood as the social construct of masculinity and femininity. In many societies, what is considered masculine is more valued than feminine; so, opportunities are connected to each sex and a relation in which more power is given to men than women may be established.
When the primary mode of HIV infection is heterosexual, young women are the worst affected. However, in countries where HIV is transmitted predominantly among men who have sex with men or by injecting drug use, young men are likely to be more at risk from HIV. Globally, approximately as many women as men suffer from HIV; however, there is a difference in the implications of the disease for men and women. Some of these result from biological differences in sex between men and women, but more result from socially defined gender differences.

In some societies, gender norms allow men and boys to have more sexual partners than women and girls. Society may also accept or encourage older men to have sexual relations with younger women. In combination with the biological factors, where heterosexual sex is the main mode of HIV transmission, infection rates are much higher among young women than among young men. Gender power imbalances, patterns of sexual networking, and age mixing are all important factors, especially for young women.

Young women may remain ignorant of the facts of sexuality and HIV because they are not “supposed” to be sexually knowledgeable, while young men may remain ignorant because they are “supposed” to be sexually all-knowing.

BOX 4 - part 2

Gender and HIV

Young women may want their partners to use condoms (or to abstain from sex altogether), but often lack the power to make them do so. Young women (who are often more socially, economically and physically vulnerable than men) may be unwilling to learn their HIV status or share that information for fear of violence and/or abandonment if the HIV result is positive.
Societies must address issues that affect the vulnerability of women and girls (e.g. gender-based violence, poverty, property rights, and education). Healthcare workers have a role in developing programmes that empower women and girls and reduce their vulnerability and risks for HIV. These should be within comprehensive sexual and reproductive health strategies.

Societies also need to address issues that affect the vulnerability of boys and young men (e.g. sex workers, poverty, injecting drug use, negative attitudes to sexuality).

These factors of inequality are not easily altered but until they are, efforts to contain and reverse the HIV epidemic are unlikely to achieve sustained success.

Adapted from: http://www.who.int/gender/hiv_aids/en/

Biological susceptibility

Biological susceptibility refers to the increased physical risk of acquiring HIV. Women are probably more susceptible than men to infection from HIV because of the greater area of mucous membrane exposed during sex by women than men, the greater quantity of fluids transferred from men to women, the higher viral content of male fluids, and the micro-lesions that can occur in vaginal or rectal tissue from sexual penetration.

Young women may be especially susceptible to infection. A young girl of 14 years may have a higher risk of acquiring HIV than a woman of 30 years (even when exposed to the same situation and viral load) for the following reasons.

- **Immature genital tract in young girls**
  In young girls, inadequate mucosal defence mechanisms and the immature lining of the cervix provide a poor barrier against infection. Once exposed to the virus, girls and young women are more susceptible than young men or adults due to the anatomy of the developing cervix and vagina. Also in young girls, the thin lining and relatively low acidity in the vagina facilitate transmission.

- **Undeveloped genitalia more easily damaged during forced sex**
  Non-consensual sex with undeveloped genitalia can lead to trauma and therefore increase the chance of transmission if exposed to HIV. In some settings there is a high rate of coerced sex among young girls. In studies, many young women report that they were unwilling or coerced into their first sexual experience. Forced sex is always very traumatic. This is even more traumatic on developing genitalia, allowing for increased risk of infection through skin tears.

- **STIs in sexually active young people**
  STIs among sexually active people also increase their chance of contracting and transmitting HIV. The infected partner has heightened infectivity due to the shedding of more viral RNA in vaginal/seminal fluid. Herpes simplex virus (HSV) and genital ulcer disease (GUD) are STIs known to encourage the spread of HIV. Prevention of STIs and early, correct treatment are important components in HIV prevention strategy. The presence of untreated STI (ulcerative

or non-ulcerative) can increase the risk of both acquiring and transmitting HIV by a factor of up to 10. Improvement in the management of STIs can reduce the incidence of HIV infection in the general population by about 40%. (From: WHO 2001: *STIs Overview and Estimates*).

- **Female genital mutilation**

  Female genital mutilation can cause lasting damage to the genital area and can increase the risk of HIV transmission during intercourse. Use of the same instrument to carry out genital mutilation on several girls or circumcision on several boys without sterilization may also cause the spread of HIV.

- **Risk of anal abrasions**

  The tissue around the anus of young girls and boys is fragile. During consensual or forced anal sex (boys with men, girls with older men or boys), anal abrasion can occur, making transmission more likely in the presence of HIV. Anal sex may be chosen over vaginal sex to preserve the virginity of the girl or to avoid the risk of unwanted pregnancy.

Natural history of HIV in young people

Young people differ from adults in the natural history of HIV infection and can differ from each other depending on their infection history (infection around birth or adolescent infection through unprotected sex or injecting drug use).

In young people who were infected around birth and have survived into adolescence, HIV disease may have a rapid progression or a slow progression. In rapid progression they are likely to have begun ART in childhood.

- **HIV acquired prior to puberty**

  Young people who were infected before entering puberty can present with slow skeletal growth, delayed pubertal maturation, and irregular menstrual periods in girls. This is due to the effect HIV has on metabolic and endocrine functions. This delay in growth and sexual maturation may also have an impact on the psychosocial development of the individual.

- **HIV acquired after puberty has begun**

  For young people infected after puberty, the infection can remain asymptomatic for a longer period of time than for adults. There appears to be an inverse correlation between age of infection and length of asymptomatic period (i.e. the younger the age at infection (after puberty), the longer the virus remains asymptomatic).

BOX 5 - part 1

Male circumcision and HIV

Male circumcision is the surgical removal of all or part of the foreskin, the tissue covering the head of the penis. Depending on culture, ethnicity and religion, circumcision is usually performed soon after birth or during adolescence.

Trials are in progress to examine the potential link between male circumcision and a lower risk of HIV acquisition and transmission during sexual intercourse. The trials have shown promising protective effects of adult male circumcision in reducing HIV acquisition. One trial in South Africa found that circumcising HIV-uninfected adult men reduced their risk of becoming infected with HIV by 60%. Trials

BOX 5 - part 2

Male circumcision and HIV

are underway in Kenya and Uganda to confirm the reproducibility of the findings and whether or not the results have more general application. It is also important to clarify the relationship between male circumcision and HIV in differing social and cultural contexts.

In addition, a companion trial is following female partners of the male participants, to determine if circumcising men reduces the risk of HIV transmission to women, as suggested by observational data.

The results of these trials will need to be considered by governments and other key stakeholders in order to determine whether male circumcision should be promoted as an additional public health intervention to reduce the risk of sexual transmission of HIV. The feasibility of such an intervention, particularly with respect to its cost-effectiveness, safety and acceptability, is still to be demonstrated. If male circumcision is confirmed to be an effective intervention to reduce risk of acquiring and transmitting HIV, this will not mean that men will be prevented from becoming infected with HIV during sexual intercourse through circumcision alone. Nor does male circumcision provide protection for sexual partners against HIV infection. It will therefore be essential that it be part of a comprehensive prevention package, which includes correct and consistent condom use, behaviour change, and voluntary counselling and testing. Any new prevention strategies must not undermine existing protective behaviours and prevention strategies that reduce the risk of HIV transmission.

When performed by a trained practitioner, male circumcision is a safe procedure, and analgesia affectively mitigates pain. However, concerns have been raised about the safety of circumcision procedures performed in resource-limited community settings.

Circumcision is an opportunity to make contact with adolescents and provide them with information and counselling about their sexual and reproductive health. Health workers need to know how to respond to a request for circumcision from an adolescent minor, to respond in ways that respect the adolescent's rights to privacy and confidentiality but at the same time do not place the health worker in conflict with the law. Ideally, an adolescent should be accompanied by a responsible adult who can give consent for the operation. However, in practice this is not always possible. Health workers should be guided by human rights principles: all adolescents have a right to use health services, and health workers should act in the best interests of the adolescent, with an understanding of his evolving capacities and his increasing ability to make independent decisions.

Adapted from: UNAIDS statement on South African trial findings regarding male circumcision and HIV. July 2005.

Statement developed by the World Health Organization (WHO), the United Nations Population Fund (UNFPA,) the United Nations Children's Fund (UNICEF) and the UNAIDS Secretariat.

Male and Female Condoms

The major transmission route for HIV globally is sexual transmission. Abstinence and condoms are the only dependable ways of avoiding HIV. For people who are having sexual intercourse, condoms are the surest way to prevent transmission of HIV and other sexually transmitted diseases. When used correctly and consistently, condoms provide an effective barrier, blocking the pathway of the HIV virus during sexual activities.

Condom breakage rates are less than 2%. Almost all breakage is due to incorrect usage (e.g. leaving no air space, improper storage, tearing by fingernails or jewellery, expiry date past, inadequate lubrication, use of oil-based rather than water-based lubricant). Condoms have tiny pores in them and some people think these leak viruses, but this is not the case. Studies have shown that HIV cannot pass through latex condoms.

The female condom has a sheath material and a flexible inner ring, and is inserted similar to a diaphragm. A woman squeezes the ring and inserts it as far as possible into the vagina. The ring covers the cervix. The sheath material lines the vaginal wall and the outer ring holds the condom in place and helps cover the lips of the vagina. The penis must stay within the confines of the female condom or the condom is ineffective.

Female condoms can be inserted up to 8 hours before intercourse and are only effective when placed prior to intercourse. At first, female condoms can be awkward to use, but they are easy with practice. Women should insert the condom before sexual play by standing with one foot up on a chair, sitting with knees apart, or lying down. Water-based lubrication can help keep the condom in place and lessen noise during intercourse. A female condom and a male condom should not be used at the same time.

BOX 6

Violence against women and HIV

Violence against women is an important factor for HIV transmission. Rape, forced sex and coerced sex, which many women (and some men) experience at some point in their lives, can make HIV transmission even more likely, since it may result in more trauma and tissue tearing. Both young women and young men are vulnerable to sexual violence, including abuse and exploitation, but a greater number of girls and young women are affected. Violence interacts with the HIV epidemic in many ways, all to the detriment of women:

- Women can be infected with HIV through forced sex. The chances of a woman contracting HIV via a forced sexual encounter are probably increased since forced sex often involves trauma and tissue tearing which can provide an opening to the virus.
- Sexual abuse in childhood is associated with risk-taking behaviour later in life, increasing an individual's lifetime risk of contracting HIV.
- Violence and fear of violence can prevent a woman, even one in a consensual union, from insisting on condom use or refusing unwanted sex. Since condom use and abstinence are currently the only dependable and widely available means of avoiding HIV infection, this leaves women with no means of protecting themselves.
- Fear of violence, stigma, and abandonment can dissuade women from learning about their HIV status – or, if they do learn it, from sharing the result with their partners.
- Since violence can affect women's willingness to be tested, it can also have a detrimental effect on HIV prevention, treatment, and access to PMTCT (prevention of mother-to-child transmission) programmes.

Adapted from: http://www.who.int/gender/violence/vawandhiv/en/index.html

4. HIV Prevention and young people

HIV prevention is the key to reducing infection rates and slowing the epidemic. Young people between the ages of 15 and 24 are at the centre of HIV epidemics for transmission and impact. They are both the most threatened and the greatest hope for turning the tide against HIV, by changing attitudes and behaviours that contribute to the epidemics.

There is an urgent need for HIV prevention strategies that work for young people because:

- Nearly half of the global population is less than 25 years old.
- Of the new HIV infections annually, about 40% are among young people (aged 15-25 years).
- HIV prevalence among young people is rising rapidly in some countries.
- The future epidemic will be shaped by the action and behaviour of young people.
- A variety of factors place young people at the centre of HIV vulnerability.

It has been shown that young people **can** protect themselves and others if they receive support. The 2006 Report on the Global Aids Epidemic documents behaviour changes, including delays in first sexual experience, increasing use of condoms by young people, and resulting decreases in HIV prevalence in young people in some sub-Saharan countries.

Health workers can use HIV prevention as an entry point for developing a broader adolescent health and development agenda because many other problems are linked to HIV in terms of cause and effect, e.g. too early pregnancy, alcohol, drugs and domestic violence.

Aims of HIV prevention

- To prevent transmission of HIV for all people who are HIV-negative or HIV-positive (whether they know their status or not) in order to reduce the number of new infections.
- To help people who are HIV-negative (whether they know their status or not) to stay negative.
- To promote testing and counselling for people who do not know their HIV status.

Young people need the information and the skills to bring about behaviour change. They need to understand the concepts of risk behaviour, such as unprotected sex and the use of alcohol and drugs, the possible consequences of such behaviour and how to avoid them. They need access to a range of information, life skills, and HIV prevention methods (including information on the advantages of delaying sexual activity, safer sex, negotiation and correct use of condoms, and the importance of sterile needles and syringes) to be able to opt for healthy choices in risky situations. Comprehensive prevention means encouraging young people and supporting them to be aware of their options for a safe life, and assisting them to make the right choices for their individual situation and circumstances.

Young people everywhere report that the education they receive about HIV and sexual reproductive health is too little and too late. Adults are often hesitant to provide young people with the facts about HIV prevention and sexual health, often because they fear this will encourage sexual activity. But there is compelling evidence from studies conducted around the world and in many different cultures that, in fact, sex education encourages responsibility. Knowledgeable young people tend to postpone intercourse or, if they do have sex, to use condoms.

Studies show that sex education does not lead to increases in sexual activity, pregnancy rates or rates of STI. Some studies show that HIV sexual education can delay the onset of sexual activity, reduces the number of sexual partners, or reduces unplanned pregnancy and STI rates. (*Impact of HIV and Sexual Education on the Sexual Behaviour of Young People: A Review Update*. UNAIDS, 1997).

The most significant services for the prevention and care of HIV among young people are those that (*Protecting Young People from HIV and AIDS: the Role of Health Services.* WHO, 2004):

- Strengthen the ability of young people to avoid infection, including information and counselling interventions.
- Reduce risks by providing condoms for those who sexually active, and clean needles and syringes for those who are injecting drugs.
- Provide diagnosis, treatment and care for sexually transmitted infections and for HIV and AIDS.

Who has a role in HIV Prevention?

HIV prevention requires a broad response from all members of society to ensure an environment where young people feel safe and supported and able to protect themselves from HIV at home, school, work and in their community.

- **Young people**

  HIV prevention must focus on young people because they have an essential role in slowing the epidemic. Many young people listen to and believe their peers, so that peer educators and counsellors have an essential role in HIV prevention among young people. Young people can be trained to spread messages and promote responsible behaviour among their friends and colleagues.

- **Parents and other adults in the community**

  All adults have a role to play in their personal capacity as parents, members of extended families and as adult role models. They may also have a professional role as teachers, sports coaches and religious leaders. Studies have identified that having a positive relationship with parents, teachers and other adults in the community and having spiritual beliefs help adolescents to avoid behaviour that puts them at risk of HIV.

  Health workers in all departments of the health service have a critical role in developing and providing HIV prevention services to ensure that effective health strategies are available for all young people.

  There are some young people who have a higher risk of HIV exposure. People in the community need to be trained, given support and provided with the tools to work with young people who are most at-risk. Targeted strategies must be available that focus on their needs. (e.g. harm-reduction strategies for young injectors, information on safer sex and free condoms for young sex workers, and outreach information programmes for out-of-school youth).

- **Public idols who are role models for young people**

  Musicians, film stars and sports figures provide role models for young people through their personal lives and through their performances. The images and messages they portray should encourage young people to adopt and maintain healthy behaviours.

- **Government leaders and the media**

  Politicians, journalists and bureaucrats can influence the social, economic, political and normative factors that determine the HIV risk in the environments where young people live and work. There are policies and_strategies (e.g. free schooling for boys and girls) that can reduce the vulnerability of young people to HIV. The public image of sexuality and HIV in the media also influences young people. There is a need for codes of practice, regulations and education of the media to ensure that they carry out responsible advertising and programming.

- **People living with HIV (PLHIV)**

  PLHIV have a role in HIV prevention. Their personal role is to ensure they do not transmit HIV to any other person. They may also choose to have a role as a supporter or an activist for other PLHIV, as an educator or speaker on living with HIV, as an advocate for the rights of PLHIV or other public or community roles. People living with HIV are frequently subject to discrimination and human rights abuses. A strong movement of PLHIV can develop a network that provides mutual support and a voice at local and national levels and can be a particularly effective method of tackling HIV stigma.

Key HIV prevention strategies for young people through health services

HIV prevention services must be offered to young people when they attend every department of the health services (tuberculosis clinics, STI clinics, ante-natal clinic, family planning clinic, and sexual and reproductive health clinics and services). These services need to be youth friendly (available, accessible, acceptable, appropriate and effective) for all young people.

Key prevention strategies for young people cannot be the same for all but need to be adapted to the different needs of many young people (e.g. boys and girls, children in and out of school, younger and older adolescents, and married and unmarried young people).

- **Information and education on HIV and safer sex**

  Many young people say they need more education on sexuality and HIV prevention to help them practise responsible sexual behaviour. It has been shown that young people can responsibly protect themselves and others if they receive support. Postponing the first sexual activity and reducing the number of sex partners can significantly protect young people from HIV. Behaviour change communication can help young people develop positive behaviours. The messages and the way they are given are very important for young people, they do not only want to hear what they cannot do, but also what they can do.

- **HIV testing and counselling**

  Provider-initiated testing and counselling and voluntary counselling and testing services need to be available at all health services and in the community. In some settings, health workers have held group counselling sessions with young people - PLHIV, HIV-negative or unknown status - to discuss difficult situations in living with HIV and HIV prevention. This method creates a good dynamic because the group looks for solutions to situations, taking the focus away from the individual. This method has been used both for giving information on sexuality and HIV and also for opening the discussion on many sensitive issues faced by young people (e.g. peer pressure, condom negotiation, unwanted pregnancy, decision- making, how to be an adult, disclosure of HIV status).

- **Access to male and female condoms**

  The use of latex condoms to prevent the exchange of body fluids during sex is an essential element of all HIV prevention. Safer sex depends on the correct and consistent use of condoms, so condom provision must be accompanied by clear instructions on condom use for every act of penetrative sex. Female condoms offer women an option that may give them more control but they also require more counselling and assistance with respect to their proper use; they are also more expensive and less available. Condom promotion also supports dual protection, i.e. the simultaneous protection against unwanted pregnancy and the possible transmission of STIs/ HIV by either the consistent use of condoms or the consistent use of condoms with another method of contraception.

- **Harm reduction for drug injectors**

  Young drug injectors are particularly at risk of acquiring HIV, since they may not have the knowledge or skills to protect themselves from infection via contaminated injecting equipment. With young injectors it is important to help them to understand the risks, and to assist them to reduce or stop injecting. Harm reduction is about reducing the harmful effects of IDU for those who do not stop injecting. Strategies include education programmes, counselling, drug substitution, and needle-syringe programmes. The strategies need to be acceptable and accessible to young people.

- **STI management**

  STIs greatly facilitate HIV transmission and acquisition between sexual partners, so treating and preventing them is an important step in HIV prevention. In some settings, STI rates among young people are high. Effective and early treatment of STIs is an essential part of HIV prevention.

Questions for the health worker when planning HIV prevention services for young people

- *What is happening in my community with young people and HIV?*

  Talk to young people and young PLHIV to find out what is happening in your community, the risk and protective factors in their lives, where transmission may be occurring, and what they identify as their needs to prevent transmission of HIV. Encourage them to plan and contribute actively to developing HIV prevention services.

- *What contribution can I make to HIV prevention?*

  Look for what you could do. Start small. Learn from what has been done elsewhere. Look for support from young people, other professionals and community members. You can begin by talking about the issues of HIV and young people to colleagues and community members.

- *What barriers are there (in myself, my work environment and my community) that could hinder my contribution?*

  HIV and young people raise many sensitive issues around sexuality and sex. Health workers, young people and community members often feel uncomfortable discussing and addressing these sensitive issues. If health workers are to work successfully with HIV and young people, it is important for them to examine their attitudes and practices and reflect on the material in the Orientation Programme. There is discrimination towards PLHIV among health workers and in health services. Identify and examine reasons why young people cannot or may choose not to go to health services in your community (e.g. legal restrictions, attitudes of personnel, lack of confidentiality or privacy, etc.).

- *What can I do to overcome these barriers?*

  Look for formal and informal ways to discuss sexuality and HIV with members of your community. Help them to see the importance of the issues and the consequences for young people of not addressing HIV prevention. Health workers have an important professional responsibility to address these sensitive issues, even if they if they do not themselves approve or condone the behaviours and life styles of the affected young people. All health workers have a responsibility to act with respect, professionalism and proper procedures towards all people, including PLHIV. Talk with others about what you have learnt and the changes that you plan in your practice. Look for help from others to overcome barriers to developing HIV prevention services in your community.

- *Who else do I need to work with?*

  Contact people who are already working with HIV and young people in your community or region and learn from their experiences (youth groups, nongovernmental organizations, health professionals, teachers, peer support groups, community leaders, etc.). Identify difficult areas of work (e.g. issues of consent and confidentiality with patients who are minors) and discuss what can be done in practical terms. Join or develop networks of people working with these issues for support and for sharing information. Plan together, so that the strategies and HIV prevention messages that youth hear and see are consistent and complementary.

BOX 7

Post-Exposure Prophylaxis (PEP)

Post-Exposure Prophylaxis (PEP) is short-term antiretroviral treatment that is given to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. Within the health sector, PEP should be provided as part of a comprehensive universal precautions package that reduces staff exposure to infectious hazards at work.

The risk of exposure from needlesticks and other means exists in many settings where protective supplies are limited and the rates of HIV infection in the patient population are high. The availability of PEP may reduce the occurrence of occupationally acquired HIV infection in healthcare workers. It is believed that the availability of PEP for health workers will serve to increase staff motivation to work with people infected with HIV, and may help to retain staff concerned about the risk of exposure to HIV in the workplace.

Prevention of exposure remains the most effective measure to reduce the risk of HIV transmission to health workers. The priority must be to train health workers in prevention methods (universal precautions) and to provide them with the necessary materials and protective equipment (e.g. gloves, sterilizing equipment).

There is significant debate on the need to use PEP after sexual exposure. PEP must be commenced less than 72 hours after unprotected sex. There are very strong ethical and societal issues for providing PEP following sexual exposure to HIV, especially following rape or condom breakage.

For more information see: http://www.who.int/hiv/topics/prophylaxis/en/print.html

5. HIV testing and counselling among young people

The current concept of HIV testing and counselling has been broadened from making these available to those who ask for it at, for example, Voluntary Counselling and Testing (VCT) sites, to provider-initiated HIV testing and counselling (PITC). In all testing and counselling situations the patient always retains the right to refuse.

In the PITC approach, each encounter between a patient and a health worker is seen as an opportunity for:

- people who have never been tested (or were previously negative) to know their current status;
- people to discuss options and make choices according to their status;
- health workers to provide the best care and prevention according to the patient's HIV status.

HIV testing and counselling is an important entry point to prevention, care, treatment and support. It is a crucial prevention intervention and is an important opportunity for people who test negative. HIV testing must only be offered with the 4 Cs: Confidentiality, informed Consent, Counselling and Condoms.

Knowing one's HIV status

Knowing their HIV status and receiving counselling and support can enable *individuals* to:

- **Initiate or maintain behaviours to prevent acquiring or transmitting HIV**

  Learning about one's HIV serostatus, with counselling support, can be a time when young people are open to making changes in their risk behaviour. This empowers those who are not infected to remain so, and those with HIV to access care and prevent further transmission. Correct and consistent condom use must be actively promoted by all testing and counselling services. Group counselling of young people can be a way of discussing difficult situations with HIV and the benefits of testing, and taking the focus away from the individual.

- **Gain early access to specific HIV-positive prevention, support, care and treatment**

  Young PLHIV will probably remain asymptomatic for a long period after a positive-HIV test result. They can benefit from the scaling up of antiretroviral therapy only if they know their HIV status. The earlier they know that they are HIV-positive, the sooner they can receive counselling and support and reduce the risk of transmitting HIV, thus protecting themselves, their partners and their loved ones.

- **Access strategies to prevent transmission from mothers to their infants**

  In some settings, mother and child health (MCH) clinics can offer HIV testing and counselling and antiretroviral drug regimens to prevent mother-to-child transmission (PMTCT). However, globally only a small proportion of pregnant women have access to these services.

Knowing their HIV status and receiving counselling and support can help *communities* to:

- **Reduce the denial, stigma and discrimination that surround HIV**

  Communities that normalize the process of including HIV serostatus as part of general health-seeking behaviour have a greater chance of tackling the stigma and discrimination associated with the disease.

- **Mobilize support and appropriate responses**

  Community mobilization can be facilitated if more people know their HIV status. In communities where people have a friend or relative with HIV, the stigma associated with the virus can be less and support for PLHIV can grow. However, we may only reach this level in high prevalence settings.

  All people, including young people, have a right to know their HIV status. However, any coercion to get tested must be strictly avoided.

Special considerations in HIV testing and counselling among young people

- **Do not discount the potential for HIV in young people**

  It is important that health workers look for the possibility of HIV infection among young people because a large number of them are particularly vulnerable. Health workers should therefore encourage them to consider being tested. Even if they don't want the test immediately, they must be invited to come back when they are ready and meanwhile be provided with links to other support services in the community. Young PLHIV will have a long asymptomatic period when early diagnosis is rare without an HIV test, and to assume there is an infection is difficult.

- **Understand the issues of consent and confidentiality in HIV testing and counselling of minors**

  As with any patient, consent and confidentiality are important considerations with under-age young people (minors) who come for HIV testing, especially if they are not accompanied by an adult. Each situation is different. If possible, an assessment should be made of the young person's risk for HIV, the possibility of not returning for testing, and his/her capacity to understand informed consent. Health workers should take into account the best interests of young persons and their evolving capacities. All health discussions with minors should be kept confidential, unless unlawful.

  Parents or guardians should not be informed of an adolescent's HIV status without the explicit consent of the adolescent who is deemed capable of providing the informed consent. The Convention on the Rights of the Child states this clearly: "Information on the HIV status of children may not be disclosed to third parties, including parents, without their consent".

  In many settings, allowances are made for groups of adolescents who are designated "mature" or "emancipated" minors (e.g. those who are married, sexually active or are pregnant) to provide consent for themselves for some services.

  Each situation is different and an assessment should be made of the young person's risk for HIV and the possibility that he/she will not return for testing. HIV testing and counselling without parental consent should be considered, if appropriate; this should be documented in writing and possibly shared between two members of staff. There may be legal restrictions on performing an HIV test without the consent of a parent or guardian and this is a significant barrier in many settings to an adolescent being tested.

- **Remember that your first meeting with a young person may be your only meeting**

  It is important to take advantage of the initial session with young persons, as it may be your only chance to communicate the importance of the reality of HIV and of living "safe". Because they may not come back, make sure that they have educational materials and links to community services and peer support, where they can access further information and support at a later date.

  Community links and referrals need to be checked out in advance, to ensure that they are legitimate. Keep the information in a resource file which you can access easily when you wish

to refer young people. If possible, you can offer to accompany them to the support service. Also encourage them to return to see you. If support services do not exist, you can consider starting a support group.

- **Promote beneficial disclosure**

  All PLHIV need support to cope with living positively. Support from family and close friends can be particularly important, but they can only access this support if family or close friends know their HIV status. Counselling can help them to understand the benefits of revealing their HIV status. They may need to think about this and even to practise, through role play, how to tell friends and family. Peer support groups are especially valuable to share their concerns and experiences, and counselling can help them as regards whom to tell and how to go about it.

  However, health workers need to be aware that there is a risk in disclosing HIV status in an unsupportive setting, particularly for young women who may be at risk of domestic violence. Young people need a lot of support around issues of stigma and disclosure of HIV status, which may involve disclosing their sexual activity and injecting drug use. The final decision on disclosure stays with the young person.

- **Take the opportunity given by a negative HIV test**

  An HIV negative test result provides an opportunity to discuss risk behaviour and promote behaviour change with young persons. Prevention education and risk-reduction counselling can help them to consider, plan and implement changes in their HIV risk behaviour. Promotion of condom use should be part of all counselling sessions, and include distribution of condoms, as appropriate.

- **Promote future counselling of client together with their sexual partner**

  Couple counselling can help to avoid the situation where the partner who receives a positive test result is blamed. It is also an opportunity to discuss condom use. With a discordant couple (when one person is HIV positive and the other is negative or of unknown HIV status), couple counselling can provide support to each partner to help them cope with the situation. However, there are situations where couple counselling is not possible.

- **Promote safer sex and harm reduction**

  Safer sex includes delaying first sexual activity, reducing the number of sexual partners (or delaying sexual activity in a new relationship), and using condoms correctly and consistently. Harm reduction includes strategies and approaches that reduce the physical and social harms associated with risk-taking behaviour. Harm reduction among IDUs can include abstinence, education programmes, counselling, drug substitution and needle exchange. Harm reduction among sex workers includes correct and consistent use of condoms.

- **Promote peer counselling by other young PLHIV**

  Young people need the support and practical experience of other people in their situation who are coping well with living with HIV.

Circumstances in which young people may present for HIV testing and counselling

There are different reasons and situations why a young person may come for testing and counselling.

- **Choice:** the young person makes the decision to come for testing

  Young persons may have recently experienced a situation which makes them think they could have been at risk for acquiring HIV (e.g. rape, condom breakage, unprotected sex, first experience

with injecting drug use). They may have a marker disease (e.g. tuberculosis) or an STI, or be on the brink of something new in their lives (e.g. marriage).

- **Recommendation:** another person advises, the young person decides

  Provider-initiated HIV testing and counselling recommends that health workers offer this service during all routine contacts with patients in healthcare settings. The health worker may be following the health centre's policy or guidelines. All people should be informed and give their consent and the patient always retains the right to refuse the test.

  A health worker may have some reason to suspect that a young person could be HIV-positive, e.g. presence of a marker disease like tuberculosis. Having an STI increases the risk of acquiring and transmitting HIV, so a young person who has an STI or TB should be advised to be tested for HIV. Young people who are vulnerable to HIV (e.g. sex workers) should be counselled to be tested for HIV. Peer counsellors, outreach workers or youth counsellors may have to recommend that the young person comes for HIV testing.

- **Mandatory:** other persons/people make the decision to test the young person

  Mandatory screening of donors is required prior to all procedures involving transfer of body fluids or body parts. There may be other reasons for HIV tests in various situations, e.g. entering the military, before marriage, and applying for a job, visa or scholarship. HIV tests may be carried out in healthcare settings without the patient knowing. Testing without counselling has little impact on behaviour and is a significant lost opportunity for assisting people to avoid acquiring or transmitting HIV.

  WHO does not recommend mandatory HIV testing as an effective public health strategy. Mandatory testing is not ethical and does not respect the human rights of an individual.

For young people who refuse HIV testing, the health worker should:

- counsel them on the benefits of testing;
- identify and discuss their barriers to testing;
- provide emotional support and refer them to peer counselling;
- re-assess their intention to test at a later date;
- offer a follow up appointment.

BOX 8

Rapid HIV testing

Rapid HIV testing with results the same day is recommended for all people, especially young people.

- Rapid testing ensures that the young person gets the result and receives counselling immediately. It took a lot of courage to come to the clinic the first time and he/she may not return a second time, even if that means never receiving the HIV test result.
- Rapid testing allows for same-day results. Most tests can be read within 20 minutes. If the first test result is positive, another Rapid HIV Test must be performed (confirmatory test). With a second positive result, the patient can be counselled for a positive result. If the second test is negative, then the result is considered inconclusive and the algorithm is repeated. This situation happens very rarely.
- There may be an algorithm for HIV testing in your national guidelines for HIV Testing and Counselling. WHO has developed an HIV Testing Policy Statement.

6. Management of HIV in young people

Management of HIV in young people includes a range of services that provide (a) care, (b) treatment, (c) support, (d) positive prevention for young people living with HIV, and (e) counselling, which is an integral part of all these services.

The aim of services is to help young PLHIV to:

- **Stay healthy and live positively**

  Positive living can help PLHIV to live a full and healthy life. Counselling and support can help them to stay healthy and improve their self-esteem and confidence, with the aim of protecting their own health and avoiding passing the infection to others. Health workers can support the efforts of these people to prevent other infections, take part in physical activity, avoid harmful treatments and maintain good nutrition. They can refer them to other community services for emotional and peer support (e.g. young PLHIV support groups, post-test clubs).

- **Adhere to care and treatment**

  Young PLHIV may need to take medication for a range of infections and illnesses. Adolescents infected through perinatal transmission may have begun antiretroviral therapy (ART) in childhood. Otherwise, as HIV progresses they may require ART. Adherence to all treatments is important. Adherence to ART is important for the health of the individual and to reduce the risk of drug resistance.

- **Understand the benefits of disclosing HIV status to family, sexual partner(s), close friends**

  PLHIV may be hesitant to reveal their HIV status to others for fear of stigma and discrimination. In order to receive the support of family and friends, young PLHIV will need to face the difficult task of telling them of their HIV status. Adolescents who were infected through perinatal transmission may not know that they are HIV-positive, though they have probably suspected. However, there is a risk of disclosing HIV status in an unsupportive setting; women, in particular, may be at risk of domestic violence.

- **Cope with stigma and discrimination towards themselves and their loved ones**

  Health workers have an important role to play in combating stigma and discrimination and assisting young PLHIV to cope with how it can affect them, their families and their loved ones. Unfortunately, health centres are still a place where there is HIV stigma and discrimination against PLHIV. Young PLHIV should be involved in developing and planning of HIV support services. This can lead to improved utilization and ownership of services, as well as reduce the stigma and present a positive role model to healthcare workers and patients.

(a) CARE

Management of HIV is based on medical care and psychosocial care in a healthcare setting. It includes antiretroviral therapy (ART), care and treatment of opportunistic infections (OI) and STIs, and also treatment of other conditions (e.g. cancers, depression).

The ten principles (see Box 10) can be used in managing many diseases, including HIV, and risk conditions. HIV can be a chronic disease, especially for young people who may be living with the virus for many years with no symptoms. ART has also changed HIV to a chronic disease. These principles are described below with regard to their application to caring for young people with HIV.

BOX 9

Young people and HIV stigma and discrimination

HIV-related stigma is when unfavourable attitudes, beliefs, and policies are directed to people who are perceived to have HIV or AIDS, as well as to their loved ones and others (like close associates, social groups, and communities).

HIV-related discrimination results when actions differentiate between people based on stigma (e.g. a confirmed or suspected HIV serostatus). Persons associated in the public mind with HIV or AIDS (e.g. homosexuals, prostitutes, drug addicts, haemophiliacs, family members and associates of HIV-positive people) may also face discrimination.

HIV-related stigma, discrimination and human rights violations are serious barriers to progress in understanding HIV infection, to providing care, support and treatment, and to alleviating the impact of the epidemic.

Discrimination occurs when ill-informed people or institutions treat individuals unfairly or unjustly because of their presumed or actual HIV status. This can be through actions or omissions to act and result in a violation of human rights.

Patterns of prejudice, which include devaluing, discounting, discrediting, and discriminating against these groups of people, play into and strengthen existing social inequalities—especially those of gender, sexuality, and race—which are at the root of HIV-related stigma.

Factors which contribute to HIV-related stigma:

- HIV is a life-threatening disease.
- People are scared of contracting HIV.
- The disease is associated with behaviours (such as sex between men and use of injecting drugs), which are already stigmatized in many societies.
- People living with HIV are often thought of as having been responsible for becoming infected.
- Religious or moral beliefs lead some people to believe that HIV is the result of a moral fault (such as promiscuity or "deviant sex") that deserves to be punished.

Stigma and discrimination discourage people from getting tested for HIV. They also discourage those who are infected with HIV from obtaining needed services because this may reveal their HIV status.

BOX 10

General principles of good chronic care

- Develop a treatment partnership with your patient.
- Focus on your patient's concerns and priorities.
- Use the 5 A's – Assess, Advise, Agree, Assist, Arrange.
- Support the patient's education and self-management.
- Organize proactive follow-up.
- Involve "expert patients", peer educators and support staff in your health facility.
- Link the patient to community-based resources and support.
- Use written information – registers, treatment plans, patient calendars, treatment cards – to document, monitor, and remind.
- Work as a clinical team (and hold team meetings). Each team must include a district ART clinician.
- Assure continuity of care.

Source: *Chronic HIV Care with ARV Therapy, Integrated Management of Adult and Adolescent Illness* (IMAI), WHO, 2004.

Good chronic care for young people with HIV

Here are some general principles for good chronic care applied to young people living with HIV.

- The treatment partnership is a treatment plan that is decided between the young person and the health worker. Young PLHIV may respond well to this because it gives them some ownership and control over their treatment and lessens the feeling that they are being told what to do. This involvement of adolescents is important because they can be encouraged during the change from paediatric to adult care.
- By asking about and listening to the young patient, it is possible to respond to the issues that they see as the most important. Each young person may have different concerns which will change over a period of time. Their concerns and priorities may be different from what we expect. Respond to any signs and symptoms that the young patient is experiencing at the moment.
- The 5 A's are a key part of good chronic care. They are a series of steps used in caring for patients: Assess, Advise, Agree, Assist and Arrange. You can respond to a patient's symptoms and problems using the 5 A's (refer participants to Box 11 in the Handout). The Assist and Arrange will be particularly important for young people in order to provide them with links and support to other services.
- Many young people continue to have misconceptions about HIV. Young PLHIV need HIV education and care plans to help them manage to live positively. Young people may especially need support in their self-management. Involvement of PLHIV peer counsellors, family and friends is essential.
- Young patients may not return to clinic appointments. Health workers need to follow up on them (e.g. home visits or going to places where young people gather). However, this needs to be done with tact and while ensuring confidentiality. Find creative ways to encourage young patients to come back.
- It is very important for young PLHIV to be part of the planning and implementing of HIV services in the clinic and community. Their perspective will influence the work of the other professionals and provide a convincing example of positive living to other young clients. Encourage training and support for young PLHIV as peer counsellors to facilitate support groups and youth support services. HIV information presentations by peer educators at schools, post-testing groups, football clubs and girls' clubs can raise awareness and encourage young people to seek testing and counselling. Encouraging self-management can improve their understanding of their care and prepare the adolescent for adult care.
- It is essential to provide links and referrals to other health services, peer support groups and other community-based resources. Ensuing continuity of care to meet immediate and longer-term needs of the young person is vital to maintain support in the community and home. Keeping a resource file of services for young people can help health workers to access local information easily.
- Patients' records need to be kept so that different support services can maintain continuity of care. Pictures, diagrams or words written out for an individual patient can assist young patients in understanding treatment plans and remembering treatments, appointments and information. Written information can be presented in a way that is interesting and attractive to young people.
- Working as a clinical team ensures that the patient receives consistent care and information from all staff at the clinic. Patients may be more comfortable if they see the same carer at each visit and are able to build up a relationship.
- Continuity of care is important in the clinic and through community support services. Young PLHIV may be using the services over many years and continuity of care ensures that the changing needs of the young client and their family can be met.

BOX 11 - part 1

Guide for health workers: using the 5 A's with a young patient living with HIV

The 5 A's are a key part of good chronic care. They are a series of steps used in the IMAI approach to Chronic HIV Care with ARV Therapy to guide health workers at each consultation. Described below are the 5 A's with particular focus on the issues that are important for a young patient living with HIV.

Note: If the patient is a minor, you must know the legal requirements in terms of consent, bearing in mind the best interests of adolescents and their evolving capacities.

ASSESS

- Assess young patient's goals for this consultation: they may be different from yours.
- Assure them of confidentiality.
- Assess the patient's physical and mental status, understanding that HIV may progress more slowly in adolescents than in adults.
- Review current treatments and assess adherence.
- Assess whether sexually active or not (or planning to be sexually active), contraception and condom use.
- Assess young women for pregnancy.
- Assess other risk factors for HIV transmission (e.g. injecting drug user, orphan, sex worker).
- Assess young patient's knowledge, beliefs, concerns, and daily behaviours related to HIV.
- Assess support structure and who knows of their HIV status (partner, family, friends, etc).

ADVISE

- Use plain language and a non-judgmental attitude. Include parents or guardians in discussions, if this is the young person's choice.
- Correct any inaccurate knowledge and complete gaps in the young patient's understanding of his/her condition.
- Advise on being young and living with HIV (relationships, sex, alcohol and drug use, etc.).
- Advise on sexual activity, condom use, contraception. and other aspects of positive prevention
- Discuss couple counselling and advise on benefits of disclosing HIV status to chosen people, in order to develop support structure.
- Advise on peer support from other young people living with HIV.
- Advise on adherence.

If developing a Treatment Plan:

- Discuss the options available to the young patient (risk reduction, positive prevention, prophylaxis and treatment).
- Advise about the simplest regimen possible. Evaluate the patient's confidence and readiness to adopt and adhere to treatment.
- Take adolescent developmental phase into consideration in prescribing ARV therapy (using Tanners Stages).
- Discuss any proposed changes in the Treatment Plan, relating them to the patient's specific concerns.

AGREE

- Agree on where the young person would choose to receive treatment and support.
- Discuss to whom they choose to disclose their HIV status.
- Discuss how they may disclose and the support they may need.
- Agree on the roles that the young person and others will play in their care and treatment.
- Agree on the treatment plan that has been developed.
- Agree on goals that reflect the young patient's priorities and ensure that the negotiated goals are:
  - clear;
  - measurable;
  - realistic;
  - under the young patient's direct control;
  - limited in number.

BOX 11 - part 2

Guide for health workers: using the 5 A's with a young patient living with HIV

ASSIST

- Provide a written or pictorial summary of the plan.
- Provide referrals to youth friendly health services in the community.
- Provide links to support services for youth living with HIV in the community.
- Provide treatments and other medications (prescribe or dispense).
- Provide skills and tools to assist with self-management and adherence, including adherence equipment (e.g., pill box by day of week and self-monitoring tools, such as a calendar or other ways to remind and record the Treatment Plan).
- Address obstacles to adherence (e.g. side-effects, weight gain, medication being a constant reminder of HIV status)
- Help patients to predict possible barriers to implementing the Treatment Plan and to identify strategies to overcome them.
- Assist with patient's physical, mental and social health, including the provision of sychological support as needed. If young patient is depressed, treat depression.
- Assist by strengthening the links with available support:
  - friends and family;
  - peer support groups;
  - community services;
  - treatment supporter or guardian (for certain treatments).

ARRANGE

- What the young person will do during the time between visits.
- Agree on the next appointment date and underline the importance of attending even if they feel well and have no problems.
- Schedule for group counselling or links with young PLHIV support group.
- Record what happened during the visit.

(b) TREATMENT

Treatment includes antiretroviral therapy (ART), prevention, treatment and care of opportunistic infections (OI) and STIs. Treatment also includes management of other chronic conditions (e.g. cancers, depression). This module does not discuss the full range of clinical care but the IMAI booklets provide guidelines. This module will give some information on ART and young people.

There are distinct groups of HIV-infected adolescents who may require ART, but have different needs because of their infection history. For adolescents who were infected around birth and have survived into adolescence, HIV disease may develop as rapid progression or slow progression. In rapid progression, they may have begun ART during childhood and are likely to have had experience with different treatments. These adolescents may face challenges relating disclosure of HIV status, developmental delays, transition of care from paediatric to adult care, and choice of appropriate ART regimens and adherence. Adolescents who were infected around birth with slow progression of HIV disease may present for the first time to ART services during adolescence; their treatment and care needs are similar to those who become infected during adolescence.

ART-related issues

- **Life-long treatment**

  ART is a life-long treatment and this creates a challenge for adherence. To be told you need to take potent drugs all your life can be overwhelming for anyone and for young people this news may be even more distressing. Adherence to ART is essential and will be discussed later.

- **Timing of when to start ART**

  Decisions on when to begin a young patient's treatment can be very difficult. Young people may not need ART for many years. WHO has developed a system of HIV Clinical Staging that gives guidance to health workers on when to begin treatment (see IMAI Guidelines).The young person should be involved in the decision to begin therapy through an agreement that shares responsibility with the health worker.

- **Fixed-dose combination (FDC) drugs**

  ART is multi-drug therapy. Mono-therapy is not recommended because of rapid development of drug resistance. FDC drugs are pills containing 2 or 3 substances in one tablet (e.g. a triple combination with three substances). Many young people prefer them as it means they do not have to take medication during the day. FDCs are easier to distribute and store, assist in improving adherence, and reduce the incidence of treatment failure and drug resistance. FDC drugs are recommended by WHO as first-line treatment in developing countries. Drug doses need to be managed with care for young people using the Tanner scale (see Box 12).

- **First- and second-line treatment**

  National regulating authorities select their first- and second-line treatment regimen which is usually a triple combination. Patients will only change to a second-line treatment regimen if the first-line treatment fails and the patient starts to decline clinically or immunologically (CD4 count falls). Generic drugs are not inferior to brand name drugs. They are subjected to the same rigorous quality assurance as brand name drugs and their active ingredients are exactly the same. The difference is in their cost, generic drugs being much cheaper, which enables drug budgets to go further to treat more people.

- **ARV drugs are potent and cause side-effects**

  ART use highly potent and potentially toxic drugs with a range of side-effects. Some can be experienced on a daily basis and others can be long-term effects on a patient's physical development and future outcomes. These include changes in body shape, fertility, puberty and growth. Young people need an opportunity to discuss and understand these effects. Fortunately, most persons starting ART are able with support to manage the early or minor side-effects and can successfully take the first-line drugs even for several years.

- **Drugs can interact with treatments of other conditions**

  ARV drugs may interact with other treatments (e.g. TB, antidepressants) and may pose problems for the patient on ART. For the individual patient, management of life-threatening opportunistic infections may be a higher priority than ART.

- **Equity and fair distribution**

  WHO advocates a public health approach to ARV drugs. Equity and fair distribution are essential for ARV drug distribution. Nevertheless, it is difficult to put this into practice and there are settings where ARV drugs are still not available.

BOX 12

ART regimens and dosages for young people

This module orients health workers to HIV and young people but does not aim to provide training in prescribing ART.

WHO has developed a clinical training course that uses simplified guidelines to train first-level health workers in chronic HIV care including ART (IMAI Basic ART Clinical Training Course). This enables health workers to provide quality ARV therapy to PLHIV in their communities.

ARV drug doses need to be managed with care for young people. WHO recommends basing the choice of ART regimens and dosages for adolescents on Tanner staging. The Tanner stages are stages of physical development in children, adolescents and adults. The stages define physical measurements of development based on external primary and secondary sex characteristics. The stages are based on observing the development of the genitalia in boys, the development of the breasts in girls and the growth of pubic hair in both sexes.

Adolescents in Tanner stage I, II and III should be begun on paediatric schedule and monitored particularly carefully because they are at a time of growth-spurt hormonal changes. Adolescents in Tanner stage IV or V are considered adult and should receive adult-dose ARV regimens. In choosing ARV regimen for adolescents it is also necessary to consider simplification and long-term adherence, and to consider the use of EFV (efavirenz) and NVP (nevirapine) in adolescent girls who are at risk of pregnancy.

Challenges in maintaining adherence to ART for young PLHIV

Adherence to ART regimens is a struggle for most people but may be especially difficult for young people. Adherence can be difficult because many young people:

- prefer to live in the present rather than plan into the future;
- desire their independence and want to move to adulthood;
- have not disclosed their HIV status to people who could support them, because of feelings of shame or fear of stigma. (Adolescents who had been infected around birth may not know their HIV status, although they may suspect this.)
- are afraid that taking regular medication can identify them as having HIV and expose them to HIV stigma and discrimination.

Some of the factors contributing to non-adherence relate to young people themselves and some to the features of drug regimens. Factors that improve adherence include:

- informing young people of their HIV status if they do not know (as with perinatal transmission);
- providing a support system to assist with clinical care and advice (e.g. management of side-effects, simplifying the dosage, monitoring of missed doses, etc.);
- accessing peer support to help them with finding strategies to assist with adherence and improve self-esteem and reduce the stigma of HIV;
- providing clear information on HIV, the aims and advantages of the regimen, and the importance of adherence. Prescribe the easiest possible ART regimen (e.g. single dose);
- giving the young person greater responsibility and understanding of their treatment by negotiating their care and coming to an agreement. This can be with a partnership or an agreement on treatment and care.

It is important to discuss adherence and adherence-related problems openly and with respect and empathy in every encounter with the young patient, and to seek solutions to any problems. Recently, health workers have moved towards making an agreement with young patients in order to give them a greater sense of personal responsibility in their HIV care.

(c) SUPPORT

Support deals with the emotional, spiritual and material support for young PLHIV, which is often provided by peers, family and community.

Support for young PLHIV

- Support may be connected to ART and care. However, support for young people should start before ART. The majority of young people living with HIV do not have symptoms and may not need ART for many years, but they do need or will need support to help them cope with their HIV status. The support needed will be different for each young person.
- Support is about assisting young PLHIV to cope with the impact of HIV on their lives - on every aspect of life. Like all people, young people can feel overwhelmed and depressed by the prospect of living with HIV. They may not have the experience, relationships, or maturity to help them to cope as adults can. Having the support and positive example of other young PLHIV can be very valuable. Peer counsellors and peer support groups can provide information and practical support in a manner that is credible and acceptable.
- Support from the health services will change with the changing needs of the young PLHIV. It can begin with post-test support, continue over the years when the young PLHIV has no symptoms, and become ongoing support. Support for young people who have acquired HIV through perinatal transmission begins in the paediatric services. When the young person becomes an adolescent or young adult, paediatric care will no longer be appropriate. The transition of care is sometimes a difficult time and comes at a stage in their development when they especially need support to cope with the changes of adolescence. There are not many special services that address their particular needs. Transition of care needs to be planned in advance and introduced gradually.
- HIV has emotional, social and economic impacts on the families who frequently experience the stigma and discrimination associated with HIV. The young PLHIV's family, partners, household, community, work and school may all need support. They can also all be a source of support.
- Support includes all measures that alleviate the impact of HIV on the young PLHIV, their family and their community. As with all chronic diseases, there is usually less money in a household where a PLHIV lives. Young PLHIV may be in need of support strategies to meet their daily needs (e.g. spiritual, nutritional, sexual, financial, legal support and support to ensure their human rights are respected).

Psychosocial issues especially pertinent to young PLHIV

For most people, sexual activity begins during adolescence and, in general, sex is an important part of the lives of young people. Young PLHIV need practical support to deal with their questions, concerns and fears around being HIV-positive, wanting to have friendships and to be loved, and having or wanting to have sexual relations and children. Like all people, PLHIV have the right to have intimate relationships and children.

People who work with young PLHIV say that in general the following questions identify the young people's greatest concerns. Health workers may find it hard to raise and discuss these sensitive

issues and young people themselves may not be able to voice their concerns. The following responses can help health workers to talk with young people about these issues.

- *Will anyone want to have sex with me if they know I am HIV-positive?*

  PLHIV can continue to have sex. However, there is a high risk of HIV transmission if a PLHIV has sex without a condom. Always use a barrier to prevent contact with blood or sexual fluid. Condoms are the most common barrier for men. Female condoms can protect the vagina or anal area during sex. There is no way to know how risky it is for two HIV-positive people to have unprotected sex. Using a condom will reduce the risk. Use condoms correctly and consistently every time you have sex. Although it is not easy, it is important to tell your partner you are HIV-positive before there is any risk of HIV transmission. Counselling and support from other young PLHIV can help you to understand your options for enjoying a healthy sexual life as a PLHIV.

- *Will I be able to have children?*

  Like all people, PLHIV have the right to have children. HIV-positive women and couples have the right to choose for themselves whether they want to have children or not. You need to have access to sexual and reproductive services, including counselling to make you aware of your reproductive choices and the health risks for your unborn child, in order to make informed decisions.

  Couple counselling should be encouraged but an individual's situation may make this impossible and the health worker needs to support the young person's decision.

- *Will I die early?*

  Some young people may not understand the difference between HIV and AIDS. They may think that a positive test result means they will die soon. With more effective drug regimens and earlier detection, it is possible to remain healthy for many years. But the reality is that many young PLHIV will die earlier than they would without HIV.

  Emotional and spiritual support can help alleviate depression, help to prevent suicidal ideas, and help deal with the strong emotions associated with having a chronic and fatal condition. This support can come from many formal and informal individuals and settings. For young people, peer support is especially important. If peer support is not available, the health worker can be active in starting a peer support group for young PLHIV.

- *I am too young to have a chronic disease*

  Adolescence is a special time in peoples' lives. All people have dreams for the future and to learn that you must live with HIV is shocking news at any age. For young people it can be hard to imagine how they are going to live their whole lives with a chronic disease, when they feel that they have only just begun to live. All their desires for relationships, family life and career are overshadowed by the news. The health worker can play an important role in providing the young person with hope, and in helping him/her to develop the perception that life can continue - and be meaningful - even in the presence of HIV infection. Health workers can also provide referral to peer support.

- *I can't tell anyone that I am HIV positive*

  Many people are naturally fearful of telling family, friends and sexual partners that they are HIV-positive. Young people should be encouraged to understand the benefits of telling family and friends their HIV status. They need their support to help them cope with living positively. They can also benefit from sharing their fears and concerns with other young PLHIV. However,

young people will need encouragement and support to tell, and all concerned must be aware that there may be a risk in disclosing HIV status in unsupportive settings.

Through counselling they can be made aware of the benefits of disclosing their HIV status to selected people who can support them to live positively. However, the young person is always the one who ultimately decides whom to tell and when.

- *I am afraid that people will reject me, shun me or be violent towards me*

  Many people with HIV experience stigma and discrimination. Acts of discrimination against people living with HIV can range from inappropriate comments to violence. Information and education about HIV can help moderate the fears and misconceptions of people in the community and reduce the stigma and discrimination. As more people learn their HIV status, being HIV-positive can become less of a stigma. HIV can have a negative impact on education and work opportunities. Young people will need support and advice on how to manage their future opportunities.

  Young PLHIV may have feelings of loneliness and isolation. They may lose friends because they are HIV-positive. They may also be wary of revealing their status to anyone (sex partner, peers, family member, school officials, etc.) due to the possibility that disclosure may ruin their image, plaguing them with the stigma associated with HIV. Although this may be true for anyone, young people have heightened difficulty because, to a certain extent, they base their self-worth on what other people think of them.

  Stigma and discrimination are serious barriers to HIV prevention.

- *Can I still smoke, drink, go out and have fun like my friends?*

  Young PLHIV should be encouraged to live the same life as their friends, but they may need to be more aware of maintaining their good health and avoiding activities that jeopardize their health.

  Health workers should ask for permission before giving young persons information on how to stay healthy. Young people will decide for themselves their limits and the risks they will take. General information on healthy living (nutrition, hygiene, exercise, adequate rest, avoiding smoking, moderate alcohol use, etc.) is important. They will also need practical information on HIV transmission, substance use, negotiating and practising safer sex, and ARV drug adherence.

  Remind young people that substance use can impair judgement, making them more susceptible to pressure to engage in unwanted or unprotected sex. Using substances can also interfere with their medication.

  Young PLHIV will need support on deciding whom (among their friends) to tell and how to tell about their HIV status.

(d) POSITIVE PREVENTION

Positive prevention for young people includes all strategies that increase the self-esteem and confidence of young PLHIV, with the aim of protecting their own health and avoid passing the infection to others.

Improving the self-esteem and confidence of young PLHIV has many benefits at the individual, family and community level. Positive prevention recognizes the rights and needs of PLHIV and can empower them and help them to take charge of their lives and encourage them to take responsibility for preventing HIV transmission. Positive prevention is focused on communication, information and support, safer and healthier sex, harm reduction, PMTCT and STI management. The concept

of positive prevention is expanding and can also include provision of safe drinking water, impregnated bed nets, screening and chemoprophylaxis (e.g. co-trimoxazole and INH) for tuberculosis.

An important part of positive prevention is counselling, with the aim of:

- Supporting positive living (emotional, psychological and physical), which can help PLHIV to live healthily and take responsibly for their health.
- Assisting PLHIV to learn how to enjoy a healthy sexual life, without fear of infecting their loved ones.
- Involving PLHIV and associations of PLHIV in community activities.

Positive prevention requires the meaningful involvement of young PLHIV in the planning and implementing of HIV strategies. Young PLHIV can work with service providers to make strategies relevant and useful to young people. They give a perspective that is unique and provide credibility and relevance to the local context. They also give a face to HIV. When programmes enlist young PLHIV and their organisations (where they exist), they become emissaries to the general community which can lead to increased awareness, decrease in stigma and discrimination, and an increase in the use of services.

(e) COUNSELLING

Counselling of young PLHIV concentrates on the emotional, behavioural, and social issues that relate to living with HIV. Counselling often begins with an HIV test result; however, counselling is an essential part of HIV management and care and is much more than explaining to a young PLHIV his/her test result.

How to modify counselling to respond to the needs of young PLHIV

- **Be prepared for the variety of ways they may respond**

  Young people are faced with a diagnosis of HIV in many different situations. By being aware of the different situations and of what the young person's thoughts and feelings are likely to be, the health worker may be able to prepare for the different responses that may occur.

  Try to "put yourself in their shoes" (i.e. try to understand what the young person may be thinking and feeling). This will help you to respond to them more effectively and with greater sensitivity. Try to encourage trust and comfort. Be supportive of their situation and their decisions. Guide them appropriately, without letting personal opinions and values interfere with the work.

- **Give referrals and links to other support services**

  Be sure to provide them with links to places in the community where they can seek further assistance. In order to do so properly, find places within the community that can be trusted and where young patients will feel comfortable. Many young people need a safe place to go and 'be' without having to feel judged. These links are essential in supporting the young person with positive prevention. Support from other young PLHIV is particularly important to lessen their feeling of being different and isolated.

- **Provide support for the development of skills in HIV risk reduction**

  Young people need support in learning skills to reduce their risk of acquiring or transmitting HIV. This information needs to be clear and practical. Handing over condoms is not enough, health workers need to ensure that the young person knows how to use condoms correctly and

understands the importance of putting one on (male) or inserting one (female) every time before intercourse. Group counselling sessions can be considered with young PLHIV as a method of discussing difficult situations in living with HIV (e.g. disclosure, sexuality, negotiating condom use, living with peers). This takes the focus away from the individual and requires the group to discuss and identify risk-reduction strategies.

If peer support services are not available for young PLHIV in a community, health workers can consider helping establish such a group. Begin with a small group and support the young PLHIV to take the lead in developing the support service.

- **Help them to develop an immediate plan for the moment they leave your clinic**

  The moment they leave your clinic, young people will likely be full of unanswered questions. By developing an immediate plan with them, they will know where to go to access more information until their next appointment with you. Focus on this short-term approach while making sure that they understand the importance of coming in again for the next step in this process.

BOX 13

Successful approaches to working with young people and HIV

- Youth participation in planning and implementation of programmes.
- Comprehensive life skills and sex-and-relationships education in and out of school.
- Peer-led programming to inform and encourage young people to protect their health.
- Youth-friendly health services offering HIV testing and counselling, and services for the diagnosis and treatment of sexually transmitted infections.
- Harm reduction to prevent HIV transmission through injecting drug use along with demand-reduction programmes, and health services directed to other vulnerable groups, such as young sex workers and mobile populations.
- Community-based programmes for young men and education of young women to tackle sexual coercion and other forms of violence.
- Sustained media campaigns using communications channels that young people find credible and acceptable to promote gender equitable norms and HIV prevention education.

Adapted from: WHO (2004), *Steady..Ready..Go!* The Tallories Consultation to review the evidence for policies and programmes to achieve the global goals on young people and HIV/AIDS, and from UNICEF (2002), *Young People and HIV/AIDS: Opportunity in Crisis*.

7. Publications on HIV and young people

1. *HIV Testing Policy Statement*. WHO, 2006. http://www.who.int/rpc/research_ethics/hivtestingpolicy_en_pdf.pdf
2. *The WHO Testing and Counselling Toolkit.* http://who.arvkit.net/tc/en/index.jsp
3. *HIV Counselling and Testing for Youth: A Manual for Providers.* Family Health International, www.fhi.org/en/Youth/YouthNet/rhtrainmat/vctmanual.htm
4. *Integrated Management of Adolescent and Adult Illness (IMAI).* Four booklets: *Guidelines on Chronic Care with ARV Therapy, General Principles of Good Chronic Care, Acute Care, Palliative Care*. WHO, 2004.
5. *2006 Report on the Global AIDS Epidemic*. UNAIDS/WHO, Geneva, 2006.
6. *HIV-Related Stigma, Discrimination and Human Rights Violations: Case Studies of Successful Programmes*. UNAIDS, 2005.
7. *Impact of HIV and Sexual Education on the Sexual Behaviour of Young People: A Review Update.* UNAIDS, 1997.
8. *Protecting Young People from HIV and AIDS: The Role of Health Services*. WHO, 2004.
9. *Risk and Protective Factors Affecting Adolescent Reproductive Health in Developing Countries*. WHO, 2004.
10. *Steady..Ready..Go! The Tallories Consultation to review the evidence for policies and programmes to achieve the global goals on young people and HIV/AIDS*. WHO, 2004.
11. *Young People and HIV/AIDS: Opportunity in Crisis*. UNICEF/UNAIDS/WHO, New York, 2002.
12. *Action for Adolescent Health: Towards a Common Agenda. Recommendations from a Joint Study Group*. UNICEF/UNAIDS/WHO, 1995.
13. *National AIDS Programmes: A guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people*. WHO, 2004.

Websites

UNAIDS: www.unaids.org

UNFPA: www.unfpa.org

UNICEF: www.unicef.org

WHO: www.who.int

8. Definition of terms

ABC: An HIV prevention acronym that was developed to help remember choices to reduce the risk of acquiring HIV infection through sex: **A**bstinence - **B**e faithful – **C**ondoms. Although each of these is an important component of HIV prevention, ABC is not gender sensitive; it reflects behaviour options that are mainly male controlled and does not address a wider prevention concept.

Adherence: The extent to which the patient continues to follow the agreed, prescribed mode of treatment or intervention. In ART, adherence is important to avoid the risk of drug resistance.

Antibodies: Molecules in the blood or other body fluids that tag, destroy or neutralize bacteria, viruses, or other harmful toxins (antigens). An antibody is specific to an antigen.

AIDS (Acquired Immune Deficiency Syndrome): This occurs because HIV has damaged the immune system of an HIV-infected individual.

ART (antiretroviral (ARV) therapy): This includes all the specialized medical and diagnostic services for outpatients to properly manage and monitor their drug treatment which aims to suppress HIV replication and improve HIV-related symptoms.

BCC (behaviour-change-communication): An interactive process with communities to develop tailored messages and approaches using a variety of communication channels. The aims of BCC are to develop positive behaviours; to promote and sustain individual, community and societal behaviour change; and to maintain appropriate behaviours.

Burnout: People who work with patients who have a chronic fatal condition (like cancer and HIV) can suffer from burnout; it is also known as fatigue or compassion fatigue.

CD4 (+) **cells** (cluster designation 4 (plus) cells): A type of T-cell that is an important part of the immune system involved in protecting against infection. HIV enters and attacks the CD4 cell. Destruction of CD4 cells is the major cause of the immunodeficiency seen in HIV disease. Although CD4 counts fall, the total T cell level remains fairly constant through the course of HIV disease because of a related increase in the CD8 cells. The ratio of CD4 to CD8 cells is therefore an important measure of disease progression.

Discordant couple: Heterosexual or homosexual couples where one partner is infected with HIV and the other is not (or has not been tested).

Discrimination: when there is action or inaction that is based on stigma that results in an infringement (disrespect) of human rights. This is often evident as some form of abuse against an individual or group. Discrimination results when actions treat people differently based on stigma (e.g. a confirmed or suspected HIV serostatus). Persons associated in the public mind with HIV or AIDS (e.g. men who have sex with men, sex workers, drug users, haemophiliacs, and the family members and associates of HIV-positive people or people suspected to live with HIV) may also face discrimination.

Drug resistance is due to the ability of HIV to mutate and reproduce itself in the presence of antiretroviral drugs. Consequences include treatment failure and the need to start second-line treatment with increased direct and indirect health costs for the patient, the spread of resistant strains of HIV, and the need to develop new anti-HIV drugs.

Dual protection: This refers to simultaneous protection against both unwanted pregnancy and sexually transmitted infections. Condoms are the only effective means to prevent both an unintended pregnancy and sexually-transmitted diseases, including HIV.

ELISA (enzyme-linked immuno-sorbent assay) is an HIV test. If the first ELISA test is positive, it is repeated. If the second is also positive, then a Western Blot test is usually carried out. If all three tests are positive, the person is considered HIV-positive.

Gender can be understood as the social construct of masculinity and femininity. Since, in many societies, more value is given to what is considered masculine than feminine, opportunities associated with gender lead to relationships in which more power is given to men than women.

HAART: highly active antiretroviral therapy.

Harm reduction for IDU: This refers to various strategies and approaches for reducing the physical and social harms associated with risk-taking behaviour. Harm reduction includes making use of needle-syringe programmes, condoms, and drug substitution.

HIV (Human Immunodeficiency Virus): The virus that causes AIDS. Infection with HIV is a lifelong infection. A positive HIV test does not mean a person has AIDS; it means that HIV antibodies have been detected in the blood.

Incidence: The number of newly appearing cases of a disease. Incidence rates can relate to the general population or a specific population.

Incubation period: the period from infection with the virus until the appearance of disease symptoms.

Microbicide: An agent (e.g. a chemical or antibiotic) that destroys microbes. Research is being carried out to evaluate the use of rectal and vaginal microbicides to inhibit the transmission of sexually transmitted diseases, including HIV.

Opportunistic infections: Illnesses caused by various organisms, some of which usually do not cause disease in persons with healthy immune systems. People living with advanced HIV infection may suffer opportunistic infections of the lungs, brain, eyes and other organs. Opportunistic illnesses common in people diagnosed with HIV include *Pneumocystis carinii* pneumonia, cryptosporidiosis, histoplasmosis, other parasitic, viral and fungal infections, and some types of cancers.

PLHIV: Person (or People) Living with HIV.

PMTCT (Prevention of Mother-to-Child Transmission of HIV): Prophylactic therapy given to pregnant women who are HIV-positive in order to prevent infection to their infants during pregnancy, at delivery or during breastfeeding.

Prevalence: the number of existing cases of a disease in the general population of a specific area.

Prevalence rate: HIV prevalence is the estimated number of (adult) persons living with HIV at the end of the year divided by the total number in the (adult) population.

Rapid HIV Test: This test uses a drop of blood collected from a fingerstick and the results can be read in 10 to 30 minutes. If a person is HIV-positive with this test, it is considered a *preliminary positive result.* Although the test is extremely accurate, it has to be confirmed by a second rapid HIV test with a positive result.

Seroconversion: The development of antibodies to a particular antigen. When people develop antibodies to HIV, they seroconvert from antibody-negative to antibody-positive. It may take from as little as 1 week to several months (average 6 weeks) after infection with HIV for antibodies to develop. After HIV antibodies appear in the blood, a person should test positive with antibody tests.

Sexually transmitted infections (STI): These are spread by the transfer of organisms from an infected person to another during unprotected sexual contact.

Stigma: HIV-related stigma includes all unfavourable or discriminatory attitudes, beliefs, and policies that are directed towards people who are perceived to be living with HIV, and also towards their families and loved ones, their social groups and their communities.

Susceptibility: A predisposition ("weakness") to a disease or infection. *Biological susceptibility* to HIV refers to the increased physical risk of acquiring HIV. For example, a young girl of 14 years has a higher risk of acquiring HIV than a woman of 30 years (even when exposed to the same situation and viral load) because of her immature genitalia and inadequate mucosal defence system. A person with an STI is also biologically susceptible to HIV.

Vulnerability: The concept of vulnerability accepts that individuals may not have a choice in whether they engage in behaviours that increase their risk of HIV. People who may have limited choices in social, sexual and financial areas of their lives are vulnerable for HIV infection. In many societies these vulnerable people include women, children, sex workers, males who have sex with other males, injectors, migrants, ethnic minorities and poor people. The majority of those who are vulnerable are young people.

Western blot: A laboratory test for specific antibodies to confirm repeatedly positive results in the HIV ELISA test.

Annex 1

Module schedule

Activities that are marked with * are optional activities which are not included in the 180 minutes planned for this module. The facilitators' decision to include the optional activities depends on the available time and whether these activities are covered in other modules in this workshop.

Sessions and activities	Time
Session 1 **MODULE INTRODUCTION**	10 min
ACTIVITY 1-1 Module objectives ACTIVITY 1-2 Spot checks	
Session 2 **THE SITUATION OF HIV AMONG YOUNG PEOPLE ***	40 min *
ACTIVITY 2-1 Mini lecture: Basic HIV *	10 min *
ACTIVITY 2-2 Mini lecture: Young people and HIV globally *	10 min *
ACTIVITY 2-3 Mini lecture by guest presenter: Young people and HIV – the national situation *	20 min *
Session 3 **HOW HIV AFFECTS YOUNG PEOPLE**	35 min
ACTIVITY 3-1 Mini lecture and brainstorming: Risk and protective factors ACTIVITY 3-2 Mini lecture: Biological susceptibility	
ACTIVITY 3-3 Brainstorming: Risk and protective factors *	20 min *
ACTIVITY 3-4 Brainstorming: Young people, HIV, stigma and discrimination ACTIVITY 3-5 Mini lecture: Young people and the natural history of HIV	
Session 4 **HIV PREVENTION AND YOUNG PEOPLE**	45 min
ACTIVITY 4-1 Mini lecture: Introduction	
ACTIVITY 4-2 Group exercise: Community mix *	20 min *
ACTIVITY 4-3 Mini lecture: Overview of HIV prevention *	10 min *
ACTIVITY 4-4 Plenary discussion: HIV preventions and the health worker ACTIVITY 4-5 Group work: HIV preventions in the clinic and community	
ACTIVITY 4-6 Condom demonstration *	30 min *

Sessions and activities	Time
Session 5 **HIV testing and counselling among young people** ACTIVITY 5-1 Mini lecture: Introduction ACTIVITY 5-2 Mini lecture: HIV testing and counselling for young people ACTIVITY 5-3 Mini lecture: Circumstances for HIV testing ACTIVITY 5-4 Plenary discussion: Feelings around HIV testing and counselling ACTIVITY 5-5 Group work: Do's and Don'ts in testing and counselling with young people	40 min
Session 6 **Management of HIV in young people** ACTIVITY 6-1 Mini lecture: Introduction ACTIVITY 6-2 Mini lecture: Care and treatment ACTIVITY 6-3 Mini lecture: Antiretroviral therapy ACTIVITY 6-4 Mini lecture: Support ACTIVITY 6-5 Mini lecture: Positive prevention ACTIVITY 6-6 Mini lecture: Counselling young PLHIV ACTIVITY 6-7 Group work: Young PLHIV and the health worker	40 min
Session 7 **Module review** ACTIVITY 7-1 Review of Spot Checks and Matters Arising Board ACTIVITY 7-2 Review of objectives and key messages ACTIVITY 7-3 OPPD ACTIVITY 7-4 Reminders and closure	10 min
180 min	**optional 120 min**

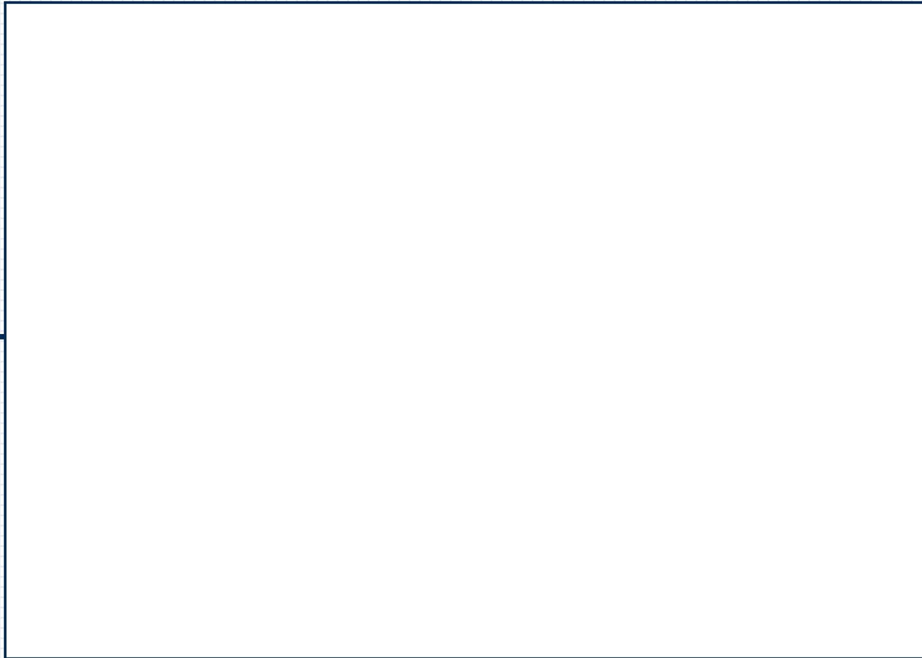
Annex 2

Spot checks

Sessions 1 and 7

SPOT CHECK 1

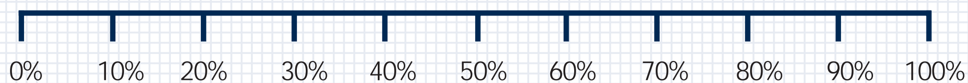
Please explain the difference between HIV and AIDS.



SPOT CHECK 2

Globally, what percentage of all new HIV infections per year is among young people?

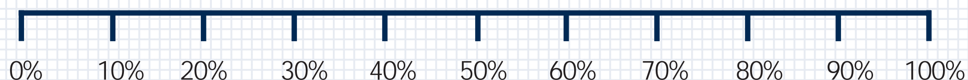
please mark your estimate with a spot anywhere along the line



SPOT CHECK 3

What percentage of young people aged 15-24 years who are living with HIV in sub-Saharan Africa are female?

please mark your estimate with a spot anywhere along the line



SPOT CHECK 4

Why are young people more likely to be exposed to HIV?

please list three reasons

SPOT CHECK 5

Why are girls and young women biologically or culturally/socially vulnerable to HIV infection upon exposure?

please list five reasons

SPOT CHECK 6

How confident do you feel about working with young people on the issues of HIV?

please mark your answer with a spot anywhere along the line

Uncomfortable | Not very confident | Confident | Very confident

SPOT CHECK 7

What can be done to reduce HIV transmission among young people in the clinic and in the community?

Clinic

Community

SPOT CHECK 8

What is important in counselling young people?

please provide three answers

SPOT CHECK 9

A high percentage of drug injectors are young people. Injectors are at high risk of acquiring HIV through use of non-sterile needles.

please name three strategies for harm reduction

SPOT CHECK 10

Read each statement and tick the box that reflects your point of view

Statement	I agree	I disagree
Young people who get HIV have brought it on themselves by their behaviour	○	○
Everyone should have to have an HIV test whether they want to or not	○	○
As a health worker, I should be allowed to refuse to treat a client who is HIV positive	○	○
It is acceptable for boys to have sex before marriage	○	○
It is acceptable for girls to have sex before marriage	○	○
It is wrong for young men to have sex with men	○	○
Our health services should not waste money on treating people with HIV	○	○
Girls and boys need to have information on sexuality and HIV	○	○
If a young person tests HIV negative I do not need to give them counselling	○	○
If a boy of 14 years came for HIV testing I would tell him I could not help him unless he comes back with a parent	○	○
If a young person tests HIV positive, it is my duty to tell their parents or their spouse	○	○
If an unmarried girl asks me for condoms, I would not give them to her and tell her to wait until she is married	○	○

Annex 3

Brief scenarios

Session 3: ACTIVITY 3-3

The facilitator will identify a scenario to be read aloud by a participant.

As a brainstorming exercise, the participants will give responses to the two questions on the flipchart:

1. What are the risk factors that could facilitate HIV transmission in this scenario?
2. What are the protective factors that may or do occur in this scenario?

You can use your imagination about some of the facts of the scenarios and you can elaborate on the story.

The responses will be written on the flipchart in two lists – **Risk factors** and **Protective factors**.

SCENARIO 1

A girl in a secondary school of a large town has sex with older men in exchange for money or favours.

SCENARIO 2

A young man at university in a medium-sized town is persuaded by his class mates to join them for an evening out. The evening includes viewing an X-rated film, dinner and drinks, and a visit to the town's red light area.

SCENARIO 3

A young man in a big city occasionally injects drugs with his friends. He uses their needles and syringes. He sees no problem in this because he says they are all healthy and he has known these friends all his life.

SCENARIO 4

A young married woman lives in a rural area. Her husband, a factory worker in a big city some 50 km away, returns home periodically. Like many of his co-workers, he occasionally visits a brothel.

SCENARIO 5

A young woman, a migrant worker, is employed as a domestic servant. She is forced into having sex with her employer. When she raises this matter with the madam of the house, she is slapped across her face and is threatened with more violence.

SCENARIO 6

A young man is part of a gang in a big city. He occasionally has anal sex with men, while continuing his relationship with a young woman.

Annex 4

Scenarios: HIV prevention in the clinic and community

Session 4: ACTIVITY 4-5

In this group work, we will identify practical ways in which health workers can develop strategies to prevent HIV transmission among young people.

You will be divided into 3 groups and assigned a scenario.

You have 10 minutes to discuss the situation within your group and complete the task.

Task

You have recently arrived as the health worker in charge of the municipal health centre in a small town.

After attending a course on HIV and young people organized by your national AIDS programme, you decide to map the situation of young people in your community.

Based on your findings, as described below, how would you respond in order to contribute to HIV prevention among these targeted groups of young people?

Write a list of possible approaches, discuss their advantages and disadvantages. Then choose one approach that can be applied:

1. Within your clinic
2. Within your community.

One participant should summarize the group's discussion and present in plenary the approach that you have considered and the approach that you have chosen. You should present one approach which can be used in the clinic and an approach in the community.

SCENARIO 1

You learn from a reliable NGO that injecting drug use is occurring among some young people in the community. The boys involved are aged 15-18 years, some attend the secondary school and some do not. Some of the boys have girlfriends at the school. Their practices are relatively unknown (or are ignored) among leading members of the community. Nothing is currently being done to address the matter. You are told that the young people want to avoid contact with the authorities for fear of getting into trouble with the law or with adults in the community.

SCENARIO 2

In the course of your work, you realize that some of your STI patients are students from some nearby secondary schools. When you ask, you learn that there is no health education on sexual and reproductive health offered in these schools. You decide to approach the principals of the schools to explore the possibility of working with them to start a collaborative sexual education programme.
The principals respond with extreme resistance. They feel that such a programme will only encourage the young people to engage in premarital sex, which is exactly what they and their staff have been trying to work against. They say they have enough of a problem with teenage girls who had to be expelled from school because they got pregnant. The principals have strong opinions about this and feel they are speaking on behalf of the parents as well.

SCENARIO 3

You discover that there is a red light area in a poor backstreet not far from your health centre. From discussions with the nurses in the health centre, you learn that young women from the brothels are sometimes brought to the centre by an older woman and a tough looking man. The nurses tell you that many of these young women cannot speak the local language. They seem sure that these women have been 'trafficked' from other parts of the country. "There is nothing we can do", one of the nurses says to you, "Powerful people are involved".

Annex 5

Scenarios: Do's and Don'ts in testing and counselling with young people

Session 5: ACTIVITY 5-5

You will be divided into 3 groups and each allocated a scenario.

Task

1. Go over the scenario you have been given and work together in your group to develop the story further, making it a real life situation. Prepare a presentation (with one person telling the rest of the story or presenting it as a short role play).

2. Identify a list of practices that the health worker should always carry out (the Do's) and practices that should never be carried out (the Don'ts) in a situation like this. Consider the practices described in the scenario and the practices in the additional story that you have developed. One person will present the list.

You have 10 minutes to carry out this task.

SCENARIO 1

A young pregnant woman, who appears to be in good health, comes to the weekly antenatal clinic. She is accompanied by an older woman, a kindly neighbour. The neighbour tells the health worker that this is their second visit to the antenatal clinic. At her first visit, in addition to a physical examination, the pregnant woman had blood taken for tests.

The health worker quickly looks at the notes from the previous visit and the laboratory test results. The test indicates that the woman is HIV-positive. "Another one. The third today….", the health worker mutters.

The neighbour leans forward and asks softly: "What did you say?"

SCENARIO 2

A young boy of 15 comes to the public health centre and asks to be tested for HIV. He appears healthy but anxious. The nurse asks him if he has come with a parent. The boy says no, neither of his parents knows that he is here. The nurse tells him he will have to come back tomorrow with one of his parents, but the boy becomes agitated and says he does not want to tell them, he just wants to be tested. He is sent away from the clinic but he is later seen waiting near the door.

SCENARIO 3

A young woman of 18 years comes to the clinic because she thinks she is pregnant. On discussion, she says she has a regular boyfriend who is the father of the baby and that she is glad to be pregnant. Later, when talking with the health worker, she says she is worried because she has recently learnt that her boyfriend injected drugs when he was younger.

SCENARIO 4

A young man, a university student, is in the consulting room of a private practitioner.

He is looking on anxiously as the doctor carries out a rapid HIV test.

The doctor is engrossed in his task, and the young man is in the grip of his fears and concerns. After several minutes of silence, the doctor scratches his head and says to the young man: "The test result is not clear. You should go to the hospital for another one." There is a sense of panic in the eyes of the young man. He says, "What do you mean that the test result is not clear?"

Annex 6

Case studies

Session 6: ACTIVITY 6-7

You have been divided into 3 groups and assigned a case study.

Task

A young person with HIV has approached you (the health worker) with a concern as described in your scenario.

Your task as a group is to discuss your case study and identify this patient's concerns and the important information that you (the health worker) should communicate to him/her in this situation.

You have 10 minutes.

Using the flipchart and pen, write down the patient's concerns and the information he/she needs.

One person in your group will present this to the other participants. Begin the presentation by reading or giving a summary of the case study.

CASE STUDY 1

Sexuality

A 20-year-old young man tested HIV-positive one week ago. He tells you that he has had unprotected intercourse over the last year with five different young men at the college he is attending. In spite of the relatively low HIV prevalence within this community, the boy became infected. After finding out about his infection, he was very upset by the fact that the man who transmitted the virus did not tell him his HIV status. Now, he wants to continue his sexually active lifestyle but does not want to put his future partners at risk. He says that there are many misconceptions and little understanding about HIV in his community, so he is afraid to tell anyone. What options can you, as the health worker, give him to consider in this situation?

CASE STUDY 2

Sexuality

An 18-year-old HIV-positive man says he believes he was infected with HIV after engaging in unprotected sex with a female sex worker. It was his first sexual experience. He says he was pressured into doing it by his peers who said that he would gain experience and enter manhood through his first sexual encounter. Now he is interested in pursuing a relationship with a particular girl. He wants to have sex with her but is afraid because of his HIV status. What can you, as his health worker, suggest to him in this situation?

CASE STUDY 3

Fertility

A young woman of 16 years has been diagnosed as HIV-positive. She recently married a man who frequently travels to neighbouring towns for work. She never had sex prior to her marriage. In her culture, it is expected that she should bear many children for her family. She believes that her husband unknowingly acquired HIV after unprotected intercourse with sex workers in the neighbouring town. The health worker at the antenatal clinic told her that she should not get pregnant but she is distressed because she wants to have children. She comes to you for advice and help. What can you, as the health worker, do for her?

CASE STUDY 4

Living with chronic disease

A 22-year-old man, who is a university student, recently tested HIV-positive. He admits to you that on a few occasions in the past he has injected drugs and shared needles. Now he feels that his life is over and he has given up on everything. He spent several months in his room not wanting to talk to anyone. He does not know anyone who has HIV but he heard of a student who people said had AIDS; he was treated badly and thrown out of the university. He says he has a girlfriend for 6 months and does not know what to tell her. He is in the clinic now for the first time since his positive test result. What can you, as the health worker, suggest to him regarding his situation?

Orientation Programme on Adolescent Health for Health-care Providers

Handout for

Module X

Young people and injecting drug use

This Handout provides additional information on Module X (*Young people and injecting drug use*) to health workers who have participated in and completed the *Substance use modul*e (Module K). Both are optional modules in the Orientation Programme on Adolescent Health for Health-care Providers.

Module X introduces health-care providers (health workers) to a serious health issue among young people that is often little understood, i.e. their injecting of psychoactive substances. The module discusses the factors that contribute to young people's use of substances by injection and the possible consequences of injecting substances. The module also highlights what health workers can do in their clinics and communities to prevent injecting drug use (IDU) among young people and to reduce the harmful results.

While it is not easy to develop services for injecting drug users, this module provides health workers with information and an opportunity to understand and discuss IDU issues, with the aim of supporting them in their work.

THIS HANDOUT PROVIDES INFORMATION ON THE FOLLOWING:

1. Introduction X-5
2. Who is the young drug user? X-7
3. Why would a young person inject drugs? X-8
4. Negative consequences of IDU for young people X-10
5. Why young injectors require special attention X-11
6. Assessment of young people for IDU X-13
7. Health worker action on IDU in the community X-15
8. Harm reduction strategies and young injectors X-17
9. Harm reduction messages for young injectors X-20
10. Important considerations when working with young injectors X-24
11. Key messages X-26
12. References X-27

Annex 1. Module schedule X-29
Annex 2. Spot checks X-33
Annex 3. Scenarios for assessment X-37
Annex 4. Scenarios for the GATHER approach X-41

1. Introduction

Injecting drug use (IDU) refers to the administration of illicit drugs by injection, using a needle and syringe, usually into a vein because this gives the quickest effect. Globally, heroin and cocaine are the most commonly injected drugs but injection of amphetamines is on the increase. Injecting drug use has been documented in 129 countries and continues to spread; it is a major public health problem throughout the world regardless of religious persuasion, stage of economic development or political system.

IDU is often initiated at a young age and there is evidence from many countries that the trend among young people is increasing. The age at which a person begins to inject varies considerably, even within a country, depending on factors such as drug availability and social cohesion and norms. Between 65% and 90% of injectors in developing and transitional countries are males aged 15-35 years. Not all injecting drug users are regular injectors and for some young people, injecting may be experimental and a passing phenomenon. However, injectors can experience serious health effects even after only one episode of injecting.

The serious health effects from injecting are due to the drug's toxic effects, impurities or contaminants mixed with the drug, and non-sterile injecting. The most common and widespread adverse health effect of injecting is transmission of viral diseases such as HIV, hepatitis B and hepatitis C. Injecting can also result in a fatal overdose. Other health effects include problems at the injecting site, abscesses, cardiac problems and systemic blood infections.

BOX 1

HIV epidemics among injectors

Globally, most people living with HIV are believed to be between 15 and 24 years old, and most of them are unaware that they carry the virus. Of the estimated 4 million new HIV infections annually, about 40% are aged 15-24 years. While injecting drug use accounts for an estimated 10% of all new HIV infections globally, in many countries IDU accounts for 30-80% of all reported infections.

HIV epidemics that are driven by drug injectors manifest very differently from epidemics in which sexual transmission is the main risk factor. While sexually transmitted HIV may remain virtually invisible for several years, the sharing of injection equipment is a much more efficient mode of HIV transmission and drug-related epidemics therefore spread more rapidly. Once the virus has been introduced into a community of injectors, tens of thousands of HIV infections may occur. Infection levels among injectors may rise from zero to 50-60% within 1-2 years, as demonstrated in different cities around the world. HIV does not stay only in the injecting community but spreads due to risky injecting practices as well as risky sexual activity. This is how HIV is transmitted to the non-injecting sexual partners of injectors and then to the general population.

New HIV infections can be prevented in drug-using populations and the impact of HIV epidemics can be reduced through effective and integrated programmes.

IDU services for young people should aim to prevent those who are not drug injectors from starting; those who are injecting drugs should be advised and assisted to stop or reduce their use; and ways should be found to reduce the harmful effects for young people who do not stop injecting drugs.

Most IDU prevention programmes aimed at young people have focused on prevention in this age group in the general population, but this may have little impact on the actual behaviour of current users. IDU programmes must consider the specific needs of adolescent and young drug injectors and develop interventions specifically targeted at young non-injectors who are vulnerable to start IDU, as well as recently initiated and occasional injectors, and also interventions that promote safer sex between young injectors and their partners.

This module helps health workers to consider how they can assist young people in their community who are already injectors and those who are vulnerable to start injecting. As young injectors are different from adult injectors, IDU services that are available to adults may not be appropriate or

accessible to young people, especially if they are occasional injectors. Thus, a needle and syringe programme may not be appropriate for the occasional young injector who may just want a needle and syringe once in a while. Methadone treatment is not appropriate for young non-dependent drug injectors. Some drug services are not available to under-18-year olds because of laws, local policies and formal and informal guidelines in the service. Young injectors may be reluctant to access adult services because of concerns about privacy and confidentiality. Peer education messages designed for older users may be inappropriate for younger users who, by not identifying with older, dependent injectors, may conclude that harm reduction messages do not apply to them. Young people who are experimenting or only inject occasionally or infrequently may need different messages and services to those required by frequent and regular injectors.

There is evidence that IDU services for young people can be more successful when they are linked with other services that young people want or need. These services can be targeted to the needs of specific groups of young injectors. IDU services must be supported, or at least tolerated, by the local authorities and the community.

This module focuses on IDU among young people (not adolescents only) because many of the issues discussed are important for people up to 24 years old. WHO defines "adolescents" as aged 10-19 years and "youth" as 15-24 years. The "young people" referred to in this module are aged 10-24 years and are not a homogeneous group because, for example, a 12-year-old will have different needs or concerns from a 20-year-old, or young people of the same age may differ in their emotional or cognitive development, and male and female young people will sometimes require different interventions. Young people therefore need services that take into account these differences.

NOTE

In this module, IDU (injecting drug use) refers to the activity and not to the persons who inject drugs; the latter are referred to as "young people who inject drugs" or "young injectors".

2. Who is the young drug user?

- Young substance users include many different people in society - e.g. coffee drinkers, cigarette smokers, alcohol (beer etc.) drinkers at social gatherings, occasional smokers of marijuana, the social cocaine sniffer, heroin injectors, and persons who take pain killers.

- Drug injectors also include a wide variety of people. Young injectors can be an adolescent living on the streets and occasionally injecting with his peers, or a young white-collar professional who injects alone at home, or a young woman who injects occasionally with friends, or sex workers who inject daily. Stereotyping of drug injectors can lead to mistakes of who is at risk and also adds to the stigma and discrimination which drug injectors face in society and in accessing health services.

- As other aspects of the life of a young drug injector may appear intact, it is not possible to look at someone and know for sure if he/she is a substance user or an injector. That is why it is important for health workers to assess for substance use during every contact with young people. If IDU is suspected, it is important for health workers to be non-judgemental in their attitude and discussions with the young person.

BOX 2

Young women and injecting

Globally, more men than women inject drugs. However, drug injecting among girls and women may be more hidden than among males because of cultural factors. Also, a lack of female-specific services may mean that female injectors do not have access to services and are not known. Female injectors may also be more vulnerable because of injecting practices over which they may have less control (e.g. whether they have a choice in sharing of equipment or drugs). They may also be involved in sex work to obtain and pay for their drugs.

3. Why would a young person inject drugs?

What are the factors that influence a young person to inject drugs rather than use them in other ways like smoking, swallowing, etc.? Understanding the many reasons why young people inject drugs can assist health workers to work with them.

Individual factors

- Young people can be easily influenced by others. They may feel the need to imitate the behaviour of a person in the family or friends who inject; or a partner who injects may pressure a young person also to inject.
- Young people often want to try out new experiences and may try injecting out of curiosity, boredom or for experimentation.
- They may not know or understand the risks of using drugs by injection.

Social factors

- Group or gang ritual, peer pressure, and being "cool" can influence the mode of use. Peer group norms are a strong influence on young people.
- Injecting of drugs may be common in some countries and in some sub-cultures, so the young person feels that IDU is not unusual behaviour.
- The level of knowledge and skills in peer groups regarding alternative ways of drug use has a large impact on the mode of use.

Transitional process

- There is usually a transitional period for the change from one mode of drug use (e.g. snorting) to a new mode (e.g. injecting). For example, a young person who snorts (inhales) cocaine may one day try injecting it. This does not mean that in future this person will only inject cocaine. There is a period during which the young person may snort or inject.
- Individuals usually move back and forth irregularly between injecting and other modes of drug use for a variety of reasons, including its availability and cultural, social and economic factors. This transitional process is especially evident among young people.
- Injecting may become the mode of choice after a period of time. Many factors can influence the length of time before injecting becomes the usual mode of use.

Drug availability and cost

- Injecting may be the mode of choice if injectable drugs are readily available in the young person's community or if the available drugs are not suitable for smoking or inhaling (for example, due to low quality, low potency or composition).
- Injecting will be the mode of choice if the effect achieved by injecting a drug is believed to (or may actually) be of a different quality from using it by other modes. With some drugs, users complain of losing a "high" if the drug is not injected. Young people are also more likely to use substances in the most economical fashion (due to limited funds).

Characteristics of the first injection

Studies (*1-4*, see below) have identified the following characteristics as being associated with the first injection:

- Around half of first injections occur between the ages of 12 and 18 years.
- It is mostly unplanned.
- It is usually in a public place, not alone, and often occurs in the presence of "experienced" injectors.
- Females are often given their first injection by a sexual partner (usually male).
- Males are most likely to be first injected by a friend.
- The injection commonly occurs while the person is intoxicated with another substance (e.g. alcohol or cannabis).
- If vomiting occurs (e.g. after an opioid), this soon stops and the analgesic effect of the drug may reduce the discomfort; peers then usually inform them that this reaction is short-lived.
- Equipment sharing is common as new and infrequent young injectors may find it hard to access sterile equipment; they also have less contact with the health services and lack money to buy new equipment (if it is not free).
- The adolescent initiate may be told that the equipment was "clean" and may not be aware of how to know if this is true.
- Use of new equipment can be seen as "bad luck".

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[1] Cucic V. *Rapid assessment and response on HIV/AIDS among especially young people in Serbia*. Belgrade, UNICEF, 2002.

[2] Roy E, Haley N, Leclerc P, Cédras L, Boivin J-F. Drug injection among street youth: the first time. *Addiction*, 97: 1003-1009 (2002).

[3] Treloar C, Nakamura T, Abelson J, Crawford J, Kippax S, Howard J, van Beek I, Copeland J, Wetherall A, Madden A. *Risk for hepatitis C: transition and initiation to injecting drug use among youth in a range of injecting user networks*. Sydney, National Centre in HIV Social Research, University of New South Wales, 2003.

[4] Wong E. *Rapid assessment and response on HIV/AIDS among especially young people in south-eastern Europe*. Belgrade, UNICEF, 2002.

4. Negative consequences of IDU for young people

Many of the negative consequences of IDU are the same as the negative consequences of substance use in general (see Handout for Module K, Section 1.2).

Consequences that specifically relate to injecting are described below.

Physical consequences

- *Overdose*. Among young people, overdose associated with opioids is one of the leading causes of premature death associated with IDU. Use of cocaine, ecstasy, methamphetamine and other amphetamine-type stimulants can also precipitate life-threatening and sometimes fatal emergencies.
- *Blood-borne infections.* HIV, hepatitis B and C, and syphilis are widespread, serious causes of mortality and morbidity related to injecting drug use.
- *Dependence.* The greater the frequency and amount of a substance used, the higher the risk of harmful use and dependence.
- *Local and systemic bacterial infections.* IDU can result in bacterial and pathogenic infections including abscesses, cellulites and septicaemia, vein damage, and loss of limbs or limb function.
- *Health problems due to adverse living conditions (social and material).* Injectors may lose their jobs because of IDU and their deteriorating social relationships may force them to live on the street or in poor conditions, which aggravate their health (e.g. malnutrition, infections due to inadequate sanitation, pneumonia, frostbite, tuberculosis).

Psychosocial consequences

- *Stigma and discrimination.* Stigmatization of injectors by the family, peer groups and community is due to lack of acceptance of their behaviour. The young injector can also experience discrimination when trying to access services.
- *Legal problems and vulnerability to exploitation.* In most countries there are laws against injecting, possessing or selling drugs, and even possessing injecting equipment. This means that injectors frequently break the law, making them vulnerable to law enforcers or criminal elements who can exploit their vulnerability. Because of their inexperience in obtaining and using injecting drugs, young people are vulnerable and dependent on more experienced injectors.
- *Mental illness.* These are mostly due to the substance and not specific to the method of administration.

5. Why young injectors require special attention

Unique nature of young people

- Young people are often curious and ready to try new experiences.
- Generally, they can be easily influenced by their peers.
- Young people are usually 'healthy' and do not frequently go to health services.
- Many young people are particularly vulnerable to trauma or have experienced violence in their lives (e.g. as young girls, refugees, immigrant and minority youth, child/young person soldiers, forced labour, persons displaced by natural disasters or civil or armed conflict, and street children and young men who have sex with men).

Nature of drug use in young people

- Young people are often poly-substance users, and may accept the most readily available or cheapest drugs. The younger the age at which substance use begins and is established, the greater the likelihood of injecting and poly-substance use and subsequent chronic and life-threatening ill health.
- IDU at a young age is associated with early school-leaving, and also with difficulty in gaining and maintaining employment.
- IDU is often linked to other behaviours that increase the risk of HIV (e.g. unprotected sex, sex for money) or violence.

Consent and confidentiality

- Young people may not seek healthcare if they feel that this is not confidential; health workers should treat them with respect and be non-judgemental.
- The age at which a young person can consent to medical treatment and receive confidential medical care depends on the laws of the country. Young people who are minors may ask a health worker for treatment, advice or condoms. Their parents may not be present for the visit or may be totally absent in their lives (e.g. orphans and those living in the street).
- There are many situations where a health worker will need to decide whether to treat a minor in the absence of parental consent. These are difficult issues which the health worker can discuss with colleagues and supervisors before the situations arise.
- Health workers should be guided by human rights principles: all adolescents have a right to use health services, and the health worker should understand their evolving capacities and increasing ability to make independent decisions, and act in their best interests.

Awareness of risks and attitudes towards risk-taking

- Young people may have limited information on the risks of injecting substances. They may not know about the risks of sharing equipment or the safest way of injecting.
- Young people may enjoy the "thrill" of risk-taking and feel that because they are young and strong, they are also resistant and invincible and that no harm can come to them.
- They may gather with peers and/or older injectors who reinforce the thrill of risk-taking.
- They may not think their drug use is a problem and may believe that they will be able to stop injecting whenever they choose to, with no adverse health consequences.

Access to support services

- Young people may be unaware of their right to health and access to health services. Given their youth "status", they may be denied access to certain services due to policies or legislation.
- Lack of specific, anonymous and free youth-friendly services in some countries can be an important barrier for young people's access to health services. Often youth care services do not accept injectors and IDU services are almost always only open to adults. The young injector needs to feel that the service knows and understands the nature of drug use among young people.
- Young people may find that adult services do not respect their privacy and right to confidentiality, or they may feel unwanted or have had negative experiences at adult services.
- The attitudes and values of health workers and health services - to be non-judgemental, respectful, confidential, professional, and sincere are especially important to young people.
- Young people may still have strong links with their family. If family members are available, it is often beneficial to involve them, if the young person agrees. This may not be possible when there has been violence or abuse in the immediate family and the young person finds no support at home. However, there may be other family members, adults or friends to whom the young person can turn for support.
- Younger injectors may receive less support from peers, family and others to seek or receive help, whereas older injectors may receive more support as they are more likely to have an accumulated problem and a longer history of injecting.
- Young people have less economic security and less access to resources to pay for healthcare or buy supplies.

6. Assessment of young people for IDU

Health workers should consider the following in assessing a young person for IDU:

- During routine visits to health services, all young people should be assessed for substance use which is common. When substance use is disclosed, a brief early intervention can prevent further problems.
- Young persons may be reluctant to discuss their substance use and the health worker needs to ask questions discretely and in a sensitive and non-judgemental manner to encourage trust and confidence.
- When substance use is disclosed, the health worker needs to ask the young person about the usual way of taking it and if it was ever administered by injection.
- The health worker may suspect that a young person is using substances or injecting if he/she:
  - has clinical symptoms;
  - causes general suspicions;
  - has a social situation that makes them vulnerable to substance use or injecting;
  - tells you about it or because other people have told you;
  - requests clean needles and syringes;
  - has been referred to you.
- When injecting is disclosed, the health worker will need to ask specific questions on injecting (see below).
- Young substance users will often come to see the health worker with different complaints (e.g. depression, headaches, poor school performance, possible pregnancy, STI, injuries). When they feel that they can trust the health worker, they may be able to talk about their substance use.
- A clinical examination should be carried out whenever indicated. During routine clinical examination the health worker should look for evidence of injecting sites.

Specific questions to drug injectors

- What do you inject? (To identify the types of substances injected including combinations)
- How much and how often? (To assess the quantity and frequency of injecting)
- How do you feel if you do not inject for "one day"? (To determine the pattern of use)
- When did you first start injecting? (To determine the duration of injecting)
- Have you had "any injecting-related problems", e.g. local or systemic bacterial infections?
- Have you had any blood tests, e.g. for HIV, hepatitis B and C? When?
- Have you had a vaccination to protect you from hepatitis B? Is it up to date?
- Have you ever shared "equipment", e.g. needles, syringes, swabs, spoons, tourniquets?
- Do you always practise safer sex? Do you use condoms consistently and correctly?

The following questions can help explore a young person's feelings about injecting:

Good things/perceived benefits of injecting

Explore what the young person sees as the "good things":

> "What are the things you like about injecting cocaine?"

The answer can give you an insight into what is important for this young person, e.g.:

> "I like it because I share good times with my friends."
> "I used to snort cocaine but now I inject because it gives me a better feeling."

Less good/not so good things about injecting

Explore the young person's concerns about the "less good things":

> "What are the 'not so good things' about injecting cocaine?"
> "Can you give me some examples of that?"

The answer can give you an opening to further discussions on the less good things, e.g.:

> "I haven't been feeling well lately."
> "My girlfriend says she is going to leave me if I don't stop injecting."

Cost of change

Explore what would be different for young injectors if they stopped injecting, or changed to another mode (e.g. snorting) or reduced the frequency of injecting:

> "What would be different in your life if you stopped injecting or injected less frequently?"
> "What would be different if you changed your mode of using cocaine, e.g. to snorting and not injecting?"

The answer can reveal what they imagine would happen if they changed their drug use, e.g.:

> "I would have more money for my family."
> "I might be able to get a job."
> "I wouldn't have marks on my arms which I have to hide with long sleeves."
> "I would lose all my friends."

7. HEALTH WORKER ACTION ON IDU IN THE COMMUNITY

The aim of health worker action, which is focused on preventing IDU and providing services for young injectors in the community, is to:

- prevent young people who are not injecting drugs from starting;
- advise and assist young drug injectors to stop or reduce their use;
- implement ways to reduce the harmful effects for young people who do not or cannot stop injecting drugs.

Raise awareness about IDU and encourage support for young people

- Raise family and community awareness about IDU and young injectors by discussing the local situation with health worker colleagues, parents, community leaders and other gatekeepers.
- Raise people's awareness and allow them to talk about IDU in their families, workplace and communities. This can contribute to challenging the stigma and discrimination of injectors which is a barrier to seeking help.
- Work with families so that they can learn skills to help them deal with the challenges presented by adolescents and assist in preventing IDU, and also skills that will support them if their adolescents do inject.
- Encourage a supportive family and social environment that can protect young people from starting to inject and help injectors to stop. Some young injectors may have experienced trauma, abuse and separation from family, friends and the community. This can leave them depressed and suicidal with the feeling that there is no reason to continue living. For these young people the health and social network may be especially important.
- Inform the community about the important issues of IDU among young people in order to prevent negative reactions from community members (e.g. "Why should we care about people who inject drugs?"). It is important to have these discussions early enough to prevent a backlash from community members who are opposed to IDU programmes and services.

Contribute to prevention programmes

- Health workers can contribute to community prevention programmes which aim to reduce the supply and demand for injectable drugs.
- The community as a whole, especially young people, should be involved in planning and implementing community prevention programmes. Giving the target community ownership is a key to the success of any initiative.
- Prevention programmes can invite former young injectors to talk to young people about the negative impact of injecting drugs.
- Prevention programmes are needed that are targeted specifically at young people who are not yet injectors but are susceptible, as well as recently started injectors and occasional injectors.
- Prevention programmes should make use of existing networks, resources and links between community organizations and health services, both governmental and nongovernmental.
- Older injectors should be made aware that they may have an influence on whether a young person begins injecting and that they should not encourage them to start IDU.

Provide young people with community links

- Inform young injectors about support services within their community, outreach services, needle and syringe programmes (NSP), peer support groups, referral services, etc.
- Provide the young person with community links and encourage them to seek support.
- Encourage them to ask their family, relations and friends for help, if appropriate.
- Use peers to reach networks that include new injectors and those at risk of injecting.
- Provide links to other health services (e.g. sexual and reproductive health clinics, STI, antenatal care).

Support harm reduction interventions and services for young injectors

- Harm reduction strategies aim to reduce the negative consequences (harm) of drug use rather than stop or reduce drug use itself. These strategies focus on the most immediate and achievable changes that can reduce the threat to the health and wellbeing of the user and of society.
- Harm reduction strategies support and work together with strategies to reduce drug supply and demand.
- Health workers have a role in raising public awareness of the importance and benefits of harm reduction for individuals and the community. Harm reduction strategies are often opposed by community members who think this would encourage substance use.
- Health workers are of key importance in providing harm-reduction and counselling services and in referring young injectors to these services.
- Harm reduction interventions include providing practical information on injecting safely, supplying injecting equipment, and promoting condom use (e.g. access to and correct use of condoms by all sexually active young people, including injectors and their sexual partners).
- Health workers and teachers should work together to encourage young injectors who are students to continue their education.
- Disenfranchised and marginalized young people should be helped to develop a sense of hope for their future.
- Health services should not discriminate against young injectors who are HIV-positive and must provide them with equitable services, including access to antiretroviral therapy (ART) and HIV support services.

8. Harm reduction strategies and young injectors

Harm reduction describes a package of interventions that aim to prevent or reduce a range of harms associated with IDU (e.g. physical harms such as blood-borne infections and social harms such as crime). These interventions are necessary for individuals who do not or cannot stop injecting.

There is strong evidence that Harm reduction strategies are effective in contributing to public health outcomes which benefit both the individual and the community. Harm reduction strategies respect the human rights of individuals who inject. Health is a human right and each individual has the right to access the information and the means to protect his/her health. Harm reduction includes prevention (risk reduction) and treatment strategies.

In developing the services and Harm reduction programmes for young injectors, it is important to ensure that young people have adequate access to these services, and also to ancillary health services. This is particularly important for new and occasional young injectors. Access to treatment and the provision of Harm reduction products can be improved by ensuring that the services are youth-friendly, geographically accessible, appropriate and affordable. Policies are needed that enable programmers to maximize young people's access to these services.

Harm reduction interventions for adolescent and young injectors should consider the different needs of young and older adolescents. Adolescents of different ages need services that are targeted at their different developmental levels. For example, interventions and messages may need to be understood at both concrete and abstract levels of thinking. The period of growth in adolescence marks the beginning of a person's ability to think in an abstract way, do problem-solving, think critically, plan, and control impulses.

There is evidence that effective Harm reduction services are those that are linked to other health and social services which young people need. Stand-alone needle-and-syringe programmes and substitution programmes are unusual. Most operate from within pre-existing services or in collaboration with other health facilities, such as pharmacies or sexual reproductive health services.

The World Health Organization and other international agencies have identified five strategies for the effective prevention of HIV among injectors. These are described below.

BOX 3

Harm reduction:

- is not a soft option on drugs;
- is not a step towards the legalization of drugs;
- does not encourage or condone drug use;
- is not a new method of prevention and treatment for drug misuse; and
- is not in conflict with the objectives of law enforcement.

(Adapted from ESCAP 1999)

Provide information on risk reduction

This is also referred to as IEC (information, education and communication) or BCC (behaviour change communication).

Risk-reduction information is important because many young people do not know the risks of injecting drugs. If they know about the risks, they can choose to reduce them. Young injectors need information on the risks of IDU (blood-borne infections, local and systemic bacterial infections, overdose), on safer injecting practice (safer injecting sites), and on safe sex (correct and consistent use of condoms). Without this information they cannot reduce their risk.

The information has to be relevant to the young injector's situation, credible (i.e. from a trustworthy provider), understandable (simple language), and presented in an acceptable manner for particular groups of young people.

Health workers can provide information and encourage discussion through the health centre, schools, clubs and youth centres. The information can aim to prevent young people from starting to inject or, if they are injectors, to stop or reduce their risk.

Increase access to needle-syringes programmes

A Needle and Syringe Programme (NSP) includes services that either exchange or provide sterile injecting equipment. NSPs give individuals the opportunity to use clean needles and syringes and so prevent the risk of acquiring or transmitting blood-borne infections. They also allow for the safe disposal of used equipment. NSPs are operated by different agencies (government health services, NGOs and private pharmacies) using various means (e.g. community outreach and fixed-site vending machines). Evidence suggests that NSPs, when linked with other services, are effective (even cost-effective) in reducing needle-sharing and HIV infection rates among injectors.

In the absence of NSPs, as there is no guaranteed safe way of cleaning used injecting equipment, the sharing of such equipment can lead to rapid spread of viruses. Studies have shown that in cities that had no NSPs, HIV prevalence among injectors rose by almost 6% each year. In cities with NSPs, the number of drug injectors and the frequency of IDU did not increase.

However, one limitation of NSP can be that they target self-identified drug injectors and often miss occasional or recreational drug users. This is an important issue because many young people are occasional users. Concerns about confidentiality can also be a barrier for young people to access NSPs. Injecting equipment needs to be easily available through other outlets to reach young injectors (e.g. health centres, pharmacy programmes, vending machines, drug-user network).

In some parts of the world, IDU is one of the fastest growing routes of HIV and hepatitis B and C transmission. In many communities the HIV, hepatitis B and C, and STI prevalence rates are higher among injectors. Although health workers may not be in a position to start a local NSP, they can understand the role of NSPs and support local efforts to begin such a programme.

Outreach services

Needle-syringe programmes are most effective when linked to outreach projects that use peer counsellors and provide other services (e.g. counselling, condoms, STI treatment). These outreach services may be provided by government or nongovernmental organizations.

Injectors are frequently marginalized in society and may not come to routine health services. Outreach takes the services to injectors in the communities where they gather. There is evidence that community-based peer outreach is an effective intervention and is widely utilized.

Outreach services can include education, advice on risk reduction, HIV testing and counselling, skills training, supplies and services to promote behaviour change among injectors, and advice on unprotected sex (e.g. use of bleach, condoms, and STI treatment).

It is often especially hard to reach young injectors and difficult to communicate with them. Research has shown that the effectiveness of communication with injectors depends greatly on who is trying to communicate and where this takes place. The outreach worker is referred to as a "peer" or someone familiar and trusted by the community of injectors. A young injector may be more willing to listen to a peer outreach worker who is close in age and experience.

Substitution programmes

Substitution treatment is the administration, under medical supervision, of a prescribed medicine with similar action to the drug of dependence. Substitution is only offered to individuals who are dependent. Substitution programmes can give dependent injectors an opportunity to reduce the risks associated with IDU (e.g. by taking the medicine orally) and to reduce or stop using substances (by gradually reducing the dose of the prescribed medicine).

Substitution programmes have been found to be effective in assisting drug users to stop or reduce injecting. They are primarily for opiate dependence (using methadone and buprenorphine). When injectors enter a programme they receive support and counselling to deal with the emotional and social issues that may contribute to their use of drugs. Substitution programmes also aim to reduce the need for criminal activity to finance drug use.

Most young injectors are not dependent. Other treatments and interventions should be thoroughly explored before substitution therapy is considered.

Supportive policies, laws and targeted advocacy

Supportive policies and laws can influence public health interventions, especially among marginalized populations, and at the national level are crucial to foster the development of a local environment that supports safer behaviour among injectors. Policies and legislation that prevent or discourage IDU programmes can lead to further marginalization of injectors and negative public health outcomes. Harm reduction services rely on injectors who have health concerns as a prime motivating factor as well as a desire to live. Like all people, injectors also need a supportive social network and access to health services. Primary healthcare services must be available and accessible to the health needs of young injectors. Health services and health workers must not discriminate against injectors and can be active in promoting equal care and support for injectors in their community.

Service providers in all sectors of society (health, education, social services, etc.) should examine their own views about young people who inject drugs because stereotyping of injectors can lead to false beliefs about the reasons for injecting, which can encourage discrimination against young injectors when they try to access services.

9. Harm reduction messages for young injectors

The following messages provide information on the most favourable circumstances and practice for the injector. However, the reality is that injectors are often unable to go through all these steps owing to lack of equipment or time, or lack of knowledge, or because they have to inject in a public place and get away quickly to avoid being arrested.

BOX 4

Messages for young people

- Stop or never start using drugs.
- Always use a condom when having penetrative vaginal or anal sex.
- If you have to use drugs, don't inject.
- If injecting, don't re-use the equipment.
- If re-using, use your own equipment.
- If re-using another parson's equipment, clean it appropriately.

Messages for young people

The following messages are for all young people - i..e. those who are not using drugs, those who are drug users, and those who use drugs by injection. The health worker can assist young people to understand the steps that increase their risk of negative consequences from injecting drugs.

- *Stop or never start using drugs*. This is a message for all young people. (Of course, if you know or suspect that a person is already using drugs, then it is not appropriate to say, Never start.)
- *Always use a condom when having penetrative vaginal or anal sex*. This is a message for all young people who are already sexually active or who may soon become sexually active.
- *If you use drugs, use them in any way except by injection.* If you do not inject drugs, you cannot acquire infections through needle-sharing or experience other problems associated with injecting. However, you will experience other problems resulting from the effects of the substance. This message is for a young person who is already injecting drugs.
- *If you continue to inject, use new injection equipment every time*. If you use new injection equipment every time, you cannot acquire viral infections such as HIV through needle-sharing. Do not let other injectors use your needles, cookers/spoons or filters.
- *There is no guaranteed safe way of cleaning needles and syringes*.
- *If you need to re-use any equipment, use your own injecting equipment every time*. If you re-use your own injection equipment every time, you cannot acquire viral infections such as HIV (unless someone else has used your equipment without your knowledge).
- *If you need to re-use any equipment and you must use someone else's (e.g. sharing needles and equipment), clean them by an approved method* (see below, section 9.5). There is still some risk of HIV transmission after needle-cleaning, but cleaning in an approved manner will reduce the likelihood of transmission.

BOX 5

Messages for young injectors: before injecting

- Choose a safe location to inject.
- Always use new, sterile needles and syringes.
- Do not share any injecting equipment.
- Wash your hands, clean the injecting site and clean all surfaces.

Messages for young injectors: before injecting

These are the messages the health worker gives to the injector:

- *Choose a safe place to inject*: one that is private, clean, well lit and with running water, if possible.

Make sure you have everything you need within reach: new sterile needle(s) and syringe, new sterile water (or cooled boiled water in a clean glass), new swabs, a clean filter, a clean spoon, and a clean tourniquet.

- *Protect yourself from infection* by always using your own new, sterile needles and syringes. Get these from a needle and syringe programme if possible.
- *Do not share any injecting equipment*. Sharing is not just using a needle or syringe that someone else has used. It is also using the mixing water, cups or pots, spoons or 'cookers'; filters; swabs/alcohol wipes; tourniquet that someone else has used; or passing these on to someone else. Splitting a large quantity of drugs from one syringe into others may also be risky.
- *Wash your hands with soap and warm water* before and after each injection. Hand washing is very important to remove viruses, bacteria, and dirt from your injecting environment. If you can't wash your hands, clean them with swabs, using a single wipe for each swab. Rubbing swabs backwards and forwards spreads the dirt and bacteria around. Clean the injecting site with soap and water or alcohol. Use soapy water to wipe down the surface where you will prepare your injection, or lay down some clean paper.

Prepare injections on a clean surface with clean hands. Use clean materials to stop bleeding after injecting. Care and use of clean preparations will reduce the risk of infection.

Messages for young injectors: mixing the drugs

- *Clean the spoon* by wiping once with a new swab and let it dry. Put the drug in the spoon.
- *Use a new sterile needle* and syringe to draw up water from a new ampoule of sterile water (or cooled boiled water in a clean glass). No matter how well it has been cleaned, never allow your used equipment (or anyone else's) to come into contact with a group mix of a drug.
- *Add the water to the spoon and mix*. Use the blunt end of your syringe, which you have swabbed clean with one wipe of a new swab, for mixing.
- *Add the filter to the spoon*. The best filters are a piece of a new swab or tampon or a cotton bud. If you are injecting pills, use pill filters if you can get them; if you can't get them, filter at least three times.
- *Draw the solution into the syringe through the filter to remove impurities*. Remove air bubbles by pointing the needle skywards and flicking on the side of the syringe. Push the plunger up slowly until the air bubbles escape through the end of the needle.

BOX 6

Messages for young injectors: mixing the drugs

- Clean the spoon and then put the drugs in it.
- Draw sterile water into a new syringe.
- Add the water to the spoon and mix with the syringe.
- Add the filter to the spoon.
- Draw the solution up through the filter and remove air bubbles.

Messages for young injectors: injecting technique

- *Use only a safe injecting site* (e.g. veins in the arm or leg, never in the neck or head). Avoid damaged, especially infected, sites. Choose injection sites, by rotation, in order to:
  - avoid bruising and infection, and allow the damaged vein to heal;
  - reduce scarring and thickening of the vein wall which may make future injections difficult.

BOX 7

Messages for young injectors: injecting technique

- Inject in a "safe" site and rotate your sites.
- Place the tourniquet around the upper arm and insert the needle in the vein.
- "Jack back" (i.e. gently pull the plunger till blood enters the barrel, then push to inject).
- Inject slowly.
- Apply pressure over the puncture site for at least two minutes.
- Safely discard the used equipment.

- *Place the tourniquet around the upper arm* (or above the injection site), but not for too long. *Insert the needle in the vein*. If you have trouble finding a vein, release the tourniquet and try again. Running warm water over the injection site will help raise a vein; or open and close your fist a few times in a pumping action. Try not to touch anything that hasn't been cleaned until you have finished injecting. Put the needle into your arm at a 45-degree angle, with the hole facing up. Blood will sometimes appear in the barrel when the needle is inserted in the vein.
- *Jack back*, i.e. gently pull the plunger to let blood enter the syringe; then push all the way down to inject into the vein. It is important to avoid injecting into an artery.

  If you suspect an artery has been hit (blood is bright red), immediately withdraw the needle and apply pressure for 5-10 minutes with the limb raised. If the bleeding does not stop, seek urgent medical help.

  If there is no visible blood in the syringe (because the needle is not in a vein), remove the needle and tourniquet from the arm, apply pressure (using a cotton ball) to stop any bleeding, take a deep breath and start again. When you are sure the needle is in the vein, loosen the tourniquet and slowly depress the plunger. If you feel any resistance or pain, you may have missed or slipped out of the vein and will have to start again. Remove the needle, keep your arm straight, and apply pressure to the injection site for a couple of minutes (using a cotton ball or tissue).
- When the needle is in a vein, *inject slowly* in the direction of the blood flow (towards the heart). This will ensure that the drug is going into the vein and not the surrounding tissue.
- *After injecting, apply pressure for at least one to two minutes*: this will stop the bleeding and reduce bruising and infection. Do not use alcohol swabs when applying pressure as this may interfere with clotting. Cover with clean material.
- *Discard used equipment safely*, especially the needle and syringe. Recap your own needle.

BOX 8

Messages for young injectors: cleaning methods for needles and syringes

- There is no fail-safe way of cleaning used equipment; the only way to ensure safety is to use sterile equipment every time.
- Cleaning of equipment for re-use should only be done in settings where NSP is not available.
- If you are using someone else's needle or syringe, ensure that it has been cleaned immediately after the first use and then cleaned again before re-use.

Messages for young injectors: cleaning methods for needles and syringes

As there is no guaranteed safe way of cleaning needles and syringes, if injectors are going to re-use the equipment it is better to re-use their own and not someone else's. It is also important to advise injectors who keep syringes for re-use to mark/identify them and keep them in a safe place where they cannot be reached or used by other people. The risk that someone else has used their syringe without their knowledge is another important reason for cleaning the syringe again before re-use.

- Re-using and cleaning of equipment should only be done in settings where NSPs are not available.

  Disinfection programmes, in which bleach or information on effective disinfection techniques is provided to injectors, can be used when a NSP is not available. Disinfection programmes most commonly operate where NSPs are restricted by government policy or lacking.
- As there is no fail-safe way of cleaning used equipment, the only way to ensure safety is to use sterile equipment every time. If someone else's used needle or syringe is to be used, make sure that it was cleaned immediately after the first use and then cleaned again before second use in order to try and reduce the risk of HIV and hepatitis B and C infection.

  Before they are put into the disposal container, the needle and syringe should be rinsed with clean cold tap water, straight after use. This removes most of the blood, prevents blocking in the needle, and helps to reduce the likelihood of "dirty hits" if the needle and syringe are used

again. Get rid of the rinsed water immediately, so no-one else can use it and contaminate their equipment.

- If you are using someone else's needle or syringe, be sure that it was cleaned immediately after first use and then cleaned again before second use. Injectors should recap their own needles and syringes and put them in the disposal container or a puncture-proof, child-proof container, which has to be returned to the NSP. Do not recap another person's needle and syringe. Use soapy (detergent) water to wipe down the area where the drugs were mixed.

Although there is no fail-safe way of cleaning used equipment, there are situations when injectors may want to re-use the equipment. The following four methods are frequently used. However, there is no firm evidence of their effectiveness.

- **"2 by 2 by 2" method**
  - Draw COLD water (sterile or boiled and cooled) into the syringe and then flush it out down the sink or into a different cup. Do this twice.
  - Then slowly draw bleach into the syringe and shake it for as long as possible (three to five minutes is ideal, 30 seconds is the minimum). Flush it out down the sink or into a different cup. Do this twice.
  - Then draw COLD water into the syringe (as in Step 1) and then flush it out down the sink or into a different cup. Do this twice as well.

- **Soaking in bleach**

  Soak the needle and syringe in either undiluted bleach or a strong detergent and water solution for as long as possible (at least several minutes) and rinse thoroughly with water.

- **Boiling the needles and syringes**

  Boil the needles and syringes for 15-20 minutes. A plastic syringe, when boiled, may become deformed and leak.

- **Washing the needle and syringe**

  Wash the needle and syringe several times (e.g. 10 times) immediately after use with cold water. Do this before the blood and drug solution has dried; this procedure is likely to flush out most infectious agents. Also, using water - or even vodka, wine or beer - to flush out the syringe and needle before re-use is likely to reduce the risk.

  Do not re-use swabs, filters, or partly used water ampoules: they could have become contaminated once opened. When you have cleaned up, wash your hands and arms with soapy water. If this is impossible, use single wipes with new swabs instead. Store all your equipment in a clean, safe place.

The above messages need to be reinforced by people in different sectors of society so that they are given to young people and frequently heard by them. The health, education, youth, and law enforcement sectors must work with young drug users to develop and implement credible and consistent drug prevention measures.

10. Important considerations when working with young injectors

There are many challenges to developing a service for young injectors and the fact that injecting of drugs is illegal makes it especially complex. In most countries, interventions for young injectors in particular must take account of sensitive legal and ethical considerations.

Because of social stigmas, injectors frequently face discrimination in gaining access to services. Young injectors may already be marginalized and living on the edge of society, or they may be experimenting with injecting and are not easy to find. To work with young injectors, health workers need to develop particular skills and personal qualities. To make contact and develop a relationship of trust and respect call for understanding and empathy with the issues and a genuine non-judgemental attitude of the health worker towards young people and their lifestyle.

Legal considerations

The laws and regulations of a country have a bearing on the development of services for young people. For example, issues like the legal age for the right to confidential medical treatment or consent to medical treatment, the reporting requirements for health workers on illegal substance use, and the purchasing and drinking of alcohol or the purchasing and smoking of tobacco by minors have a direct or indirect influence on young peoples' access to services.

Injecting of drugs is an illegal activity, so it is important that services for injectors take into consideration and meet the legal requirements or restrictions of the country in which the service is being offered.

Ethical considerations

Ethical considerations include respect for the human rights of individuals who inject drugs. In some countries, drug injectors may be turned away and refused any services, or forced into treatment programmes or imprisoned.

Ethical considerations may need to be addressed concerning injectors who are under-age. Health workers need guidance on issues of confidentiality for minors and on whether to provide health services to a minor in the absence of a parent's or guardian's consent. Notification of drug use to the authorities and disclosure of drug use by a minor to parents or guardians need to be in line with the country's laws and regulations. Health workers should be guided by human rights principles, i.e. all adolescents have a right to use health services, and health workers should act in the best interests of adolescents, whose evolving capacities and increasing ability to make independent decisions must be understood and respected.

It may be useful to consult the Ministries or Departments of Health, Welfare and Youth, and any relevant Child Protection Agency for guidance. Some countries have developed guidelines that draw upon a child protection framework in order to overcome age or other barriers to the access of sterile injecting equipment. Some guidelines require that all who make such equipment available must abide by child protection guidelines, which call for the notification of any 'at-risk' adolescents to the child protection authorities.

Substance users, and especially injecting substance users, frequently face discrimination and stigmas from society in general and also when accessing health services. Health workers who work with

young substance users will need to examine their own values and attitudes to substance use. They will also have to privately consider and review their own personal use of substances. This is necessary to enable them to provide the best possible care and support to their clients and to equip them to challenge the stigmas and discrimination in society and healthcare settings.

Evidence base for harm reduction

Harm reduction is an evidence-based public health concept. It aims to prevent or reduce negative health consequences associated with certain behaviours. Harm reduction is one part of the strategy to decrease IDU. In relation to drug use, harm reduction is consistent with a public health and human rights approach to the broad range of problems associated with IDU, including prevention and treatment, in which evidence-based strategies aimed at drug users are promoted. Harm reduction strategies include needle and syringe programmes, drug substitution programmes, and condom promotion.

In addition to a broad range of other problems, injecting drug use is the cause of the fastest growing HIV and hepatitis C epidemics in some parts of the world, primarily because needles, syringes and drug preparation equipment are frequently shared, which leads to spread of the viruses.

There is strong evidence that Harm reduction strategies for injectors benefit both the individual and the community. However, in many places, the public perception is often contrary to this. There are strong and vocal views that Harm reduction strategies will encourage or condone behaviours that are illegal and socially unacceptable. These views are based on misinformation.

In 2004, WHO prepared a report to evaluate the evidence on the effectiveness of sterile needle and syringe programmes for HIV prevention among injectors in different settings and contexts, in order to guide public health policy-makers. The following conclusions are taken from this report.

BOX 9

Conclusions

- There is compelling evidence that increasing the availability and utilization of sterile injecting equipment by injecting drug users reduces HIV infection substantially.
- There is no convincing evidence of any major, unintended negative consequences.
- Needle-syringe programmes are cost-effective.
- Needle-syringe programmes have additional and worthwhile benefits apart from reducing HIV infection among injecting drug users.
- Use of bleach and other forms of disinfection (of injecting equipment) is not supported by good evidence of effectiveness for reducing HIV transmission.
- Pharmacies and vending machines increase the availability and probably the utilization of sterile injecting equipment.
- Injecting paraphernalia legislation is a barrier to effective HIV control among injecting drug users.
- Needle-syringe programmes on their own are not enough to control HIV infection among injecting drug users.

See: *www.who.int/hiv/pub/prev_care/en/effectivenesssterileneedle.pdf* for more details.

Source: Evidence for Action Technical Papers: *Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS among Injecting Drug Users*. WHO, 2004.

11. Key messages

- *The injecting of drugs is a growing problem among young people in many countries.*

  Experimental or occasional injecting is common. Around half of first injections occur between the ages of 12 and 18 years.

- *Injecting causes many negative consequences.*

  The main consequences are physical (e.g. overdose, dependence, blood-borne infections) and psychosocial (e.g. stigmatization, discrimination, problems with illegal activity, mental illness).

- *Young injectors require special attention.* The reasons for this are:
  - The unique nature of young people
  - The nature of drug use by young people
  - Issues of consent and confidentiality
  - Young people are often not aware of the risk associated with IDU
  - They have less access to support and services.

- *There are many challenges to developing a service for young injectors*; they include legal and ethical considerations and concerns about Harm reduction strategies.

- *It is important to assess all young people for IDU* (prevention, early detection, risk reduction) because it is not possible to know who among them is injecting.

- *Appropriate attitudes and values are essential for health workers working with young injectors.*

  They include being sincere, respectful, knowledgeable, and professional and treating the interviews as confidential.

- *Reducing the harm of injecting is important for injectors who do not or cannot stop.*

- *Harm reduction is an evidence-based public health concept, which benefits the individual and* society as a whole.

12. References

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3. UNAIDS/UNODCCP. *Drug abuse and HIV/AIDS: Lessons learned. Case Studies Booklet: Central and Eastern Europe and the Central Asian States*. New York, United Nations, 2001.
4. UNICEF/UNAIDS/WHO. *Young people and HIV/AIDS: Opportunity in crisis*. New York, UNICEF, 2002.
5. World Health Organization. *Working with street children: A training package on substance use, sexual and reproductive health including HIV/AIDS and STDs*. Geneva, WHO/MDP/00.14, 2002.
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8. World Health Organization. *Advocacy Guide: HIV/AIDS prevention among injecting drug users*. Geneva, 2004.
9. World Health Organization. *Evidence for action: Effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users*. Geneva, 2004.
10. World Health Organization. *Training guide for HIV prevention outreach to injecting drug users*. Geneva, 2004 (http://www.who.int/hiv/pub/prev_care/hivpubidu/en/)
11. World Health Organization. *Neuroscience of psychoactive substance use and dependence*. Geneva, 2004.
12. World Health Organization. *SEX_RAR guide: The rapid assessment and response guide on psychoactive substances and sexual risk behaviour*. Geneva, 2002.
13. World Health Organization. *Policy and programme guide for HIV/AIDS prevention and care among injecting drug users*. Geneva, 2005.

Annex 1

Module schedule

Activities that are marked with * are optional activities which are not included in the 180 minutes planned for this module. The facilitators' decision to include the optional activities depends on the available time and whether these activities are covered in other modules in this workshop.

Sessions and activities	Time
Session 1 **Module introduction**	10 min
ACTIVITY 1-1 Module objectives ACTIVITY 1-2 Spot checks	
Session 2 **Young people and injecting drug use**	40 min
ACTIVITY 2-1 Mini lecture: Introduction ACTIVITY 2-2	
Individual exercise: Who is the young injector? *	25 min *
ACTIVITY 2-3 Brainstorming: Why injecting? ACTIVITY 2-4 Brainstorming: What substances are injected? ACTIVITY 2-5 Brainstorming: Negative consequences of IDU for young people ACTIVITY 2-6 Mini lecture: Why young injectors require special attention? ACTIVITY 2-7	
Mini lecture by guest presenter: Local situation with young people and IDU *	15 min *
Session 3 **Assessment of young people for IDU**	40 min
ACTIVITY 3-1 Brainstorming: Suspecting a young person is injecting ACTIVITY 3-2 Mini lecture: Assessment for IDU ACTIVITY 3-3 Role play: Assessment of the young injector	
Demonstration of role play *	15 min *
Extra role play *	20 min *
Session 4 **Health worker action with young injectors**	40 min
ACTIVITY 4-1 Mini lecture: Aims of action with young injectors ACTIVITY 4-2 Role play: Action in the clinic using GATHER	
Extra role play *	10 min *
ACTIVITY 4-3 Group work: How to contact young injectors *	20 min *
ACTIVITY 4-4 Mini lecture: Action in the community	

Sessions and activities	Time
Session 5 **Harm reduction and young injectors**	40 min
ACTIVITY 5-1 Mini lecture: Introduction to harm reduction	
ACTIVITY 5-2 Needle and Syringe Use: Demonstration *	30 min *
ACTIVITY 5-3 Mini lecture: Specific harm reduction strategies for injectors	
ACTIVITY 5-4 Mini lecture by guest presenter: Local IDU services for young people *	15 min
Session 6 **Module review**	10 min
ACTIVITY 6-1 Review of objectives	
ACTIVITY 6-2 Review of spot checks and Matters Arising Board	
ACTIVITY 6-3 OPPD	
ACTIVITY 6-4 Key messages from Module and closure	
180 min optional 170 min	

Annex 2

Spot checks

Sessions 1 and 6

SPOT CHECK 1

Why may young people choose to inject substances?

SPOT CHECK 1

What are the negative physical consequences of injecting drugs?

SPOT CHECK 3

List FIVE injecting-related questions you could ask when assessing a young injector

SPOT CHECK 4

List FIVE harm-reduction strategies for IDU

Annex 3

Scenarios for assessment

Session 3: ACTIVITY 3-3

The purpose of this exercise is to use role play to practise the assessment by the health worker of a young injector.

You have been counted into groups of three persons (triad), each given a number 1, 2 or 3. (Please remember your number and your group because they will be the same in the next session).

The number 1s will be the young person, the number 2s will be the health worker and the 3s will be the observer.

Each triad (group) is given a scenario.

The young person and the observer (number 1 and 3) should now read their scenario.

The health worker (number 2) does not read the scenario but will understand the situation with their young person during the role play, using listening and assessment skills. There is a lot for the health worker to remember to ask in this role play.

Slide X3-5 will be displayed and can be used as a prompt.

In this exercise, do not spend much time on the presenting complaint. Focus on Greeting and Assessment of the young person and stop the interview when you have completed the Greet and Assess components.

The observer will watch the role play. At the end of the role play, he/she will comment on the interview with the other two participants.

You have 2 minutes to prepare, 5 minutes for the interview and 3 minutes to report back in your triad.

Remember to come out of your "role" at the end.

SCENARIO 1

Kenko

You are a 16-year-old boy and have come to the health centre because you injured your knee when playing football. If the health worker asks you, say that you live at home with your parents and older sister. You have a delivery job after school.

You have smoked cigarettes since you were 14 and smoke about 15 every day. You smoke cannabis each weekend and you like the feeling it gives you. You do not drink alcohol. You have been snorting cocaine for the last six months with a group of older boys whom you meet after work. You snort whenever you have the money to pay - about 10 times in the last 6 months. Two months ago the older boys offered to let you shoot up (inject) cocaine. You found injecting was a very exciting experience and you have injected two more times since then. You use a needle and syringe which the boys lend you. You know it is clean because the boys say it is and you have seen them rinse it in hot water. You don't see any problem with trying new drugs. You like to go to parties when you have had cocaine because you have more fun. You do not have a girlfriend and have never had sex yet, but would like to if you had the chance.

SCENARIO 2

Soo

You are a 19-year-old woman and have come to the health centre for contraceptive advice. If the health worker asks you, say that you live with your boyfriend Meeko who is 26 years old. You work in a clothes shop. You smoke cigarettes (about 20 a day) and drink some alcohol most evenings (1 to 3 beers).

You have been injecting methamphetamines for about 1 year, ever since you met Meeko. You inject 2 or 3 times at the weekend. You are worried about your use of methamphetamines and have wanted to stop for 3 months now. You have had some problems with remembering things and concentrating. A couple of times after injecting, you have done things that seem crazy and have felt scared that you are going mad. You did stop injecting for one month but Meeko said you were no fun anymore and so you began to inject again. You have no concerns about your cigarette smoking.

You always use your own equipment and Meeko taught you to clean your needle and syringe carefully. Whenever possible, you get new needles and syringes.

SCENARIO 3

Boris

You are a 23-year-old man and have come to the clinic because you have noticed a discharge coming from your penis. If the health worker asks you, you say that you have no family and live with a group of friends (squatters) in town. You are involved in sex work and make a good living, sufficient to buy the drugs you need, food and drink, and some nice clothes.

You have been injecting heroin for two years. You look forward to and enjoy injecting because you do it with your friends and like the rush you feel when you inject. You have your own equipment, but have sometimes shared needles and syringes with your friends. Occasionally you have bouts of heavy drinking with your friends.

Annex 4

Scenarios for the GATHER approach

Session 4: ACTIVITY 4-3

The scenario is the same as the previous role play but we have more information on the young person.

If only one role play was completed by your group in Activity 3.3, then stay in the same groups and change roles (health worker, young person, and observer) for this activity, so that another participant has an opportunity to role play the health worker.

This time the number 1s will be the observer, the number 2s will be the young person and the 3s will be the health worker.

Numbers 1 and 2 can read the scenario. Take the next scenario on the list:

- If you had scenario 1 (Kenko) before, now take Scenario 2 (Soo)
- If you had scenario 2 (Soo) before, now take Scenario 3 (Boris)
- If you had scenario 3 (Boris) before, now take Scenario 1 (Kenko).

SCENARIO 1

Kenko

You are a 16-year-old boy and have come to the health centre because you injured your knee when playing football. If the health worker asks you, say that you live at home with your parents and older sister. You have a delivery job after school.

You have smoked cigarettes since you were 14 and smoke about 15 every day. You smoke cannabis each weekend and you like the feeling it gives you. You do not drink alcohol. You have been snorting cocaine for the last six months with a group of older boys whom you meet after work. You snort whenever you have the money to pay - about 10 times in the last 6 months. Two months ago the older boys offered to let you shoot up (inject) cocaine. You found injecting was a very exciting experience and you have injected two more times since then. You use a needle and syringe which the boys lend you. You know it is clean because the boys say it is and you have seen them rinse it in hot water. You don't see any problem with trying new drugs. You like to go to parties when you have had cocaine because you have more fun. You do not have a girlfriend and have never had sex yet, but would like to if you had the chance.

You like being with the group of older boys because even though you are younger, they make you feel a part of their gang. You did not know you could get HIV from sharing injecting equipment. You have heard of AIDS and it scares you.

Your family are worried about you. You are close to your older sister and can talk with her easily. Your grades at school are worse than they have ever been. You want to get a good job when you leave school. You like playing football and are good at it but find you often get short of breath. You would like to have some condoms in case you meet a girl who is willing to have sex with you because you wouldn't want her to get pregnant.

SCENARIO 2

Soo

You are a 19-year-old woman and have come to the health centre for contraceptive advice. If the health worker asks you, say that you live with your boyfriend Meeko who is 26 years old. You work in a clothes shop. You smoke cigarettes (about 20 a day) and drink some alcohol most evenings (1 to 3 beers).

You have been injecting methamphetamines for about 1 year, ever since you met Meeko. You inject 2 or 3 times at the weekend. You are worried about your use of methamphetamines and have wanted to stop for 3 months now. You have had some problems with remembering things and concentrating. A couple of times after injecting, you have done things that seem crazy and have felt scared that you are going mad. You did stop injecting for one month but Meeko said you were no fun anymore and so you began to inject again. You have no concerns about your cigarette smoking.

You always use your own equipment and Meeko taught you to clean your needle and syringe carefully. Whenever possible, you get new needles and syringes.

Meeko does not want to stop injecting methamphetamines and you are afraid that you will not be able to stay together if you try to stop. You know that you want more in your life and you hope to train as a hairdresser one day. You would also like to have children in the future. Your parents are worried about you.

SCENARIO 3

Boris

You are a 23-year-old man and have come to the clinic because you have noticed a discharge coming from your penis. If the health worker asks you, you say that you have no family and live with a group of friends (squatters) in town. You are involved in sex work and make a good living, sufficient to buy the drugs you need, food and drink, and some nice clothes.

You have been injecting heroin for two years. You look forward to and enjoy injecting because you do it with your friends and like the rush you feel when you inject. You have your own equipment, but have sometimes shared needles and syringes with your friends. Occasionally you have bouts of heavy drinking with your friends.

You have been beaten up by customers a number of times. You find that as you get older, you are attracting less business and as a result you take more risks to attract customers. Last week you started offering sex without a condom as a way of getting more business.

You have heard of HIV but do not know much about it. You want to know more. Your friends are the only family you have and they all inject drugs.