

ORIENTATION PROGRAMME

for Medical Officers

to provide

Adolescent-Friendly Health Services

HANDOUTS

FOREWORD

PREFACE

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Handout 1

Introduction

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1. Introduction

This handout provides information to complement the material covered in the Introductory Module to the Orientation Program on adolescent-friendly health services. The facilitator may refer to the text in this handout during the sessions and read some extracts.

Adolescence

By definition, the term, adolescence, is applied to the lifespan, usually between 10 to 19 years, in which children undergo rapid changes in body size, physiology and psychological and social functioning. This is the net result of surging hormones and social expectations designed to foster the transition from childhood to adulthood. True to the literal meaning of the term (the Greek word, *adolescere* denotes “to grow and to mature”), the sentinel occurrence during the period of adolescence is, “rapid growth”, not just physical and biological (sexual) but also emotional, cognitive, psychological, and social.

Adolescence begins with the onset of puberty, defined by the UNICEF as “the sequence of events by which the individual is transformed into a young adult by a series of biological changes.” It is during this period that secondary sex characteristics develop. These sex characteristics have been rated into five stages by Tanner. Globally a secular trend is being noticed towards earlier puberty. What indeed constitutes end of puberty remains controversial.

Arbitrarily, adolescence is divided into three phases: early, middle and late adolescence. Early adolescence refers to age 10 to 13 years, middle adolescence to 14 to 16 years and late adolescence to 17 to 20 years.

2. Why invest in Adolescents?

Adolescents (10-19 years) constitute about one fourth (21.4% or 243 million) of India's population and young people (10-24 years) about one third (or 350 million) of the population. This represents a huge opportunity that can transform the social and economic fortunes of the country

In order to enable adolescents to fulfill their potential, substantial investments must be made in: education, health, growth and development and other areas like nutrition and mental well being. Investments in adolescents will have returns which are immediate and cause direct positive impact on India's health goals and achievement of MDGs - especially Goals 1, 2, 3, 4, 5¹ and at the same time enhance economic productivity, effective social functioning, and overall population development.

Thanks to the concerted efforts of the World Health Organization (WHO) and the UNICEF, a worldwide campaign has begun to focus attention on adolescence. In India, the Indian Academy of Pediatrics (IAP) took lead in focusing attention on adolescence by declaring the year 2000 as the IAP Year of the Adolescent and the August 1 (first day of the World Breastfeeding Week) every year as the Teenager Day. Health problems of children up to 18 years (inclusive) should be the responsibility of pediatricians.

Taking cognizance of the need to respond to health and development requirements of adolescents in a comprehensive manner, the Ministry of Health and Family Welfare has developed a national strategy based on principles of participation, human rights, inclusive, gender sensitive issues, and intersectoral partnerships. The strategy envisions that all adolescents in India are able to realize their full potential by making informed and responsible decisions related to their health and well-being.

¹Goal 1 *Eradicate extreme poverty and hunger*; Goal 2 *Achieve universal primary education*; 3*Promote gender equality and empower women*; Goal 4 *Reduce child mortality and*; Goal 5 *Improve maternal health*

3. Social context of adolescents in India

Adolescence is characterized by rapid rate of growth and development, though most of adolescents are healthy or show lower levels of morbidity and mortality compared to children and adults. It is well recognized that adolescents developed health problems due to their unfavorable social conditions and their adaptive nature to unhealthy behaviors.

A considerable proportion of adolescents, both boys and girls, face challenges to their healthy development into adulthood, due to a variety of factors, including structural poverty, lack of information, unfavorable social norms, missed opportunity of education, lack of vocational training and societal expectations of early marriage, childbearing, forceful parenting with social discrimination.

Service provisions for adolescents are influenced by many factors. For example, at the level of the health system, a lack for adequate privacy and confidentiality and the judgmental attitudes of service providers, who often lack counseling skills, are barriers that limit access to services.

3.1 Education

A strong positive relationship exists between education and health outcomes whether measured by death rates, illness, health behaviors or health knowledge. There are marked inequalities in education among adolescents in India, access and completion being influenced by social class, caste, ethnicity and gender. While 32 million children enroll in class I, only 8 million graduate from class 12. One out of two children (53%) dropout during class I-10, with an even higher proportion for marginalized sections (75%). Only 2.35% of adolescent continue higher secondary education with high dropout rates for both girls and boys.

3.2 Early childbearing

Teenage pregnancy and motherhood, is frequent. One in five young women age 20-24 had their first baby before 18 years of age. Overall, 16% of adolescent girls had begun childbearing in 15-19 years age group (had a live birth or were pregnant with their first child). Among married adolescents a much higher proportion i.e. 58% are mothers or have already begun childbearing and in many cases they have already had more than one birth.

3.3 Gender discrimination

Adolescent girls continue to face gender discrimination and boys are bestowed with socially accepted advantages. The declining sex ratio, lower school-enrolment and higher drop-out rates, early marriage, incidence of domestic violence, under-age pregnancy, unsafe motherhood and increasing incidence of sexual abuse (UNFPA, 2006) clearly are unfavorable for the girls while the boys are at a risk of unhealthy behaviors which promote mental health problems, violent behaviors and non-communicable diseases. These factors have a direct or indirect influence on the health and well-being of adolescents and form an essential component of the background environment in which adolescent health issues should be understood. Program interventions must therefore adopt a gender sensitive approach towards promoting health and well-being of adolescents.

3.4 Health Issues

Adolescence is considered a healthy period nonetheless, more than 33% of the disease burden and almost 60 percent of premature deaths among adults can be associated with behaviors or conditions that began or occurred during adolescence—for example, tobacco and alcohol use, poor eating habits, sexual abuse, and risky sex (WHO 2002).

Nutrition

Malnutrition and anemia affect large sections of the Indian population, and are particularly high among adolescents. Findings from National Family Health Survey 3 (NFHS 3) indicate that as many as 56% of females and 30% of males in the 15-19 age group are anemic. Out of this, 17% females and 13% males suffer from moderate to severe anemia. More than half of women are anemic in every age group with the prevalence being higher for younger. Similarly prevalence of anemia in boys is higher for adolescents aged 15-19 years than for men aged 20-24 years and older age groups.

In the age group 15-19, nearly half of the females (47%) and nearly three-fifth of the males (58%) are thin. At the same time, 2.4% females and 2% males in the age group 15-19 suffer from obesity. Young people in rural areas are more likely than youth in urban areas to be abnormally thin and less likely to be overweight or obese. As is to be expected, the likelihood of being abnormally thin generally declines with education and wealth and the likelihood of being overweight/obese increases. NFHS-3.

Sexual and Reproductive Health (SRH)

Findings from the Youth Study (2006-07) suggest that adolescents and youth have limited awareness of majority of sexual and reproductive health matters. Only 15% young men and women in 15-24 age group reported that they had received family life or sex education in school or through special program sponsored by the government or NGOs although they expressed the need.

Findings from NFHS-3 suggest that age-specific fertility rate in the age group of 15-19 years contributes to 17% per cent of the total fertility rate. The contraceptive prevalence rate among married adolescent teenagers (age 15-19) is as low as 23%, which increases to 46% among women age 20-24 years. Contraceptive use in adolescents increases with education and wealth index. Condom use at first intercourse in 15-19 years adolescent is only 3% in girls and 19% in boys, indicating wide gender gap and lack of both contraceptive information and accessibility among girls.

Awareness of Sexually Transmitted Infections (STIs) and comprehensive knowledge of Human Immunodeficiency Virus (HIV) among adolescents is a concern. As per NFHS 3 awareness of STIs other than HIV/AIDS was limited in 15-24 years age group, just 19% of young men and 15% of young women reported awareness of STIs.

The contraceptive knowledge is quite high among adolescents but there are huge gaps between knowledge and usage. Only 23% of married girls reported use of any contraceptive method.

In context of maternity care, a little over three-fourths of mothers in the age group 15-19 received antenatal care (ANC) for their most recent birth during the five years preceding the survey. However, only 53% received three or more antenatal care visits and only 43% received the first antenatal care visit in the first trimester, as recommended. Only 47% of adolescent deliveries were assisted by health personnel, compared to 51% for older youth (age 20-24). Utilization of all maternity care services is much higher in urban than rural areas, and increases sharply with wealth and education.

Non-Communicable Diseases

According to WHO- NCD country Profiles 2011, non-communicable diseases are estimated to account for 53% of all deaths in India. NCDs also cause significant morbidity both in urban and rural population, with considerable loss in potentially productive years of life. It is estimated that the overall prevalence of diabetes, hypertension, Ischemic Heart Diseases (IHD) and Stroke is 62.47, 59.46, 37.00 and 1.54 respectively per 1000 population of India. As the main preventable risk factors for NCDs are tobacco & alcohol consumption; poor dietary habits, sedentary life style and stress, it is imperative to initiate promotion of healthy life style at a younger age. The adolescent period provide an opportune

time for positive behaviour modification to mitigate emergence of risk factors leading to non-communicable diseases.

Gender Based Violence

In India, among female adolescents age 15-19, 23% reported having experienced physical or sexual violence (NFHS 3). Nearly one out of three (31%) ever-married female adolescents age 15-19 reported experiencing physical, sexual, or emotional violence perpetrated by their spouse. Of these, 25% have experienced physical violence, 13% sexual violence, and 13% emotional violence. In the case of sexual violence, the prevalence declines to 11% for age 20-24, and 10% for age 25-49. There is wide variation between Indian states, ranging from 3% spousal violence in Himachal Pradesh, to 52% in Bihar. The incidence is higher in rural than urban areas.

4. National Adolescent Health Strategy

The strategy is a paradigm shift as it realigns existing approaches to focus on community based health promotion and prevention and strengthening of clinic based preventive, diagnostic and curative services across levels of care. The approach proposed in the strategy is based on a continuum of care for adolescent health and development needs through provision of information, commodities and services at the community level with mapped out referral linkages through the three tier public health system. Most importantly, it proposes a convergent model of service delivery which will actively engage adolescents and first level service providers like teachers in schools, ASHA and ANMs in the community, AWW under the ICDS and Youth volunteers of the civil society to secure and strengthen mechanisms for access and relevance.

To implement this paradigm shift the strategy identifies seven critical components: coverage, content, communities, clinics (health facilities), counseling, communication and convergence that need to be leveraged across strategic priority (program areas) which have emerged from a situation analysis of adolescent health and development in India. These are: nutrition, sexual and reproductive health, mental health, injuries and violence including gender based violence, non-communicable diseases and substance misuse. These interventions and approaches work toward building protective factors in the individual, family, school, and community levels by providing a comprehensive package of information, commodities and services.

To deliver these interventions the health system will need to strengthen effective communication measures, training and capacity building of critical stakeholders with an inbuilt monitoring and evaluation systems in place.

4.1 The Vision

All adolescents in India are able to realize their full potential by making informed and responsible decisions related to their health and well-being.

4.2 Objectives

- Increase the availability and access to information about adolescent health;
- Increase accessibility and utilization of quality adolescents counseling and health services; and
- Forge multi-sectoral partnerships to create safe and supportive environments for adolescents.

4.3 7Cs

A combination of prevention, health promotion and healthy development strategies are proposed, offering a continuum of care for adolescent health and development needs. Interventions in the strategy are designed to provide information, commodities and services at the community level and map referral linkages through the three tier public health system.

Most importantly, the strategy proposes a convergent model of service delivery which will actively engage with adolescents through first level service providers. To implement this paradigm shift, seven critical components need to be leveraged based on Health Promotion and Prevention Models and encompassing elements beyond the clinical services. These are as below:

1. Coverage

The new adolescent health and development strategy brings in dedicated programming for 10 to 19 years with universal coverage i.e. urban and rural; in school and out of school; married and un-married including the vulnerable and underserved subgroups.

2. Content

The revised Strategy identifies six strategic priorities based on 'at risk' analyses. The enhanced scope of the program will now incorporate the following areas: Nutrition, Sexual and Reproductive Health, Mental Health, Preventing Injuries and Violence (including Gender Based Violence), Substance Misuse and Non-Communicable Diseases. Life-skills education is identified as a key and cross cutting intervention.

3. Communities

The mainstay of this approach will be peer educators / mentors (both girls and boys) - selected, trained and mentored by the teachers in an institutional setting and jointly by ASHAs and AWWs in community based settings.

Field level functionaries will be providers of information, services and commodities at the community level and make appropriate referrals to Adolescent Friendly Health Clinics as and when required. Creating an enabling environment at the community level for adolescent health and development activities will be done through existing platforms like Aanganwadi Centres (AWCs), Sabla-Kishori Samooch, Teen Clubs and VHNSC and creating new spaces like organizing the quarterly Adolescent Health Day.

4. Clinics (Health Facilities)

The strategy envisages a dual focus: on developing community-based interventions and on strengthening Adolescent Friendly Health Clinics, which are dedicated spaces for adolescent in the existing health system. Trained staff sensitized with Adolescent issues will be made available from the existing health systems. There will be walk in services at Sub-Centre level and a dedicated weekly Adolescent Clinic at the Primary Health Centre. A dedicated counselor will be available from block/ CHC onwards. Specialty clinics are planned at District and Medical colleges.

Capacity Building

In view of enhanced scope of program, capacity building is planned to equip the relevant service providers across levels and departments with the necessary skill to deliver the proposed interventions with ethical conduct.

For quality training, inter-sectoral convergence is imperative. The strategy also proposes to include Adolescent Health specific additions/modifications in curriculum of undergraduate and post-graduate medical and nursing courses.

5. Counseling

Provision of appropriate awareness and information is a key strategy in health promotion approach. The strategy builds channels of information provision at every level of adolescent universe, for instance: peers, nodal/school teachers, ground level health service providers. This service is aimed not only at the adolescents but also influencers, care givers and families who act as gatekeepers and stakeholders.

6. Communication

Effective communication is an integral part of this strategy and will be a catalyst in successful implementation. The strategy proposes communication intervention at every level. The strategy proposes that health professionals should act as advocates on behalf of young people and as providers to young people and their care givers / parents of most relevant and up to date evidence based information; they should use methods and language deemed appropriate by the adolescents themselves.

7. Convergence

The Adolescent Health Strategy envisages all intra-departmental activities with existing programs of the Ministry of Health and Family Welfare and relevant inter-ministerial convergence. Strategic partnerships with other allied ministries, departments as well as key stakeholders will strengthen existing linkages and create new opportunities for partnerships and prevent duplication.

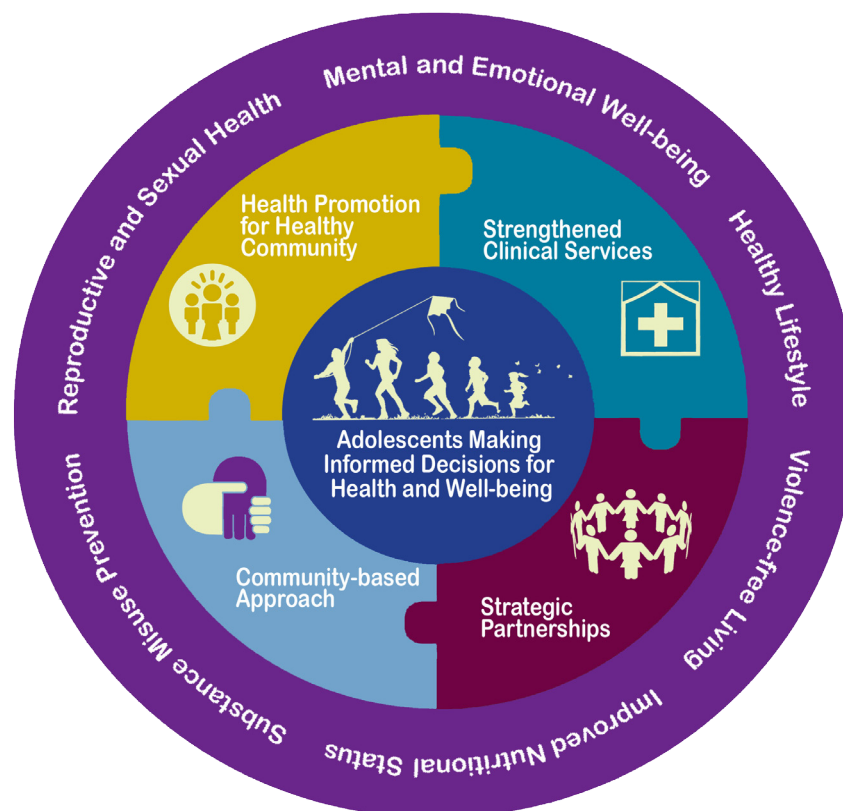


Fig. 1

4.4 Strategic Priorities

IMPROVE NUTRITION

- To reduce the prevalence of malnutrition among adolescent girls and boys
- To reduce the prevalence of iron deficiency anemia among adolescent girls and boys

ENABLE SEXUAL AND REPRODUCTIVE HEALTH AND

- To improve knowledge, attitudes and behaviors in relation to sexual and reproductive health
- To reduce teenage pregnancies
- To improve birth preparedness, complication readiness and; provide early parenting support for adolescent parents

ENHANCE MENTAL HEALTH

- To address mental health concerns of adolescents

PREVENT INJURIES AND VIOLENCE (INCLUDING GENDER BASED VIOLENCE)

- To promote favorable attitudes for preventing injuries and violence (including gender-based violence) among adolescents

PREVENT SUBSTANCE MISUSE

- To increase adolescents' awareness of the adverse effects and consequences of substance misuse

ADDRESS NON COMMUNICABLE DISEASE

- To promote behavior change in adolescents for prevention of non-communicable diseases hypertension, stroke, cardio-vascular diseases and diabetes

5. Brief overview of Operational Framework – Rashtriya Kishor Swasthaya Karyakaram(RKSK)

The goal of adolescents making informed decisions for health and well-being will be achieved through the following as shown in the (fig 1):

- Health Promotion for Healthy Community
- Strengthened Clinical Services
- Community-based Approach
- Strategic Partnership

5.1 Key Interventions for Operationalising for RKSK

5.1.1 Community based interventions:

- Peer Education (PE)
- Quarterly Adolescent Health Day (AHD)
- Weekly Iron and Folic Acid Supplementation Programme (WIFS)
- Menstrual Hygiene Scheme (MHS)

5.1.2 Facility based interventions

- Strengthening of Adolescent Friendly Health Clinics (AFHC)

5.1.3 Convergence

- within Health & Family Welfare - FP, MH (incl VHND), RBSK, NACP, National Tobacco Control Programme, National Mental Health Programme, NCDs, IEC
- with other departments/ schemes - WCD (ICDS, KSY, BSY, SABLA), HRD (AEP, MDM), Youth Affairs and Sports (Adolescent Empowerment Scheme, National Service Scheme, NYKS, NPYAD)

5.2 Peer Education

The PE programme aims to ensure that adolescents or young people between the ages of 10-19 years benefit from regular and sustained peer education covering nutrition, sexual and reproductive health, conditions for NCDs, substance misuse, injuries and violence (including GBV) and mental health. This is eventually expected to improve life skills, knowledge and aptitude of adolescents.

Key features of the PE operational framework in rural areas include:

- In every village, it is expected that at least four peer educators i.e. Two male and two female peer educators will be selected per village/1000 population/ASHA habitation. To ensure coverage of adolescents in both schools and out of school, two peer educators (i.e., one male and one female) will be selected to work with young people in school, and similarly, two peer educators will be selected to work with young people out of school. States / districts can vary this norm depending upon the number of adolescents in school/ out of school (drop outs).
- Each male and female peer educator will be expected to:
 - Form a group of 15-20 boys and girls respectively from their community and conduct weekly one to two hour participatory sessions using PE kits, which include books detailing a curriculum for PE sessions and games.
 - Participate in Adolescent Health Day to inform and educate young people
 - Refer young people to: 1) AFHCs and/or Adolescent Helpline; and 2) the Adolescent Health Day for health check-ups.
 - PEs will constitute Adolescent Health Club at sub-centre level, under the overall guidance of ANM. These clubs will meet monthly to discuss issues of PEs and get support from ANM.
- Peer Educators are expected to maintain a diary, including a brief overview of each session and the number of participants. At the end of each month, Peer Educators are to develop a brief composite report of the number of sessions and average attendance rates.

The PE programme in urban areas will operate in a similar manner as rural areas.

It provides operating guidelines for implementing Peer Education (PE) at the village and urban slum levels. The guidelines cover programme planning and preparation, including implementation modalities; b) recruitment and retention of peer educators; c) training; d) facilitating PE sessions; e) supportive supervision and management; and finally, f) monitoring and review.

5.3 Adolescent Health Day

AHD, one of the strategies to achieve the objectives of the adolescent health program seeks to:

- Improve coverage with preventive and promotive interventions for adolescents
- Increase awareness among adolescents, parents and families and stakeholders about the determinants of adolescent health such as nutrition, SRH, mental health, injuries and violence (including GBV), substance misuse and NCDs
- Improve awareness of other AH related services, in particular Adolescent Friendly Health Clinics (AFHCs)/helplines.

The AHD should be organized in every village once every quarter on a convenient day (preferably on a Sunday) following the VHND; in Sabla districts, this day should coincide with the existing Kishori Diwas. AWCs or community spaces may be used as venues for organizing the AHD. During an AHD, services should be offered to all the adolescent target groups (male/ female; 10-14 and 15 – 19 age; school going, drop out; and married adolescents). Efforts should also be made to reach out to other stakeholders including parents, school teachers and PRI members to sensitize them on adolescent health needs.

5.4 Weekly Iron And Folic Acid Supplementation (WIFS)

The Ministry of Health and Family Welfare has launched the Weekly Iron and Folic Acid Supplementation (WIFS) Programme to meet the challenge of high prevalence and incidence of anaemia amongst adolescent girls and boys. WIFS is evidence based programmatic response to the prevailing anaemia situation amongst adolescent girls and boys through supervised weekly ingestion of IFA supplementation and biannual helminthic control. The long term goal is to break the intergenerational cycle of anaemia, the short term benefits is of a nutritionally improved human capital.

Salient features of WIFS:

- Objective of Weekly Iron Folic acid Supplementation (WIFS)
 - To reduce prevalence and severity of anaemia in 10-19 years adolescent population.
- Target groups

Weekly Iron folic Acid supplementation programme to be planned and implemented for the following two target groups in both rural and urban areas:

- School going adolescent girls and boys in 6th to 2th class enrolled in government/government aided/municipal schools.
 - Out of school adolescent girls.
- Intervention
 - Administration of supervised Weekly Iron-folic Acid Supplements of 100mg elemental iron and 500ug Folic acid using a fixed day approach. States have been requested to establish Monday as WIFS day - identifying Monday as the day for ingestion of IFA supplementation
 - Screening of target groups for moderate/severe anaemia and referring these cases to an appropriate health facility.
 - Biannual de-worming (Albendazole 400mg), six months apart, for control of helminthes infestation.
 - Information and counselling for improving dietary intake and for taking actions for prevention of intestinal worm infestation.

d. Convergence:

WIFS Programme will serve as an entry point for counseling adolescents and addressing their health and nutrition needs through programmes and platforms like Ministry of Women and Child Development's Sabla, Government/ Government aided and Municipal school that come under the aegis of Ministry of Human Resource Development and MOHFW's Adolescent Reproductive and Sexual Health Programme and Menstrual Hygiene Scheme

Convergence with key stakeholder ministries like the Ministry of Women and Child Development and Ministry of Human Resource Development is an essential part of implantation plan of the WIFS programme. Key convergent areas include: joint programme planning, capacity building of nodal service providers including Medical Officers, Aganwadi Worker (AWW) Staff Nurses, School teachers, monitoring and a comprehensive communication component.

5.5 Menstrual Hygiene Scheme

The Ministry of Health and Family Welfare has launched a new Scheme for Promotion of Menstrual Hygiene among adolescent girls in the age group of 10-19 years in rural areas. This programme aims at ensuring that adolescent girls (10- 19 years) in rural areas have adequate knowledge and information about menstrual hygiene and have access to high quality sanitary napkins along with safe disposal mechanisms. In addition to this, the scheme includes guidance for states on sourcing and procurement, quality assurance, distribution mechanisms, incentives and subsidy, storage, and safe disposal. The programme is administered as part of the NRHM programme at the State and District levels.

Objectives:

- To increase awareness among adolescent girls on Menstrual Hygiene
- To increase access to and use of high quality sanitary napkins to adolescent girls in rural areas.
- To ensure safe disposal of Sanitary Napkins in an environmentally friendly manner.

Coverage:

In the first phase, the scheme will cover 25% of the population i.e. 1.5 crore girls in the age group of 10-19 years in 152 districts of 20 states. The scheme includes providing a pack of 6 sanitary napkins under the NRHM's brand 'Freedays'. These napkins will be sold to the adolescents girls at Rs. 6 for a pack of in village by Accredited Social Health Activist (ASHA). On sale of each pack, ASHA will get an incentive of Re. 1 per pack besides a free pack of sanitary napkins per month.

Out of 152 districts, 107 districts are under Central supply wherein Sanitary Napkins are to be supplied by Gol. Rest 45 districts are SHG districts wherein SHGs will be manufacturing the Sanitary napkins and it will be sold to Adolescent girls. The SHG districts have yet to roll out the scheme. Central supply of sanitary napkins has reached the 107 districts (1092 blocks) and sale to girls has also started in most of them, with all blocks having started implementation by end April, 2012.

Key activities under the scheme include:

1. Community based Health education and outreach in the target population to promote menstrual health
2. Ensuring regular availability of Sanitary napkins to the adolescents
3. Sourcing and Procurement of Sanitary napkins

4. Storage and distribution of Sanitary napkins to the adolescent girls
5. Training of ASHA and nodal teachers in Menstrual Health
6. Safe disposal of Sanitary napkins

5.6 Adolescent Friendly Health Clinics (AFHCs)

Both the Peer Education Programme and the AHD should lead to referrals to AFHCs which would seek to provide a combination of commodities, IEC and curative services at PHC, CHC and DH levels plus outreach and referral services:

Commodities

- Weekly Iron & Folic Acid Supplementation & Albendazole
- Sanitary napkins
- Contraceptives
- Medicines
- Pregnancy testing kits

Information (IEC & IPC)

- Counseling on nutrition, menstrual hygiene and disorders, personal hygiene, use of sanitary napkins, use of contraceptives, sexual concerns, depression, sexual abuse, gender violence, substance abuse and promoting healthy behavior to prevent non communicable diseases
- Posters/booklets/pamphlets, wall writing and Visuals

Counsellors should be recruited at AFHCs operationalized at CHC, SDH and DH level

Curative Services

- Treatment of severe malnutrition and Iron deficiency anaemia
- Treatment of common RTI/STI problems
- Treatment menstrual disorders
- Management of puberty related or sexual concerns of males and female
- Mental health service/management of depression
- Management of injuries
- Management of sexual abuse among girls
- Management of substance abuse
- Management of non-communicable diseases like hypertension, stroke, cardio-vascular diseases and diabetes

6. Objectives of the Orientation Programme

Use of services by adolescents is limited. Poor knowledge and lack of awareness are the main underlying factors. Service provision for adolescents is influenced by many factors. For example, at the level of the health system, lack of adequate privacy and confidentiality and judgmental attitudes of service providers, who often lack counselling skills, are barriers that limit access to services. Shortcomings in their professional training often result in service providers being unable and sometimes unwilling to deal with adolescents in an effective and sensitive manner.

To address this need, “Orientation Programmes” for Programme Managers, Medical Officers, ANMs and LHVs have been developed to enhance skills of Programme Managers to implement and service providers to deliver adolescent-friendly health services in Rashtriya Kishore Swasthya Karyakram.

Objective

The objective of this programme is to orient Medical Officers and ANMs/LHVs to the special needs and concerns of adolescent boys and girls and to design appropriate approaches to address them. This will strengthen the abilities of health-services providers to be able to respond to adolescents’ needs more effectively and with greater sensitivity.

Intended Participants

The Orientation Programmes are intended for Programme Managers (for 1 day) and for other health service providers (Medical Officers (MOs) for 4 days and ANMs, LHVs for 5 days) to help them provide preventive, promotive and curative health services to adolescents.

Programme Objectives and Expected Outcomes

It is expected that **MOs and ANMs/LHVs** who participate in this programme will be:

- More knowledgeable about the characteristics of adolescent development.
- Able to understand the needs of adolescents.
- Better equipped with information and resources, thereby be able to provide adolescent-friendly health services and refer them to appropriate facility, if required.
- Able to make a Plan of Action to deliver adolescent-friendly health services.

In practical terms, this Orientation Programme will provide participants with ideas and practical tips for the key questions:

For MOs and ANMs the two key questions answered will be:

- What do I, as an MO or ANM/LHV, need to know and do differently if the person who walks into my health centre is aged 10-19 years, rather than 6 or 36?
- How can I help? In the Health centre? Away from the health centre? Are there other influential people in my community who understand and respond better to the needs and problems of adolescents.

7. Components of the Orientation Package

The Orientation Programme is designed to be implemented mainly in a workshop setting. It is intended to be a dynamic and interactive programme in which facilitators actively engage the participants in the teaching/learning process. A range of teaching and learning methods has been carefully selected to enable this to happen in an effective manner.

The Orientation Package consists of three documents:

- Facilitator’s Guide
- Handout
- Physician Chart Booklet

The **Facilitator's Guide** is for the facilitators. It provides all the information and material needed to conduct the orientation. It includes the workshop schedule and the "step-by-step instructions" to the facilitator to conduct each of the sessions in a module. It also includes all the support materials needed to conduct the sessions, such as flipcharts and their contents, and case study materials with notes on issues that may be raised during discussion. It also includes "Tips for Facilitators" to help facilitators respond to questions that may be raised by participants, identify matters that may be sensitive and about how to deal with them.

The **Handout** consists of support materials for each module including the Self Assessment Tool in handout for MOs and a pre/post test for ANMs/LHVs.

The Handout is to be given to each participant, so that they can refer to it at a later date for leisure reading and better understanding of issues related to adolescent health and development. The facilitators will also have a copy of the Handout to refer to during preparation for the session and while conducting the session.

The **Physician Chart Booklet** consists of clinical algorithms for management of common problems faced by adolescents.

Orientation Programme Modules & Agenda

Figure 1 shows the list of modules which have been prepared and the Agenda for 4 days. All participants in the Orientation Programme must follow all the modules.

Schedule of the Orientation Programme for Medical Officers	
Day 1	
Module I	Introductory Module
Module II	Adolescent Growth and Development and its Implications on Health
Module III	Dealing with the Adolescent Client
Day 2	
Module IV	Adolescent-friendly Health Services
Module V	Sexual and Reproductive Health Concerns of Boys and Girls
Module VI	Nutritional Needs of Adolescents and Anaemia
Day 3	
Module VII	Pregnancy and Unsafe Abortions in Adolescents
Module VIII	Contraception for Adolescents
Module IX	RTIs, STIs and HIV/AIDS in Adolescents
Day 4	
Module X	NCDs, Injuries, Aggression and Violence
Module XI	Mental Health
Module XII	Concluding Module

8. Methodology

The teaching and learning methods used throughout the Orientation Programmes 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 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 difference;
- 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;
- 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.

Evaluation method to measure changes in participants practice (expected post training)

After having undertaken this Orientation, it is hoped that some of what participants learn will influence how they work in the future with adolescents. One way to support this is to help the participants translate what they have learned into changes that they intend to make. This should improve the chances that they will put what they have learned into practice. Developing a personal 'Plan of Action' in the Concluding Module will help participants to provide adolescent friendly health services at their clinics.

The Concluding Module focuses on changes and leads the participants through the process of making their personal plans to change the way they work with and for adolescents. The process is important for two reasons. First, it helps the participants apply what they have learned in practical ways, enabling them to think of realistic changes that they can make, or new things that they can do, in order to improve the way in which they work with adolescents. It is definitely best for them to do this as part of the Orientation Programme, with the support of the facilitators and other participants, rather than leaving them to do it when they will be busy back at work. Second, by making personal plans the participants provide the facilitator and themselves with goals, against which the changes that they make may be measured.

As Medical Officers you will have to provide the services to adolescents and supervise ANMs at PHCs and Sub-centres during the implementation of the Programme. The indicators by which the services will be monitored will be from the log frame discussed earlier.

Handout II

Dealing with the Adolescent Client

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1. Introduction
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I. Introduction

Communication plays a vital role in everybody's life. It is very important when we deal with an adolescent client. Learning basics of communication is essential for fruitful clinical interaction with an adolescent. This handout deals with communication and counselling. This handout also introduces clinical algorithm. Communication is a process through which we convey our thoughts and feelings to other people. One of the major components of communication is to listen and to understand others' points of view and feelings. Communication is more effective if it is two-way rather than one-way. The exercises in this module involve discussion, behaviour change and role-plays. It will help Medical Officers to understand the realities and the mindset of their adolescent client and will foster better communication and responsiveness to their needs.

I.1 Communication

It is the art of expressing and exchanging ideas, thoughts and feelings in speech or writing.

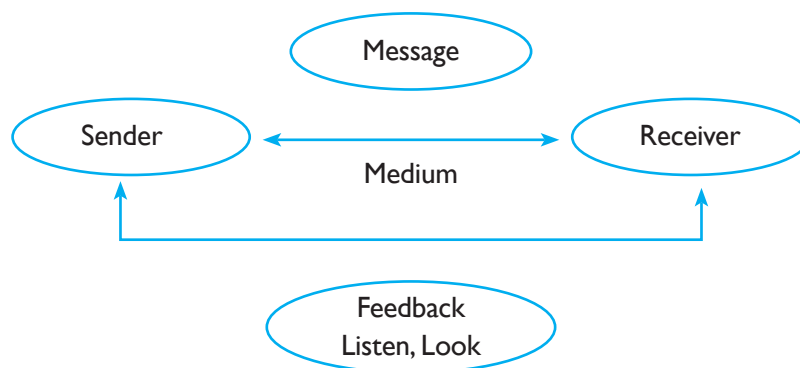
Communication is both a tool and a vehicle to reach out to adolescents. Health providers need to use communication effectively so that information and counselling can be provided to adolescents and their doubts can be cleared.

This section will help Medical Officers:

- To enhance their verbal and non-verbal communication
- To help understand key non-verbal cues that would help them to become better communicators.

I.1.1 Communication - a two-way street

Communication is an exchange of information, knowledge, ideas or feelings. In a face-to-face situation, communication is not just exchange of information. It also conveys one's feelings by use of gestures, facial expressions, language, and the manner of tone.



Communication is a two-way street - the 'Sender' sends a message to a 'Receiver'. In turn the 'Receiver' gives a feedback to suggest that the message has been understood. For transmitting the message, as well as the feedback, a medium is used that commonly is a spoken or a written word or just plain gestures. Communication occurs in a context and within an environment that influences the communication process.

Depending on the medium, communication is of two kinds - that which uses a medium (such as radio or television) to reach a large audience, is called mass communication. The other kind of communication does not use any kind of electronic or mechanical medium. This is called interpersonal communication. During interpersonal communication 'listening' is an important element.

Thus communication is much more than the words we use. It is the art of connecting with others, of breaking down the walls and building bridges. Those who communicate effectively build a strong and healthy relationship with one another. But positive communication is a skill that requires practice.

Communication has a definite purpose. The main purpose of communication is to change or guide the other person's behaviour. There are various functions of communication - informative, commanding, influencing or entertaining.

1. **Informative Function:** The basic function of communication is to provide or receive information. Communication is not going to occur unless someone is acquiring and consuming some information about himself or his environment.
2. **Command or Instructive Function:** Another function of communication is to command or instruct a person as to how a work is to be done. Those who are hierarchically superior (in family, business, office) are both privileged and obligated to command and to control certain task-related behaviour of their subordinates. This function is sometimes used by health providers also.
3. **Influence or Persuasive Function:** Communication influences one's ideas, feelings, knowledge, thoughts and behaviour. The purpose of influencing a person would be to alter his general beliefs, understanding, values, orientation etc., in some desired way, e.g., to encourage them to practice healthy behaviour, avoid risky practices, etc.

As doctors, adults or parents, we most often use all three functions. However, some may use the first two functions more than others. Whereas while working with adolescents the persuasive function is most useful.

Conversation is verbal communication. Communication can be non-verbal also, such as gestures (waving to somebody or frowning to show that you are angry). You may use a gesture to emphasize what you are saying. It is also important to interpret others' gestures and body movements so that you can understand what your client is trying to convey. Gestures (such as head nods or direct eye contact) help you to understand whether your audience has understood what you want to say. Non-verbal communication (gestures and body language) is as important as verbal communication (what we say or speak). Remember that the client watches your body language just as you are able to tell when your client is getting bored or restless.

When more than two people are involved in communication, it is called small group communication. For instance you are talking to your friend and his/her family joins you. From two your number goes up to five or six, your conversation includes all the people present. That is an example of small group communication.

It is important to remember that communication does not occur in a vacuum. Communication should always have a context. For example - if you are convinced about the importance of what you have learnt, then you should share it with others. When you have gone to a seminar or to a training, you have learnt something. You think that maybe your colleagues will benefit from what you have learnt so you ask them to join you for a discussion. That becomes the context of your communication. When you share specific things, in a sustained manner with other people it creates what is known as a ripple effect. The term comes from the ripples (small disturbances) created when you throw something solid into a mass of water. Ripples are best seen in pond or a big tank full of water. E.g. when you share a positive experience with your clients and their parents, maybe some of them will discuss the issues with their families and friends thus creating a ripple effect.

Communication that is targeted, has a specific purpose and seeks to influence people is known as advocacy. Young people make the best advocates, because they are sincere, creative and innovative in their approach to problems. Adults also become good advocates if they are convinced that the subject

is important, interesting and relevant.

1.2 An important part of communication is listening!

1.2.1 Listening to understand:

Most of us don't listen to understand; rather we listen to reply. Active listening means listening carefully to understand the client's point of view. It means listening for feeling and for meaning. By trying to understand each other's feelings, we open the door for further communication.

Too often we try to listen while our minds are not on the subject, the phone is ringing, or we're feeling rushed. As others speak, we do chores, interrupt clients while they are speaking, and give advice they didn't ask for, or even 'tune out'.

When we do get our adolescents to talk, we need to put aside our own purposes and just listen - really listen. If you rearrange the letters in the word listen, you can discover an important characteristic of an effective listener-the word silent! If we as listeners interrupt the flow with our own thoughts and opinions, we lose the opportunity to fully appreciate the client's point of view. Before trying to evaluate or prescribe, seek first to understand. Adolescents, just like the rest of us, need to be heard and feel understood.

1.2.2 Tips on effective listening

Effective listening means that you:

a. Give your undivided attention.

When an adolescent walks into the room give him your undivided attention. You will be able to detect his mood and disposition.

b. Tune in to the feeling being expressed.

Listen not only for what is said, but also how it is said, and watch for the body language that goes with it. Listening "between the lines" helps you understand the meaning behind the words.

c. Check for understanding.

To make sure you understand your client correctly on key points, occasionally rephrase what you think you've heard; "It sounds like you think your parents are being unfair," or "Are you saying that you are unable to control your anger?" Rephrasing allows a client to "re-hear" what he or she is communicating, and, if necessary, clarifies any misunderstandings.

d. Put aside judgment, criticism, and your own stories.

Step outside yourself and try to understand what your adolescent is saying. This means holding back your own opinions and not interrupting.

e. Encourage more talk.

Use questions or phrases that encourage your client to keep going. Ask, "Then what happened?" or repeat the last words, "...you did not think that I would mind?" Often a simple "Mmmhmm," is all you need to say to keep the conversation ball in your adolescent's court.

1.3 Elements of interpersonal communication

Communication is not merely talking and listening. As mentioned above, verbal communication is only one component of the communication between people. We use sounds to communicate. Some of these sounds are non-verbal, like grunts, moans, sighs, laughter, giggles, chuckles and many others sounds that we produce. Verbal communication consists of the sounds that are structured by language.

Speech, the verbal component of interpersonal communication, is described in this section. Reading this section alone will not make you a better communicator. It is the practice of these principles that create the skill. The elements of verbal communication have been separated so that you can train yourself.

2. Verbal / Non-verbal Communication

2.1 Verbal Communication

Speech is used for a variety of purposes—to describe feelings, to communicate ideas, to reason and to argue. Without speech we are handicapped in our ability to inform, comment, question, instruct and persuade others. To improve our conversation skills let us tackle elements one by one.

2.1.1 Talking

Each person has a set of experiences, feelings and knowledge, which are shared through conversations. Most of our conversations are about everyday matters. People also talk about what they have done or are involved in.

When you meet the client for the first time you may start the conversation, which starts with general conversation about family, friends, school, etc. This is followed by specific statements enquiring details of what concerns him/her. It thus moves on to include the expressions of feelings, attitudes and opinion.

2.1.2 Listening

Listening is not a passive or just a non-verbal attitude. It is an active way of providing feedback to the patient who needs to know how his/her messages are being received; whether it is being understood and accepted or rejected. Listening is used not only to understand but also to communicate interest in, and feeling about, what the other person is saying.

Non-verbal skills like eye contact, facial expression, raising an eyebrow, a nod, all communicate their own signals but the verbal communication can over-ride them. The verbal aspects include isolated words of agreement or encouragement. Comments like 'that sounds terrible' or 'Oh, that must have been exciting!' etc. play a major role in verbal communication.

2.1.3 Voice

Each person has a unique voice. Yet it may change tone and quality depending on situations. Besides what is actually being said we learn more about the speaker by his voice.

The tone of the voice can signal a message, which may actually be the opposite of what is being said.

2.2 Non verbal communication

Without using words, we communicate with a look, an expression, a gesture or a grunt. Appearance, facial expression, posture, gesture etc. tell us more about people than words. These elements of communication are non-verbal, mostly unconscious and occur at instinctive levels. Yet, we can train ourselves to bring it to consciousness and take control of these elements.

2.2.1 We communicate with our eyes

Eyes are windows through which you see the person's inside. Eyes express emotions and attitudes. Eye contact is a common means of expressing attentiveness. Gaze aversion is interpreted as unwillingness to interact.

A strong gaze may indicate dominance or aggression and a person with little eye contact is seen as submissive or shy. Eye movements indicate that we are attending to others. It is used to open and close communication channels between people while speaking in turns.

A period of eye contact often starts an interaction during which you look at the client who is talking to you. The client looks away while she/he is talking, once in a while checking whether you are looking (listening) at him/her. After she/he has finished, the gaze is returned to you to signify your turn to talk.

2.2.2 Facial Expression

When we look at people we are not looking only at their eyes. Facial expression is the most important means of non-verbal communication. By looking at a face we can say whether the person likes or dislikes, understands or not. Faces can communicate interest and involvement. It can also express emotional status ranging from happiness to despair. Feelings are often reflected on the face even if the person wishes to disguise them. Your face responds instantaneously and is the most effective feedback to another person. Facial expression as an action may be difficult to control, but is possible by a little practice.

2.2.3 Hand Gesture

Hand gestures are second in importance to facial expression in non-verbal communication. Some deaf and dumb people do manage very well in interpersonal communication using gestures. So the power of this element is not to be misjudged. We do use gestures normally to repeat, emphasize or sometimes even to contradict our verbal messages:

You wave and also say good-bye: This is an example of both verbal and non-verbal signals in daily use.

A clenched fist with wide-open eyes and loud voice: Here the verbal and non-verbal components emphasize one another, that is, anger.

Says she is all right but throws her hand in despair: Here, there is an element of contradiction between the verbal and non-verbal components.

Like the look, gesture can be used to put the ball in the other's court; when you are speaking in turns.

Health care providers need to exhibit many different nonverbal and verbal behaviors when communicating with clients.

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

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

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

2.2.4 Positive nonverbal cues include:

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

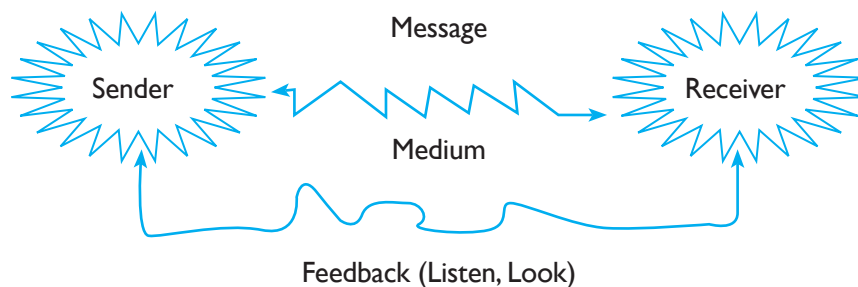
2.2.5 Negative nonverbal cues include:

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

Communication skills are the basic but essential attributes of a health provider, especially those who work with adolescents. Inter-personal communication is the backbone of the counseling process.

Barriers to communication

Sometimes communication just does not take place. Any disturbance or harshness in any one or more component of the two-way street of communication acts as a barrier to communication.



Even if two persons want to communicate there can be some situations which prevent an easy communication process. Factors which are barriers to communication are:

- Too much noise and distraction
- Lack of audio and visual privacy
- Inability to make the adolescent feel comfortable
- Use of medical terms-complicated, unfamiliar words for the adolescent
- Too much information given by the provider
- Own perception, beliefs and values clash with the adolescent's needs
- Not enough time devoted with the adolescent client to elicit complete history and provide

Here are some issues that block the process of communication.

1. Ordering, directing, commanding
2. Warning, threatening - directly or indirectly
3. Preaching, moralizing
4. Advising, judging, criticizing, blaming
5. Name calling, ridiculing, shaming
6. Teaching, instructing

3.1 Giving feedback

Feedback is a part of communication that gives information to the client or another person about how s/he is functioning or how their behaviour is affecting others. Feedback can be positive or negative. If it's positive, it lets the person know what s/ he is doing correctly - and encourages the person or group to continue with that behaviour. If it's negative, it helps people to change their behaviour to something more acceptable.

One of the roles of medical officers is to supervise the work of LHV & ANMs. To monitor the ARSH services of ANMs & LHVs, medical officers will need to provide supportive & effective feedback to help them perform better.

The most important thing to remember about feedback is that feedback should be helpful. Telling a client "it's your background..." is finding fault with something he/ she is unable to change. On the other hand, letting someone know you appreciate her/his skills and attempt to resolve problems is a helpful feedback - it encourages.

3.2 How to make your feedback helpful

1. Make sure your feedback is descriptive. It should paint a clear and specific picture of the behaviour you are trying to encourage or change. E.g. "Can you try not to argue with your father when he is angry?"
2. In general, give your feedback at the earliest appropriate time. If you wait too long, you may not remember specifics - and the person may not remember the situation either.
3. Be consistent in giving feedback. Work it into your interactions with others on a regular basis. E.g. "The last time we spoke..."
4. If the feedback is negative, add constructive ideas on how to improve and offer your assistance in making changes. Don't assume that the person getting the negative feedback can figure out what went wrong and then how to correct it by him/herself. Especially to adolescents you have to explain what went wrong and how to make amends.

Doing all these things at one go may not be possible. Also it may take time to develop these skills. Try and work with colleagues to practice these skills - that way you will get more help and create an enabling atmosphere. Time invested in empathic communication skills ensures that clients share their problems and fears with you.

3.3 Feelings of the Adolescent

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

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

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

4. Challenges in Communication with the Adolescent

During communicating with an adolescent, there are two actors: The person who is communicating, who may be a counsellor and/or a service provider, and the adolescent.

Just as the counsellor’s personal characteristics and skills can facilitate or hinder the process, so can the adolescent’s behaviour or mood.

The following are some situations that require appropriate handling:

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

Is that what is going on?”

- “If the client is shy, the provider can legitimize the feeling by saying, “I’d feel the same way in your place. I understand that it’s not easy to talk to a person you’ve just met.”
- “If the adolescent has difficulty expressing her/his feelings or ideas, the counsellor can use some brochures or posters to encourage discussion or refer to a story or anecdote so the adolescent can talk about others rather than her/himself.
- “If the adolescent cannot or will not talk, the counsellor should propose another meeting.
- Crying: The counsellor should try to evaluate what provoked the tears and assess if it makes sense in the given situation.

- “If the crying is consistent with the situation, the counsellor should allow her/him to freely express emotions and not try to stop the feeling or belittle its importance.
- “If the client is crying to relieve tension, the counsellor can give the adolescent permission to express her/his feelings by saying, “It’s okay to cry since it’s the normal thing to do when you’re sad.”
- “If the client is using crying as manipulation, the counsellor can say, “Although I’m sorry you feel sad, it’s good to express your feelings.”
- Threat of suicide: All suicide threats or attempts must be taken seriously. It is essential to determine if attempts were made in the past, if s/he is really considering suicide, and the reasons for doing so-or if it’s something that was said without thinking.
 - “It is best to refer the adolescent to a psychiatrist or psychologist and accompany her/him to the appointment.
- Refusal of help: The counsellor should discreetly try to find out why the adolescent feels this way.
 - “If the client has been sent against her/his will, the counsellor can say, “I understand how you feel. I’m not sure I can help you, but maybe we could talk for a minute and see what happens.”
- Need to talk: Challenges in counselling may also include a situation where the client is very vocal and wants an outlet to express other concerns that may not be directly related to the immediate counselling need as perceived by the service provider.
 - Give the client the opportunity to express her/his needs and concerns. If you cannot help the client, show that you are listening to the concerns that s/he is trying to express. When possible, direct the client to someone who can help with the problem.
 - “The counsellor may say, “I can see that you are very concerned about this problem. I wish that I could do something to help you. Have you discussed this with ...”
 - “If you cannot help the client or direct her/him to someone who can provide assistance, then demonstrate care and concern about the client’s problem. However, be clear when you cannot help with the problem.

4.1 Counselling

It is helping people to identify problem, make decisions and giving them confidence to put their decisions into practice. Counselling is based on the following principles:

- Helps the client to identify the problem and make decisions for himself or herself
- The client (not you as service provider) has the right to choose his or her own action
- Accurate information is provided
- Is strictly confidential
- Takes into account psycho-social, financial and spiritual needs of the client

4.2 The GATHER approach:

- G = Greet the person
- A = Ask how can I help you
- T = Tell them any relevant information
- H = Help them to make decisions
- E = Explain any misunderstanding
- R = Return for follow up or referral

The GATHER approach for counseling

Greet the adolescents
<ul style="list-style-type: none"> • put them at ease, show respect and trust • emphasize the confidential nature of the discussion
Ask how can I help you
<ul style="list-style-type: none"> • encourage them to bring out their anxieties, worries and needs, determine their access to support and help in their family and community; • find out what steps they have already taken to deal with the situation • encourage the person to express their feelings in their own words • show respect and tolerance to what they say and do not pass judgement • actively listen and show that you are paying attention through your looking • encourage them through helpful questions
Tell them any relevant information they need
<ul style="list-style-type: none"> • provide accurate and specific information in reply to their questions • give information on what they can do to remain healthy. Explain any background information they need to know about the particular health issue • keep your language simple, repeat important points and ask questions to check if the important points are understood • provide the important information in the form of a leaflet, if possible, that they can take away
Help them to make decisions
<ul style="list-style-type: none"> • explore the various alternatives • raise issues they may not have thought of • be careful of letting your own views, values and prejudices influence the advice you give • ensure that it is their own decision and not one that you have imposed • help them make a plan of action
Explain any misunderstanding
<ul style="list-style-type: none"> • ask questions to check understanding of important points • ask the adolescent to repeat back in his/her own words the key points
Return for follow-up or Referral
<ul style="list-style-type: none"> • make arrangements for a follow-up visit or referral to other agencies • if a follow-up visit is not necessary, give the name of someone they can contact if they need help

5. Counselling the Adolescent Client for Behaviour Change

Counselling is a person-to-person, two-way communication during which the counsellor:

- Provides adequate information to help the adolescent make an informed decision, and then implement it.
- Enables the client to identify his problem and possible solutions.
- Helps the adolescent evaluate her/his feelings and opinions regarding the problem for which help was sought.
- Acts as emotional support for the adolescent.

Counselling is not:

- A method to provide solutions to the adolescent's problems.
- A method for giving instructions or advise.

- The promotion of a life plan that has been successful for the counsellor.

The purpose of counselling the adolescent on reproductive health issues is to help the adolescent to:

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

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

6. Fostering Good Communication during Counselling

6.1 Several principles help assure effective counselling with adolescents:

- The service provider must accept responsibility for leading the analysis and reflection of the issues troubling the young person, encouraging her/him to explore and express feelings.
- The counsellor avoids giving advice and recipes or magic formulas for solving problems. Rather, the counsellor helps the adolescent to evaluate her/ his own behaviour and the possible solutions to the problem.
- The provider respects the adolescent, encouraging her/his ability to help her/himself, to trust in her/himself, and to take responsibility for her/his decisions.
- Counsellors should consider adolescents as individuals, emphasizing their qualities and potential, respecting their rights as people, and promoting the exercise of their capacity to think and make decisions.
- The counsellor must accept adolescents as they are and not judge them as good or bad. The counsellor should help adolescents to examine their conduct and make the changes they consider necessary. This will promote ownership of the decisions, greater self-confidence, and self-control.

6.2 Several techniques help assure good communication with adolescents: Create a good, friendly first impression

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

6.3 Establish rapport during the first session

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

6.4 Eliminate barriers to good communication

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

6.5 Use "active listening" with the client

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

6.6 Provide information simply

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

6.7 Ask appropriate and effective questions

- Use a tone that shows interest, attention, and friendliness.
- Begin sessions with easy questions, gradually moving up to more difficult questions.
- Try not to take notes except in a structured interview that has an established order for special cases.
- Ask a single question and wait for the response.

- Ask open-ended questions that permit varied responses and require thought. Allow for explanations of feelings or concerns.

Examples: “How can I help you?”, “What’s your family like?”

- Ask in-depth questions in response to a previous question and to solicit more information.

Example: “Can you explain that better?”

- Avoid biased questions that lead the client to respond in a pre-determined way.

Example: “Have you heard that the condom makes sex less pleasurable?”

- Avoid questions that begin with the word “Why” since the adolescent may think you are incriminating her/him.
- Ask the same question in different ways if you think the adolescent has not understood.
- Recognize and take advantage of teachable moments
- Use a positive approach when discussing developmental change.
- Evaluate learning by asking the adolescent to describe a healthy SRH behavior that s/he is practising.
- Reinforce health messages from other settings.
- Provide printed or other materials that are developmentally and culturally appropriate.
- Provide practical advice, encouragement, and factual information.
- Don’t underestimate the potential usefulness or effectiveness of education and counselling.

7. Communicating and Counselling about Sexuality

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

7.1 Good communication and counselling about sexuality requires:

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

- Helping the adolescent plan how to implement her/his choice.

These approaches will foster the making of good decisions by the adolescent. When the adolescent makes a decision with appropriate information, s/ he will feel a sense of satisfaction and will feel capable of voluntarily modifying her/his behaviour.

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

- How to discourage and prevent unwanted sexual advances.
- Whether or when to engage in sexual relations.
- How to prevent pregnancy and STI/HIV.
- Whether or when to conceive a child.
- Whether to continue or terminate a pregnancy.
- What kind of antenatal care to seek and where to go.
- How to deal with sexual abuse and/or violence.

Most of these decisions can be worked through during counselling sessions that follow the described approach. Sexual abuse and violence are more difficult and require additional help like from social workers, psychologists etc.

7.3 Counselling in Cases of Sexual Abuse and/or Violence

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

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

If violence is associated with the abuse, even more severe physical and emotional problems can result. A qualified, multi-disciplined staff should deal with these cases. But it is the duty of first line provider to suspect and uncover the sexual abuse as early as possible.

The objectives of the counselling session addressing sexual abuse are:

- Provide psychological and emotional support.
 - "Be understanding but not pitying.
- Help the adolescent to not feel guilty.
 - "Explore feelings of guilt.
 - "Tell the adolescent s/he is not responsible for what happened.
- Help the adolescent recover her/his sense of self-esteem.
 - "To regain self-confidence.
 - "To trust others.
- Counteract anxiety or depression.

- Refer her/him to a specialist.
 - “Explain why it is necessary to do so.
 - “If possible, accompany the adolescent to the referral appointment.

8. Clinical interaction with adolescents

Adolescents are different individuals so when they are dealt with in a clinic the methods have to be different than what we use for a 6 year old child or a 36 year old adult.

WHO has developed an easy method of dealing with an adolescent client. This includes some initial steps to make rapport and elicit history using a well established method. Several common clinical conditions have been described in the form of clinical algorithms. This section describes these methods of history taking and introduces the patterns used in algorithms.

8.1 The following paragraphs describe the important issues in first clinical interactions with an adolescent client.

8.1.1 Development of your adolescent clients/patients

What you should be aware of:

1. Adolescence is a phase in life during which major physical, psychological and social changes occur. As they encounter these changes, adolescents have many questions and concerns about what is happening to their bodies. In many places, adolescents are unable to share their questions and concerns, and to seek answers from competent and caring adults.



2. While adolescence is generally considered as a healthy time of life, it is also a period when many behaviours that negatively affect health both during adolescence and later in life, start. Furthermore, many adolescents die every year – mostly from unintentional injuries (e.g. car crashes), intentional injuries (suicide and interpersonal violence) and pregnancy-related causes.
3. Health workers like you have important contributions to make in helping those adolescents who are well to stay well, and those adolescents who develop health problems get back to good health. You can do this through:
 - providing them with information, advice, counselling and clinical services aimed at helping them maintain safe behaviours and modify unsafe ones (i.e. those that put them at risk of negative health outcomes);
 - diagnosing/detecting and managing health problems and behaviours that put them at risk of

negative health outcomes; and referring them to other health and social service providers, when necessary.

Health workers like you have another important role to play – that of change agents in your communities. You could help community leaders and members understand the needs of adolescents, and the importance of working together to respond these needs.

8.1.2 Establishing rapport with your adolescent clients/patients



What you should be aware of:

1. Some adolescents may come to you of their own accord, alone or with friends or relatives. Other adolescents may be brought to see you by a parent or another adult. Depending on the circumstances, the adolescent could be friendly or unfriendly with you. Also, depending on the nature of the problem or concern, the adolescent could be anxious or afraid.
2. Adolescents may be reluctant to disclose information on sensitive matters if their parents or guardians, or even spouses are also present.

What you should do:

1. Greet the adolescent in a cordial manner.
2. Explain to the adolescent that:
 - you are there to help them, and that you will do your best to understand and respond to their needs and problems;
 - you would like them to communicate with you freely and without hesitation;
 - they should feel at ease and not be afraid because you will not say or do anything that negatively affects them;
 - you want them to decide how much they would like to involve their parents or others;
 - you will not share with their parents or anyone else any information that they have entrusted you with, unless they give you the permission to do so.
3. If the adolescent is accompanied by an adult, in their presence, explain to the accompanying adult that:
 - you want to develop a good working relationship with the adolescent. At some stage you may need some time to speak to the adolescent alone.

8.1.3 Taking a history of the presenting problem or concern

What you should be aware of:

1. Many adolescent health issues are sensitive in nature.
2. When asked by health workers about sensitive matters such as sexual activity or substance use, adolescents may be reluctant to disclose information because of fears that health workers may scold or mock them.

What you should do:

1. *Start with non-threatening issues:* Start the clinical interview with issues that are the least sensitive and threatening. The *Adolescent job aid* algorithms contain many direct questions that health workers need to ask to determine classification and subsequent management. However, if you were to ask an adolescent, "Are you sexually active?" without first establishing rapport, the likelihood of obtaining any answer, let alone a true answer will be low. It is usually best to start with some introductory questions (e.g. about the adolescent's home situation) before proceeding to more sensitive topics such as sexual and reproductive health. Then when one is ready to commence questioning about sexual and reproductive health, it is best again to start with the most non-threatening questions before proceeding to the more sensitive ones.
2. *Use the third person (indirect questions)* where possible: It is often best to ask first about activities of their peers and friends rather than directly about their own activities. For example, rather than ask an adolescent directly, "Do you smoke cigarettes?" you could ask, "Do any of your friends smoke?" If the adolescent replies, "Yes", you could then ask, "Have you ever joined them?" This can lead to other questions such as, "How often do you smoke?" etc.
3. *Reduce the stigma around the issue by normalising the issue:* An adolescent who has an unwanted pregnancy or a sexually transmitted infection may feel embarrassed or even ashamed. You can reduce the stigma around the issue by saying to the adolescent that, "I have treated a number of young people with the same problem you have".



What you should be aware of:

Even with adequate training, many health workers are uncomfortable discussing sensitive matters with anyone, whether adults or adolescents.

What you should do:

1. The first step in dealing with this is being aware of the issue, and then trying to overcome it. It may be useful to reflect that your discussions with the adolescents, although uncomfortable, will help you identify their needs and address their problems. It may also be useful to discuss your thoughts and feelings with a colleague.

2. Learn as you go along. In the beginning, you may use the questions listed in the *Adolescent job aid* as they are written. With time you may choose to modify them, using words and phrases that you are more comfortable with and a more relaxed conversational style. You will also find that you will get faster with practice, and will learn which issues to spend time on, and which other issues you can address quickly.

8.1.4 Going beyond the presenting problem or concern

What you should be aware of:

1. When adolescents seek help from a health worker, they tend to volunteer information about the health problem that seems most important to them (i.e. the presenting complaint). They may have other health problems and concerns but may not say anything about them unless directly asked to do so. In such a situation, the health worker is likely to deal with the presenting complaint only (e.g. fever and cough) and go no further thereby missing other existing problems.
2. Further, adolescents may not volunteer information about a health problem or concern because they may be embarrassed or scared to do so, or because they may not be comfortable either with the health worker or the situation they are in.

What you should do:

You could consider using the HEADS assessment which could assist you to:

- detect health and development problems that the adolescent has not presented with;
- detect whether the adolescent engages in behaviours that could put one at risk of negative health outcome (such as injecting drugs or having unprotected sex);
- detect important factors in their environment that increase the likelihood of their engaging in these behaviours.

In this way, you would get a full picture of the adolescent as an individual and not just a case of this or that condition. It would also identify the behaviours and the factors in the adolescent's environment to address –yourself and in conjunction with other health and social service providers.

The HEADS assessment is structured so that you can start the discussion with the most non-threatening issues. It starts by examining the home and the educational/employment setting. It then goes on to eating, and then to activities. Only then does it deal with more sensitive issues such as drugs, sexuality, safety and suicide/depression. See the listing of “Information that can be obtained from a HEADS assessment” towards the end of this part of the *Adolescent job aid*.

If time does not permit you to do a full HEADS assessment, you will need to prioritize which sections of the HEADS assessment to do. You may choose to prioritize the sections which are most related to:

- Presenting complaint:

If an adolescent presents with an injury after a fall while drinking alcohol, you may prioritize the “Drugs” section of the HEADS assessment. and/or

- Important health issues in your local area:

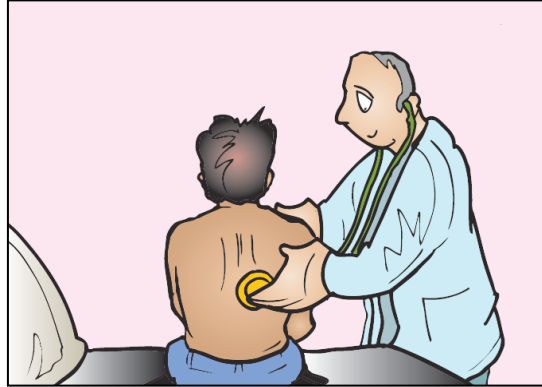
HEADS is an acronym for

- **H**ome
- **E**ducation/**E**mployment
- **E**ating
- **A**ctivity
- **D**rugs
- **S**exuality
- **S**afety
- **S**uicide/**D**epression

If you are working in an area of high HIV prevalence you may prioritize the “Sexuality” section of the HEADS assessment.

8.1.5 Doing a physical examination:

What you should be aware of:



1. In order to make a correct classification, all the signs listed in the Look/Feel/Listen column of the algorithms need to be carefully checked for.
2. Some items in a physical examination are unlikely to cause embarrassment (e.g. checking the conjunctivae for anaemia); however, some other items are likely to do so (e.g. checking the vagina for the presence of abnormal discharge).

What you should do:

1. Before doing a physical examination:

- If the adolescent is with an accompanying person, reach an agreement as to whether they want this person to be present during the examination.
- Inform the adolescent about what examination you want to carry out and the purpose of the examination.
- Explain the nature of the examination.
- Obtain the consent of the adolescent. (If the adolescent is below the legal age of being able to give consent, you will need to obtain consent from a parent or guardian. However, even if you have obtained consent from a parent or guardian, you should not proceed with the examination unless the adolescent agrees).

As part of the physical examination check the following things:

- Temperature
- Pulse rate
- Presence of anaemia
- Presence of jaundice
- Presence of lymphadenopathy
- Presence of obvious over/ under-nutrition
- Any abnormal heart and lung sounds
- Any evidence of swellings or tenderness in the abdomen
- Presence of teeth and gum problems
- Presence of skin problems

2. During an examination:

- Respect local sensitivities regarding gender norms (e.g. whether it is appropriate for a male health worker to examine a female patient). If needed, ensure the presence of a female colleague during the examination.

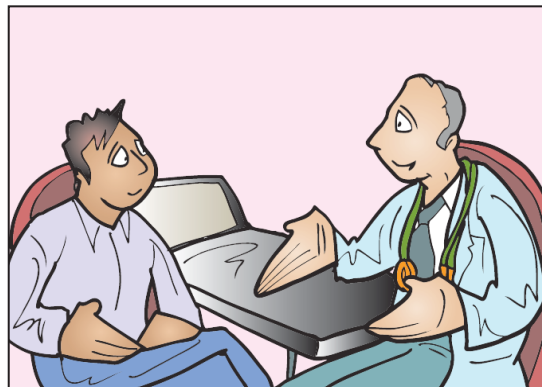
- Ensure privacy (e.g. make sure that curtains are drawn, doors are shut and that no unauthorized person enters the room during the examination).
- Watch for signs of discomfort or pain and be prepared to stop the examination if needed.

8.1.6 Communicating the classification, explaining its implications, and discussing the treatment options



What you should be aware of:

1. Informing your adolescent patients about the classification and explaining its implications for their health can help them become active partners in protecting and safeguarding their health.



2. Informing them about the different treatment options and helping them choose the one that matches their preferences and circumstances will increase the likelihood that they will adhere to the treatment.

What you should do:

1. When you have made a classification, you will need to communicate it and explain its implications to the adolescent.

Before doing so:

- check whether they want to have the parent or other accompanying person present.

While communicating:

- demonstrate your respect and empathy to the adolescent through your speech and your body language

(e.g. if the adolescent is with a parent or another accompanying person, address them);

- use language and concepts that they are likely to understand;

- periodically assess their understanding (e.g. by asking them to say in their own words what they understand about an issue).
2. Provide information on the implications of each treatment option and help the adolescent choose the one best suited to his/her needs.

While doing this:

- present all the relevant information;
 - respond to questions as fully and honestly as you can;
 - help them choose;
 - respect their choice even if it is not the one you would have wanted them to make.
3. When providing medication, explain why they need to take it, and when and how they need to do so. If prescribing medication, make sure that they will be able to find the money to buy it.

8.1.7 Dealing with laws and policies that affect your work with your adolescent clients/patients

What you should be aware of and do:

1. Ensure that you are fully aware of the national and local laws and policies.
2. Where appropriate, help your adolescent patients and their parents become aware of them.
3. As a health worker, just like all other citizens of your country, you have the responsibility to respect these laws and policies. As a health worker, you have an ethical obligation to act in the best interests of your adolescent patients. In your work with adolescents, you may find that in some situations, prevailing laws and policies may not permit you to do what is in the best interests of your adolescent patient (e.g. in some places, the provision of contraceptives to unmarried adolescents is illegal). In such situations, you may need to draw upon your experience and the support of caring and knowledgeable people to find the best way to balance your legal obligations with your ethical obligations.

I. Laws and policies that govern health service provision:	II. Laws and policies on social issues that could affect your work with adolescents:
<ul style="list-style-type: none"> • laws and policies that specify the age at which diagnostic tests (e.g. an HIV test) or clinical management (e.g. provision of contraception) can be done with the independent consent of the adolescent; • laws and policies on requirements to report infections (e.g. HIV) or assault (e.g. physical or sexual assault); • laws and policies that require partner notification (e.g. in the context of a sexually transmitted infection); • laws and policies that require a health worker to use government- approved standards and guidelines for clinical management. 	<ul style="list-style-type: none"> • laws and policies on protecting and safeguarding minors; • the stipulated age of consent for sex and the stipulated age of marriage (and any discrepancies between the two); • the stipulated age at which tobacco and alcoholic products can be sold or purchased; • laws and policies on the possession and use of psychoactive substances; • laws and policies on homosexuality.

Information that can be obtained from a HEADS Assessment

Home	Where they live With whom they live Whether there have been recent changes in their home situation How they perceive their home situation
Education/ Employment	Whether they study/work How they perceive how they are doing How they perceive their relation with their teachers and fellow students / employers and colleagues Whether there have been any recent changes in their situation What they do during their breaks
Eating	How many meals they have on a normal day What they eat at each meal What they think and feel about their bodies
Activity	What activities they are involved in outside study/work What they do in their free time – during week days and on holidays Whether they spend some time with family members and friends
Drugs	Whether they use tobacco, alcohol, or other substances Whether they inject any substances If they use any substances, how much do they use; when, where and with whom do they use them
Sexuality	Their knowledge about sexual and reproductive health Their knowledge about their menstrual periods Any questions and concerns that they have about their menstrual periods Their thoughts and feelings about sexuality Whether they are sexually active; if so, the nature and context of their sexual activity Whether they are taking steps to avoid sexual and reproductive health problems Whether they have in fact encountered such problems (unwanted pregnancy, infection, sexual coercion) If so, whether they have received any treatment for this Their sexual orientation
Safety	Whether they feel safe at home, in the community, in their place of study or work; on the road (as drivers and as pedestrians) etc. If they feel unsafe, what makes them feel so
Suicide/ Depression	Whether their sleep is adequate Whether they feel unduly tired Whether they eat well How they feel emotionally Whether they have had any mental health problems (especially depression) If so, whether they have received any treatment for this Whether they have had suicidal thoughts Whether they have attempted suicide

Sexual and reproductive health assessment

Here is an example of how a health worker may do a sexual and reproductive health assessment.

Menstrual history

- Have your periods started yet? If so, how old were you when your periods started?

Pain during the periods

- Do you have pain with your periods?
- Does the pain prevent you from carrying out your daily activities?
- What do you do to ease the pain?

Excessive bleeding during the periods

- How many days do your periods last when they come?
- How many pads (or equivalent) do you use a day?

Regularity of the periods

- Are your periods regular? Do your periods come at the same time every month?
- How many days are there normally between your periods?

Knowledge about sexuality

- Have you learned about sexuality at school, at home or elsewhere?

Note: Probe to find out whether the adolescent is knowledgeable about basic anatomy and functioning, menstruation, pregnancy and contraception, and sexually transmitted infections. Do this using questions tailored to the age, level of development and circumstances of the adolescent.

Sexual activity

- Depending on the context, ask whether their friends have boyfriends/girlfriends, and then whether they do so themselves.
- Again depending on the context, ask whether their friends have had sex, and then whether they have done so themselves. (Be aware that the word “sex” may mean different things to different adolescents. Probe about penetrative sex, e.g. “Does he touch your genitals only?” and “Does he put his penis in your vagina/mouth?”)

Pregnancy and contraception

- Do you know how one could get pregnant?
- Do you know how one could avoid getting pregnant?
- Are you currently trying to get pregnant?
- Are you currently trying to avoid getting pregnant?
- If so, what do you do to avoid getting pregnant?
- Do you know about contraceptive methods?
- If so, do you use any contraceptive method?
- Have you had sex in the last month?
- Is your period delayed? Have you missed a period?
- Do you have any of the following symptoms of pregnancy: nausea or vomiting in the morning, and swollen and sore breasts?
- When was the last time you had sex?

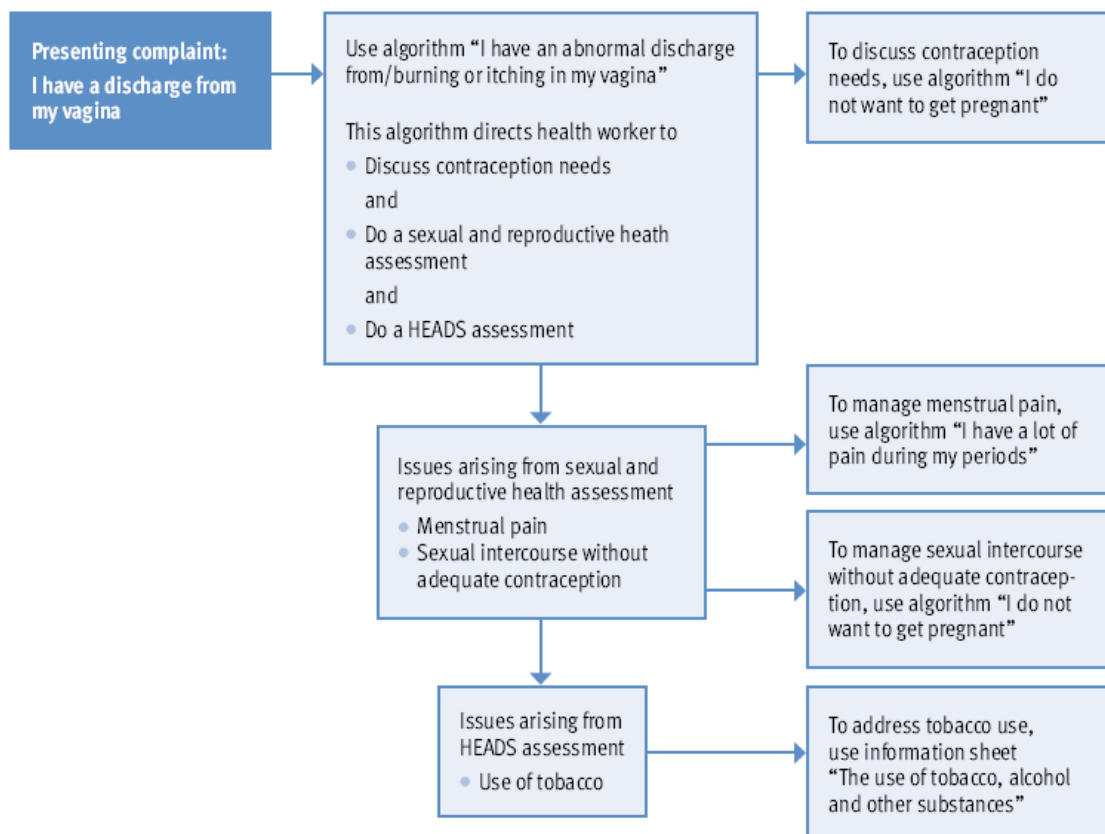
If sexually active... Sexually transmitted infections

- Do you know what a sexually transmitted infection is?
- Do you do anything to avoid getting a sexually transmitted infection?
- Do you know about condoms? Do you use them when you have sex? If so, do you use them always? If not, why not? Where do you get condoms?
- How many sexual partners have you had in last three months?
- Have you ever had an infection: genital sore, ulcer, swelling or discharge?
- If so, have you received any treatment for this?

8.2 Clinical Algorithm

The starting point for each algorithm is the presenting complaint, either by the adolescent or by his/her parents. As you go through the “Ask” and Look/Feel/Listen” columns, you are likely to be pointed to other algorithms to use. Go to them after you have completed the classification, defined the management approach to be used, provided information, and responded to questions, if any. In this way, the Algorithm aid guides you to go beyond the presenting complaint to identify and deal with other problems that were not raised by the adolescent or his/her parents.

When you start using the Algorithm, take the time to go through each algorithm and the accompanying communication tips carefully. With practice, you will be able to do this faster. You will also learn which issues you will need to spend time on, and which ones you could go through quickly or even skip altogether.

Example of entry points for use of algorithms, accompanying communication tips and information

9. Summary

- Communication is very important aspect of clinical dealing with adolescents. Principles of good communications should always be used for successful clinical management of adolescents.
- Counseling an adolescent client, their parents and other care-givers is critical in managing adolescence-related issues and it becomes part of therapy in several mental health conditions.
- A systematic method should be used while taking history (HEADS) and examination and their interpretation. Clinical algorithms present a simple and scientific method for management of common issues encountered during adolescence.

Annexure 1: Role Play

Scenario I

Sheela is a 14 year old girl who comes hesitatingly to the PHC. The MO calls her into the room and asks Sheela what is her problem? He does not ask Sheela to sit on a stool or chair and his expression is also very firm. Sheela is feeling very shy and is not saying anything. The MO asks her again about the problem. There is a lot of noise outside the clinic room. Anxious and shy, Sheela tells that she is having a lot of pimples on her face. The MO asks for how long is she having pimples. Sheela says for the last 2-3 months'. A PHC staff comes to get a paper signed by the MO, which he signs. The MO asks her age. Sheela says 14 years. The MO tries to explain to her that pimples are normal during her age. An adult patient comes in to confirm how he is to take his medicines. The conversation between the MO and Sheela is interrupted as the MO explains to the patient how to take the medicines. He again turns to Sheela and says that she should not worry as the pimples will disappear as she grows older. He asks Sheela to leave. She is still hesitant to go and is trying to linger in the room. The MO again reassures her not to worry and asks Sheela to go home as she does not require any medicine. Reluctantly, Sheela goes out of the clinic.

Sheela was mainly worried because she had irregular periods with pain in the lower abdomen. The MO failed to identify the fact that Sheela has some other problem.

Annexure 2: Case Studies

Case Study I

Ramesh is a 17 years old boy who lives in Kalyanpuri, a slum in Delhi. His friend Raghu, who studies in his class, keeps boasting about the many girl friends he has. Raghu laughs at Ramesh for not having engaged in sexual activity. Raghu jokingly says that Ramesh is not man enough. Ramesh feels embarrassed about this and thinks, may be he is not normal but he is not able to talk to anybody about his fears. Of late, Ramesh has developed some blotchy brownish-red patches in the groin. Ramesh suspects that he has some deadly disease but is scared to talk to any one as they may think he is a bad boy. There is a health clinic in his area that runs in the morning hours.

He used to be a bright student in his class but slowly he has started lagging behind the other students as he lives with fear that he is soon going to die of some deadly disease.

One day he decides to go to the clinic and waits for his turn to discuss his problem with the doctor. However, the doctor calls him in when he has 3-4 patients in the room and asks Ramesh about his complaint. When Ramesh hesitantly starts telling his problem, when the doctor tells him to hurry up as he has so many other things to do.

Q.1 Why did Ramesh's status change from that of a bright 17 years old school boy to a dull student full of fears?

Q.2 What are the communication barriers in this case?

Q.3 What could have been done to enable Ramesh to obtain the sexual and reproductive health information and services he needed?

Case Study 2

Surekha, a 12 years 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 splotted with blood. She was scared and did not know what was happening to her. On her way home, Surekha met the ANM. She wanted to ask the ANM about her problem but as other women were also standing nearby, she felt shy and was not sure how the ANM would react to her question. She went home and started crying.

Q.1 Why was Surekha so unprepared for this important event in her life?

Q.2 What are the communication barriers in this case?

Q.3 What could have been done to enable Ramesh to obtain the sexual and reproductive health information and services she needed?

Annexure 3: Role Play

Scenario 1

A 19 year old girl comes to your health centre because she had unprotected sex last night and she is worried about becoming pregnant.

How will you counsel the client?

Scenario 2

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

How will you counsel the client?

Scenario 3

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

How will you counsel the client?

Scenario 4

A 16 year old boy comes to you saying that he masturbates several times a day and is worried that he will become "impotent" when he becomes an adult. He cannot stop himself from masturbating.

How will you counsel the boy?

Scenario 5

An 18 year old, unmarried adolescent girl comes to you. She explains that she is engaged to be married and her fiancé is pressing her to have sex with him.

How will you counsel her?

Scenario 6

A 17 year old boy comes for counseling. He has a girlfriend and all his friends are pressuring him to have intercourse with her. He has strong sexual feelings for his girlfriend and doesn't know what to do.

How will you counsel him?

Annexure 4: Observer Role play Checklist

TASK	PERFORMED	
	YES	NO
Non-verbal Communication		
Friendly/ welcoming/ smiling?		
Non-judgemental/ empathetic?		
Listens/attentive/ nods head to encourage and acknowledge client's responses?		
Allows client enough time to talk?		
Verbal Communication		
Greets client		
Asks clients about themselves		
Tells clients about their choices/options		
Helps clients choose		
Explains what to do		
Counsels to return for follow-up		
Language was simple and brief		

What did you learn from observing this role-play?

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

Annexure 5: Self-Assessment Tool (SAT)

1. *How do you think an adolescent feels when he/she walks into your health centre?*

- i.
- ii.
- iii.
- iv.

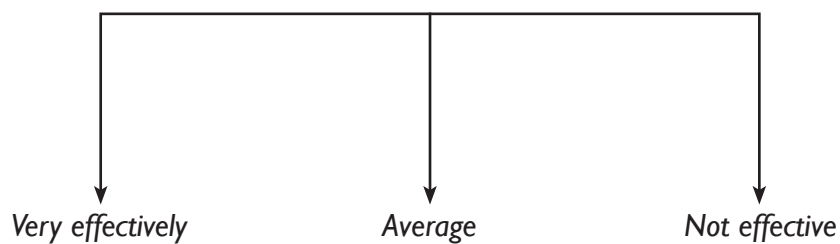
2. *How would you strike a rapport with an adolescent client?*

- i.
- ii.
- iii.
- iv.

3. *What are the barriers to good communication?*

- i.
- ii.
- iii.
- iv.

4. *How effectively can you communicate with an adolescent girl/boy?*
(Please mark your answer with a cross (x) anywhere along the line)



5. What do you understand by HEADS? Write below against each letter.

H _____

E _____

A _____

D _____

S _____

Handout III

Adolescent Growth and Development and its Implications on Health

CONTENTS

1. Introduction
2. Definition of adolescent and related age groups
3. Growth during Adolescence
4. Pubertal Disorders
5. Psychosocial Development
6. Supporting the development of adolescents
7. Adolescent sexual behavior and its health
8. Vulnerability of Adolescent
9. Role of health system to help adolescents attain and maintain optimum health
10. Summary
11. References
12. Annexures

1. Introduction

Adolescence (10-19 years) is a phase of life which has recently gained recognition as a distinct phase of life with its own special needs. This phase is characterized by acceleration of physical growth and, psychological and behavioural changes thus bringing about transformation from childhood to adulthood. This module defines adolescence and it aims at generating an understanding of what is special about adolescence and provides an overview of important matters concerning adolescent health and development. It examines the perceptions of adolescents and of adults regarding adolescents' health concerns and explores the rationale for investing in adolescent health. This module is a foundation for all the subsequent modules wherein issues pertaining to adolescent health and development have been dealt with in greater depth.

2. Definition of “adolescence” and related age groups

Adolescence

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

2.1 Age Groups

Adolescents are defined as individuals in the 10-19 year age group.

“Youth” covers ages 15 to 24 years. GOI defines this age group as 15-35 years. “Young people” covers age 10 to 24 years.

“Young adults” covers ages 20 to 24 years.

“Adolescence” is recognised as a phase rather than a fixed time period in an individual's life. As indicated above, it is a 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 homogenous group. Their needs vary with their sex, stage of development, life circumstances and the socio-economic conditions of their environment.

2.2 Puberty

Puberty is a very special phase of life. This transforms a child into a grown up person, an adult with adult like looks and responsibilities. Pubertal events are important landmarks and it is very important to know various changes and their normal time of appearance.

Health care workers should be very well aware of the normal variations in pubertal changes and in varying nutritional and psychological needs. They should also know what is not normal so that appropriate referrals can be made.

3. Growth during Adolescence

Physical growth during adolescence brings dramatic changes in body. These pubertal changes transform a person from a child into an adult. These changes play a definitive role in determining the

personality of an individual.

The signals to begin puberty originate in hypothalamus then the pituitary gland and gonads work in harmony to produce required hormones which actually bring change in end organs and tissues. Adrenal androgens are not necessary for pubertal growth spurt. However, they lead to appearance of hairs around genitals, axilla, and over face.

Pubertal events

3.1 When puberty occurs

The average age at which external pubertal changes begin is average 10½ - 11 years in girls and 12½ - 13 years in boys. However, pubertal changes beginning between 8 and 13 years of age in girls and 9½ and 14 years of age in boys are normal. Thus, there is wide range of normal variation in age of beginning of puberty.

3.2 Duration of puberty

It takes average 3-4½ years from first sign of puberty to final maturation of secondary sexual characteristics. However, some changes can still take place. Whenever, more than 5 years pass after appearing first sign of puberty to completion of it, then this is not normal and reasons for this delayed puberty should be looked for.

3.3 Pubertal events in boys

a. Increase in size of testicles and scrotum

This is the first visible sign of puberty in males. The size of testicles is measured as volume in milliliter with the help of orchidometer (beads of different volumes in a string). Pre-pubertal size is <4ml that increases to 4-12 ml and achieves adult size of 12-25 ml when maturation completes. Scrotum also enlarges and its rugosities become less prominent as skin of scrotum becomes thinner.

b. Increase in size of penis

The size of penis increases during puberty. First the length increases. Width increase in later part of puberty and glans penis becomes prominent in final stages.

c. Appearance of pubic hairs

At the same time (in the beginning of the puberty) hairs begin to appear in pubic area. First, these are sparse, slightly pigmented, and appear at the base of penis. Gradually the hairs become dark and curly and spread laterally and ultimately reach to medial surface of upper thigh.

d. Height spurt

Growth in height is rapid during these years. Maximum gain in height in Indian boys is average 10.5 cm per year. Legs and hands grow first and then truncal growth occurs. Total gain in height is 27-29 cm during puberty. Boys gain more height than girls.

e. Weight spurt

Total weight gain during adolescence is about 50% of ideal adult weight i.e. 25-30 kg.

f. Other changes

Facial bones also grow and length of ramus of mandible increases by 25% during these years, thus bringing about changes in facial features. All organ systems increase in mass except lymphatic systems, which actually decrease during adolescence. Shoulders become broad. More sweating occurs. Sperm production begins and there may be ejaculations mostly during sleep (i.e. wet dreams). Skin becomes oily and acne may appear. In males, voice begins to crack and becomes male like.

Body composition also changes. Under the effects of androgens, lean body mass increases to about 90%. Bone mineral density increases in both sexes.

Table 1: Mean age of attainment of various pubertal events in Indian boys.

S. No	Pubertal event	Age in years	
		Urban	Rural
1.	Pubic hair	14	13.8
2.	Axillary hair	14.6	14.2
3.	Cheek hair	17	16.6
4.	Chin hair	16.5	16
5.	Upper lip hair	14.7	14.8
6.	Change of voice	14.2	14.3

Table 2: Physical growth parameters in boys during adolescence

S. No.	Parameter	Range of normalcy
1.	Total height gain	27-29 cm
2.	Average peak height velocity	10.5 cm/year
3.	Age of initiation of peak height velocity	11-11.5 years
4.	Age at peak height velocity	13-14 years
5.	Mean gain in sitting height	15.4 cm
6.	Mean gain in leg length	12.1 cm

Table 3 - Sequence of pubertal events in boys

S. No.	Pubertal Events
1.	Early testicular growth
2.	(Appearance of pubic hairs)
3.	Testicular, penile growth
4.	Nocturnal emissions
5.	Attainment of Peak height velocity
6.	Voice changes(breaking voice)
7.	Facial hair growth
8.	Final pubertal changes (Adult size of genitala)
9.	Muscle development
10	Attainment of final adult stature and genitalia size

3.4 Pubertal events in girls

a. Appearance of breast bud (Thelarche) and increase in size

Thelarche or appearance of breast bud is the first visible physical sign of puberty in females. This can be associated with appearance of pubic hairs also. However, pubic hairs may appear up to 6 months later also.

Breast bud appears on an average at 10.2 years in Indian girls. However, this may vary from 9.5 to 14 years. Gradually, the size of breast increases and shape also changes, reaching to adult size by 17 to 20 years of age. The sizes of two breasts may be unequal in some girls.

b. Appearance of pubic hairs (Adrenache)

Pubic hairs start appearing either along with breast bud or within 6 months of this. First, these are sparse, long and slightly pigmented and appear along medial border of labia majora. Later, the hairs darken in color and become curly and spread to cover whole labia majora, spreading to pubic symphysis and medial surface of thigh. Thus, it attains adult feminine triangular pattern.

c. Beginning of periods (Menarche)

This is the most dramatic event of puberty in girls. This occurs in middle of puberty. The age at menarche is determined by several factors including genetic factors like age at menarche of mother, and environmental factors like nutritional status and socio-economic status. The average age at menarche in Indian affluent girls is 12.6 years. However, in various studies from India it has been reported from 11.5 years to 14.7 years.

d. Height spurt

Maximum height gain in girls occurs earlier in puberty. Most of the height is gained by menarche after which height gain is very minimal. Total gain in height in girls during puberty is 24-26 cm.

e. Weight spurt

Similar to boys girls also gain about 25-30 kg during puberty.

f. Other changes

Like boys girls also have changes in organ systems including skin and acnes may appear. There is more accumulation of fat than muscles, which is deposited more in buttocks. The latter causes decrease in lean body mass to 75-80%. There is more lateral growth of upper part of thigh so that hips look wide. Bone mineral density also increase.

Table 4: Mean age of attainment of various pubertal events in Indian girls.

S. No	Pubertal event	Age in years	
		Urban	Rural
1.	Pubic hairs	12.7	13.
2.	Axillary hairs	12.6	13.3
3.	Breast areola raised	11.7	12
4.	Breast tissue enlarge	12.1	12
5.	Menarche	13.4	14

Table 5: Physical growth parameter in girls during adolescence

S. No	Parameter	Range of normalcy
1.	Total height gain	24-26 cm
2.	Average peak height velocity	9.0 cm/year
3.	Average age of initiation of peak height velocity	9.5-10 years
4.	Age at peak height velocity	11-12 years
5.	Mean gain in sitting height	13.5 cm
6.	Mean gain in leg length	11.5 cm

Table 6: Sequence of pubertal events in girls

S. No.	Pubertal Events
1.	Breast Bud(Thearche)
2.	Pubic hair development (Pubarche)
3.	Attainment of peak height velocity
4.	Menarche
5.	Axillary Hair
6.	Adult contour breast
7.	Final adult stature ,breast, and pubic hairs.

3.6 Sexual Dimorphism

Pubertal events are on an average 2 years earlier in girls than boys. Height growth occurs early in girls and average height of girls becomes higher than boys during middle adolescence. However, ultimately boys take over and become about 5 cm taller than girls. Shoulders grow more in boys and hips grow more in girls. Boys gain more muscle mass and girls gain more body fat.

3.7 Variations

There is a lot of variation in beginning, occurrence & magnitude of changes in puberty and it is these variations that make a person unique. A wide range of normality is there and whenever the growth changes are beyond the limits then this may be because of some disorder and the adolescent should be evaluated accordingly.

3.8 Sexual Maturity Ratings

Secondary sexual characteristics appear in a defined manner and these can be grouped into various distinct stages. These stages are known as Sexual Maturity Rating (SMR) or Tanner Staging. Various physical changes can be better understood when they are studied according to SMR stages. This staging is a very important clinical tool for evaluation of adolescents for pubertal disorders.

SMR Stages in Boys

Testicular and Scrotal SMR Stages

SMR Stage G-1	Pre adolescent size, testis volume is <4 ml
SMR Stage G-2	Scrotum enlarges, reddening of scrotal skin and texture is altered, testis volume >4 ml to 6 ml
SMR Stage G-3	Scrotum further enlarges, and testis volume becomes about 6-8 ml
SMR Stage G-4	Scrotum enlarges and scrotal skin darkens in color, and testis volume is 10-12 ml
SMR Stage G-5	Adult size scrotum and testicular volume is minimum 12 ml and average volume is 18.6 + 4ml

Penis SMR Stages

SMR Stage G-1	Pre adolescent size
SMR Stage G-2	Slight or no enlargement
SMR Stage G-3	Penis enlarges mainly in length
SMR Stage G-4	Penis further enlarges in length and breadth also. Glans penis develop
SMR Stage G-5	Adult size is reached

Pubic Hair SMR Stages

SMR Stage PH-1	No pubic hairs
SMR Stage PH-2	Scanty, long, straight or slightly curved, mildly pigmented hairs at the base of penis
SMR Stage PH-3	Pubic hairs become darker, more curly and coarse. Hairs spread sparsely over the junction of pubis
SMR Stage PH-4	Hairs are adult type but less in quantity
SMR Stage PH-5	Amount of hairs increase and spread to medial surface of thigh. Later, hairs spread upwards to linea alba.

SMR Stages in Girls

Breast SMR Stages

SMR Stage B-1	Preadolescent
SMR Stage B-2	Breast bud stage, papilla elevated as small mound, and areola diameter increased
SMR Stage B-3	Breast and areola further enlarged without separation of their contours
SMR Stage B-4	Areola and papilla enlarge and make a secondary mound projecting over remaining breast contour
SMR Stage B-5	Mature breast stage, only papilla projects over breast and areola becomes part of breast contour.

Pubic Hair SMR Stages

SMR Stage PH-1	No pubic hairs
SMR Stage PH-2	Scanty, long, straight or slightly curved, mildly pigmented hairs at medial border of labia
SMR Stage PH-3	Pubic hairs become darker, more curly and coarse. Hairs spread sparsely over the junction of pubis
SMR Stage PH-4	Hairs are adult type but less in quantity
SMR Stage PH-5	Amount of hairs increase and spread to medial surface of thigh. Later, hairs spread horizontally making classic feminine triangle pattern.

Table 7: Age at SMR Stages

SMR Stages	Average Age at appearance (in Indian affluent adolescents)	
	Boys	Girls
SMR Stage -1	Preadolescent	Preadolescent
SMR Stage -2	11.3 years	10.2 years
SMR Stage -3	12.8 years	11.6 years
SMR Stage -4	14.1 years	13.5 years
SMR Stage -5	16.4 years	15.6 years

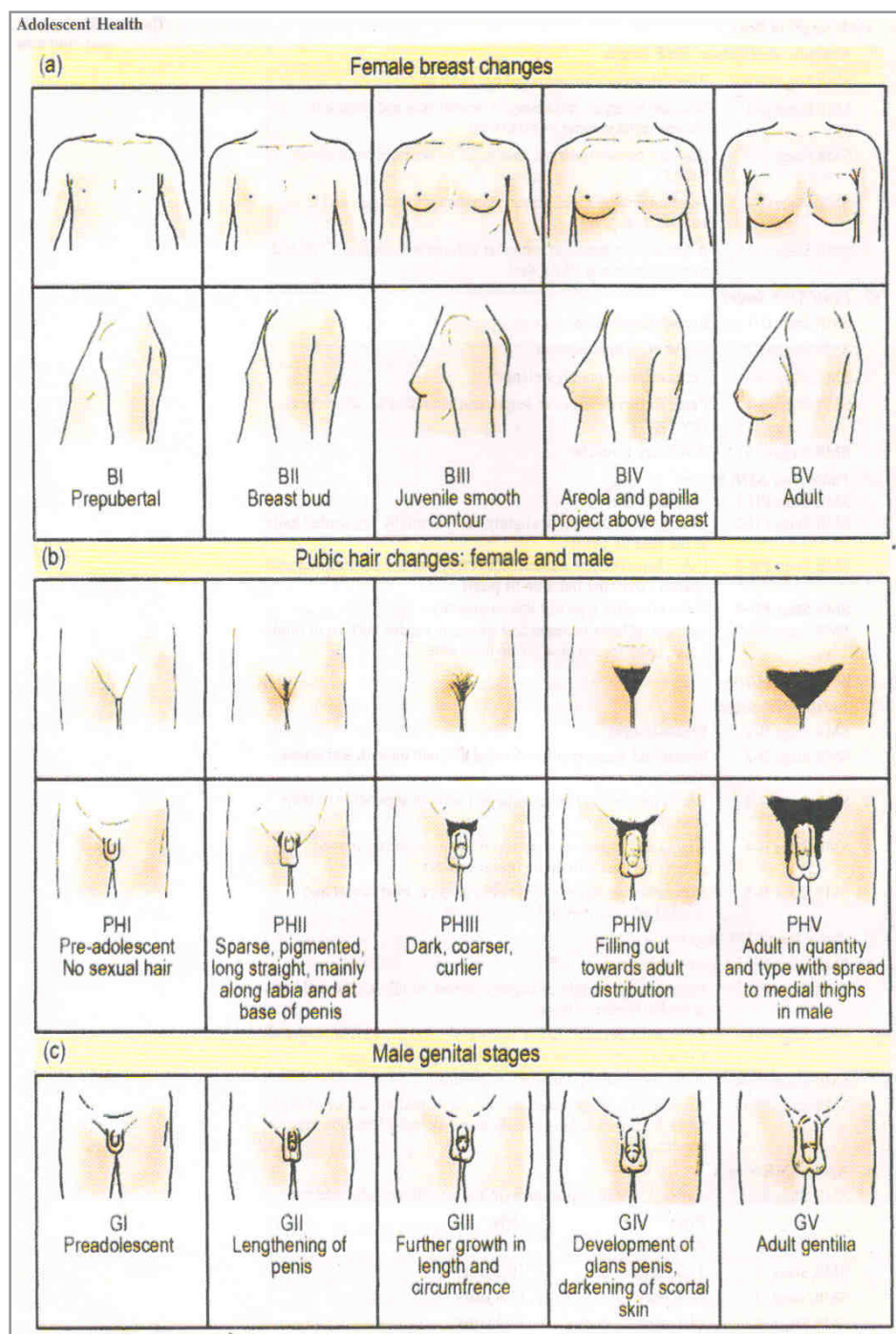


Figure 1: SMR Stages

4. Pubertal Disorders

4.1 Short Stature in Adolescence

Short stature is a major cause of concern in adolescents and their parents. Most of the centers report that about 50% of adolescents reporting for short stature have one or other form of physiological short stature. Thus it is important to identify true short stature. Adolescents with short stature may have lots of body image issues and need counseling. Clinical evaluation and management is illustrated in algorithms given in Physician Chart Booklet.

4.2 Delayed puberty

Delayed puberty is suspected when there are no signs of puberty by 14 years in boys and by 13 years in girls or more than 5 years have elapsed between first sign of puberty and completion of genital growth and menarche. Congenital anomalies in genital organs including syndromes, endocrinal diseases like hypothyroidism, and chronic illnesses are the common causes of it. Careful physical examination and appropriate laboratory tests under some expert's supervision will identify the underlying condition. Algorithms for delayed puberty in boys and in girls are given in Physician Chart Booklet.

Constitutional delay in puberty

This is most common cause of delayed puberty in boys. This is a physiological state characterized by short stature, delayed bone age, and very often a positive family history. Birth history and milestones are normal but delay in growth can be traced to early childhood also. Pubertal growth is delayed, less pronounced, and prolonged. The final adult height is normal.

4.3 Gynecomastia

Benign enlargement of breasts in boys can occur in many of normal boys during puberty. It is more common in obese boys. It is important to distinguish this physiologic condition from any underlying disease or drug causing it. Clinical history and physical examination will be useful for this. In pubertal or physiological gynecomastia in boys, the glandular tissue is usually less than 4 centimeter in diameter and it generally resolves in 2 years' time. Signs of sexual development precede and are typically present before breast enlargement begins. This is a self-limiting illness and does not require any treatment except good counseling.

4.4 Prepubertal hyperandrogenism and hirsutism

Excess of androgens produces masculine characteristics in girls including hirsutism, acne or both (in mild excess) and clitoral enlargement, temporal hair loss, masculine body habitus, voice changes, amenorrhea, and delayed puberty. Adolescents with these problems need evaluation for adrenal or ovarian androgen excess. Hirsutism can be managed by some drugs depending on the etiology. Mechanical methods for hair removal can also be used.

5. Psychosocial Development

Along with changing body, mind also changes i.e. thinking process changes, reaction to events changes, expectation and realization of them also change. Brain changes occur in the first and second decades of life and extend into the third decade - possibly until the second half of the twenties. In adolescence, there is the second cycle of overproduction of synapses (just before puberty), followed by an extended pruning process. Profound changes occur in brain connections and in signalling mechanisms during adolescence. Some of the most important changes take place in the pre-frontal cortex. This region is responsible for; Organizational ability, strategic thinking, and impulse control. These physical changes in the brain are affected by social influences.

These changes lead to a typical behavior in adolescence. To understand this behavior we need to understand psychological development during adolescence.

5.1 Cognitive development

During adolescence, thinking process changes a lot. A gradual shift occurs from concrete thinking to abstract thinking. Concrete thinking is considering specific things, objects and situation in existential terms i.e. in the real forms as in here-and-now. Concrete thinkers cannot apply experience of one situation to another situation. They lack the capacity to foresee future except as a direct projection of clearly visible, current situations and known options. Most decisions are in definite clear terms – yes or no, black or white. Shades of gray cannot be appreciated. They have difficulty in finding multiple possible solutions of same set of circumstances.

Abstract thinking utilizes intellectual creativity and permits one to find possibilities beyond past and present experiences. When adolescents develop this ability, they begin to think beyond past and present time and this is reflected in their fantasies and ideas. The development of abstract thinking has important bearing on formulation of identity, gaining independence, perception of further possibilities in career and development of value system. Abstractive ability becomes very important in today's ever changing society.

On an average, ability to abstract thinking begins at about 12 years of age and is fully operational by age of 16 years. There after, this ability improves with personal experiences. A word of caution, that this ability is not universal and it is not acquired in 30% of normal persons. Similarly, even if an adolescent is capable of abstract thought, its application in all situations is not universal and this is difficult in stressful situations.

It is important to recognize thinking abilities of adolescent client as counseling process will have to be planned accordingly. At the same time it helps in identifying vulnerability of adolescents when they are less efficient abstract thinker so that appropriate steps could be taken to prevent coercion and gender based violence.

5.2 Psychological development

Psychological Development is the process by which a child who is dependent on parents for everything becomes a self-reliant adult. In this process three tasks are to be accomplished-

a. *Surrender of childhood dependence on parents*

The process of emotional independence begins early in adolescence, reaches at peak during middle adolescence complete by late adolescence. Initially children are dependent on their parents for everything. As their thinking capabilities develop and peers (friends) begin to play a greater role, adolescents feel to do something on their own, in their own ways. This may seem to parents that it is

not going the way family or parents want. Some conflicts may arise between adolescents and parents. However, adolescents use their newly developing capacity of abstract thinking and they think beyond the things available to them and beyond the scope of their environment. At times, this is the reason of conflict. By the time adolescents gain their independence parental values are now better understood and appreciated. Advice of parents and other parent like authorities in their life is once again sought and accepted.

This transition from dependence to independence is smooth and easy for 80% of adolescents and difficult and stormy for 20% of them. Physically early blooming girls, late blooming boys and cognitively immature adolescents are especially vulnerable and may find difficulty in gaining independence from parents.

b. Formation of self identity

As adolescents grow, the importance of home diminishes and friends/peers play a bigger role in life. Adolescents make groups with adolescents having similar interests and preferences. Formation of image and self-identity begin to take shape and this is in conformity with peer group and friends.

During early adolescents, same-sex friendship is common. This is important as adolescent realize that s/he is not alone in this world going through these changes. This type of friendship also determines the dimensions of popularity and the first step in discovering what it takes to attract and relate positively to others. This is the time when adolescents compare their bodily changes with those of others of same age. As there are a lot of variations in physical changes, adolescents often ask themselves a question "Am I normal". Most of the times concerns related to physical changes and body are not genuine and are within ranges of normality. At the same time adolescents also begin to assess themselves in relation to others and try to find their worth in society. This forms their self-respect and self-esteem. It is a way one thinks of himself or herself and this has an important bearing on image and personality of individual.

By the time adolescents reach near completion of their development, peer group also include friends of opposite sex. By this time many of the concerns of body image are over and they would have found their self-esteem and self-identity. Relationship begin in this age, but most of them are mere a physical attraction than emotional mutuality or love.

c. Functional role in decisions

As adolescents achieve physical growth and cognitive maturity they increasingly demand their involvement in decisions on matters related to them directly. This newly found capability or desire, at times, takes them to experiments. These decisions help in social development but certain experiments are habit forming and harmful like smoking, drugs and watching indecent movies and photographs, even detrimental for their self esteem and may instill guilt at later stage eg homosexuality and sexual experimentations. Adolescents need to be reminded not to "misuse" their independence and decision-making capabilities. They should be advised to act according to their conscience and social values whenever they are in such situations. They need to be told that going too far is risky for rest of their lives and their decisions should be according to the values of their family and society.

Near to the completion of adolescence, peer group becomes less important and they become more close to their family. As their abstract thinking become more mature and they are at a place in their life they have to take certain decisions about their future life like decisions related to further studies and carrier, and what role to take in this world as an adult and what plans to make for family formation.

This is the time adolescents need a lot of support from parents and society. Their capabilities and

desires of taking part in making decisions related to their life should be respected and be given due importance.

5.3 Developmental Levels

Psychosocial development takes place through a defined sequence as described above. It may or may not correspond to the physical changes of puberty. This development corresponds more to the chronological age than the age at appearance of secondary sexual characteristics. It may happen that an adolescent has achieved all physical growth of puberty but is lagging behind in psychosocial development.

It is important to understand the developmental level as the questions, explanations, instructions, and counseling will depend on this level. These developmental levels can be distinguished in three distinct phases i.e. early, middle and late adolescence.

Table 8 : Development during adolescence

Developmental parameters	Early Adolescence	Middle Adolescence	Late Adolescence
Age	10 to 13 years	14 to 17 years	17 years upwards
SMR Stage	I and 2	3 and 4	5
Physical development	Rapidly occurring changes in body baffles the adolescents and they have frequent comparisons with their peers. Body image issues can begin at this stage. Interest about anatomy and physiology of sex organs increase. It is common to find adolescents anxious about breast or penis size, menstruation or night ejaculations.	Peaks in growth in height and weight occurs and this slow down by the end of this phase. They focus on making themselves more attractive to others.	The body develops like an adult and they have a realistic body image.
Cognitive development	At this level, they are concrete thinkers. There is lack of control of impulsive actions and this may result in risk taking behavior and experimentation. Adolescents may set unrealistic academic or vocational goals.	Abstract reasoning and formal operational thinking begin at this level. They may revert back to concrete thinking at the times of stress. Feeling of supremacy and immortality increase and this may lead to risk taking behavior. Intellectual ability and creativity further increase and this lead to more realistic choices in carriers and other important life decisions.	Establishment of abstract reasoning is achieved. Ability to weigh different options develops and decision making become more rational and realistic. Interests about education and vocation are more stable. They develop ability to delay gratification. Desire for financial independence increase and some may actually attain it.

Developmental parameters	Early Adolescence	Middle Adolescence	Late Adolescence
Family	Desire for autonomy begins at this age and adolescents have less interest in family. They find flaws in home rules and traditions and are reluctant to listen to parental advice. Adolescent try to define his/her authority resulting in increased tension between the adolescent and parental figures. Adolescents become labile emotionally and wide mood swings are common.	Adolescents become more autonomous and spend more time with friends and may acquire rules and roles of their friendship group. This may lead to conflict between parents and adolescents.	The desire to become autonomous is more or less complete and they reconcile the relationship with parents and the conflicts with parents are less. They begin to have faith in moral, religious, and sexual values of family and community.
Friends	Friends and peers become more important than family as a process of achieving their own identity. Friendship with same sex friends is common. Adolescent become aware of the feelings of sexual attractions. However, sexual activity is uncommon.	Friendship with both sexes is common now. Adolescent behave more like their peers and according to peer group values and codes. Experimental and exploitative relationship becomes common as they explore boundaries of their own and of their friends.	Value system of peers becomes less important and they are more comfortable with their own values and identity. Relationship becomes less exploitative. Committed relationship with opposite sex partner can begin at this level.
Scholastic competence	Conceptual comprehension of the material begins. Learning disabilities can be identified.	Higher order thinking begins. Ability to appreciate nuances of language, creative thinking and writing blossoms.	Skills achieved during middle adolescence further enhance. Able to make realistic decisions about education and carrier.

6. Supporting the development of adolescents

Adolescents require a lot of support for psychological changes occurring in them. They need support from everyone in their immediate environment and who are in contact with him/her. These people may be grandparents, parents, relatives, friends, siblings, and teachers. Everyone should understand the changes and the turmoil going on in mind of adolescents and act accordingly.

First kind of needs is for self-identity, status, recognition, and respect in society. Other needs are related to self-esteem, self-confidence, feelings for authority and independence, knowledge and achievements.

The adult figures in life of adolescents should help them in developing better social skills including life-skills so that they achieve greater self realization and they prepare themselves for life's emergencies. Thus, adolescents should be able to capitalize on their strengths and develop one's unique potentials.

6.1 Helping adolescents in establishing social status

On the one hand, adolescents want to be independent and on the other, they want to be part of a group. Being part of a group in which one is accepted and appreciated triggers a stronger positive response in adolescents than in adults. Being part of a group is both reassuring to them and helps them to prepare for collaborative relationships in adulthood. Also, adolescents find it supportive to be part of a group of peers who are going through the same changes that they are.

An important point to note is that the more important it is to an adolescent to belong to a group, the more susceptible he/she is to peer pressure. Adolescents may smoke, drink alcohol, use drugs or have sex as a means of being accepted by their group.

A strong sense of belonging to one's ethnic group is protective. It is associated with high self esteem and performance. Adults can help promote ethnic identity by promoting a positive identity. They can also help by speaking openly about discrimination, by helping them use effective strategies e.g. seeking outside support and avoiding ineffective strategies e.g. engaging in verbal exchanges with perpetrators.

6.2 Why are peers important?

- They help adolescents:
- Learn how to interact with others
- Shape who they are and why their interests are
- Build their autonomy
- Get emotional support
- Observe how others cope with similar problems, and judge how effective the methods they use are
- Value loyalty and trust

6.3 Dealing with peer pressure

If adolescents are treated as responsible by important adults in their lives, they are more likely to behave responsibly with their peers. Adults should respect their ideas and support them in making decisions. All of us – adolescents and adults – face peer pressure. Adults should help adolescents understand that making decisions usually means juggling competing pressures.

Adolescents may not decide wisely when unexpectedly faced with a risky situation. Adults should discuss possible situations and risky strategies in advance and encourage adolescents to discuss how to deal with them.

6.4 Examining sexual identity ('Who am I sexually?')

Sexual identity is one's identification with a gender (masculine or feminine) and sexual orientation one's awareness of being attracted to the same or opposite sex (heterosexual, homosexual or bisexual).

The formation of sexual identity begins in childhood but developed fully during adolescence. As with other areas of development, developing a sexual identity can be uneven and confusing. Adolescents may consider different options before establishing their sexual identity and orientation. Adults can help them by giving them honest and accurate information and responses to their questions. They should take care not to label emerging thoughts, feelings and behaviours as abnormal or immoral.

6.5 Adolescent Body Image

Adolescence is a period of changes. Perception of these changes by adolescents as normal or not normal or not so normal depends on the comparison of their own perception of their body (image) with the model images. These comparisons lead to changes in behavior of adolescents in order to achieve the self perceived 'model' image. At times, these attempts to acquire 'model' body become pathological and manifest as psychosomatic disorders. These adolescents need professional help and treatment.

Table 9: Important Changes during Adolescence events/changes

Physical Events / Changes	
BOYS	GIRLS
Penis and testes enlarge	Breasts develop
Growth spurt occurs	Growth spurt occurs
Muscles develop	Skin becomes oily
Skin becomes oily	Hips widen
Shoulders broaden	Waistline narrows
Voice cracks	Underarm hair appears
Underarm and chest hair appears	Pubic hair appears
Pubic hair appears	External genitals enlarge
Facial hair appears	Uterus and ovaries enlarge
Emotional and Social events / Sexual Development changes	
Preoccupied with body image	Sexual organs enlarge and mature
Curious, Inquisitive	Erections in boys
Want to establish own identity	Sexual desire
Attention seeking behaviour	Sexual attraction
Fantasy / daydreaming	Menarche, Ovulation
Rapid mood changes, Emotional instability	Sperm Production, Ejaculation
Sexual attraction	Initiation of sexual behaviours
Full of energy, Restless	
Concrete thinking to abstract thinking	
Self exploration and evaluation	
Conflicts with family over control	
Seek affiliation to counter instability	
Peer group defines behavioural code	
Formation of new relationships	

Table 10: Possible health implications of adolescent development:

Changes during Adolescence	Health Implications
Physical Changes	
Normal growing-up	Undue anxiety and tension
Increase in height and weight	Increase nutrition requirement - if inadequate, undernutrition and anemia
Breasts Development	Stooping of shoulders, poor posture, back pain
Skin becomes oily	Acne
Desire to be thin, have a good figure	Protein-energy malnutrition, anemia, Stunting
Sexual Development	
Desire to have sex	Unsafe sex leading to unwanted pregnancy, STIs, HIV; Need of health education and services
Ejaculation	Fear, guilt, myths - emotional problems
Menstruation	Dysmenorrhea, Menorrhagia - Anemia, RTI (Menstrual Hygiene)
Emotional changes and Social development	
Development of Identity	Confusion, moodiness, irritation
Very curious	Experimentation, Risk taking behaviour
Peer pressure	Effect on lifestyles <ul style="list-style-type: none"> • Unhealthy eating habits life styles leading to obesity • Smoking and alcohol use leading to ill health • Speed driving, accidents • Risk taking behaviour

Adolescent Issues - Different Perspectives:

- **Parents' Perspective:** examination marks, growth, career, happiness, good citizen
- **Teacher's Perspective:** examination marks, all round development, career, civic sense, safe behaviour
- **Health Sector's Perspective :** growth, health protection and promotion, safety, HIV/STI
- **Administrator's/Policy makers' Perspective:** Healthy and productive population
- **Adolescents themselves:** Body image, career, sexuality, general health

It is noteworthy that priorities of adolescents themselves are at variance from adults' perspectives.

Benefits of Investing in adolescent health

Health benefits for the individual adolescent: in terms of his/her current and future health, and in terms of the intergenerational 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.

7. Adolescent Sexual Behaviour and its Health Implications

Most young people (10-24) initiate sexual behaviour during this age and have many misconceptions and myths related to sexual and reproductive health. There are numerous myths attached to sexuality and reproductive health (concept of “manhood”, STIs and virginity, semen myths etc.) that are at the root of High Risk Sexual behaviour in this particular age group. In addition many mental health and social problems (anxiety, depression, poor body image, stigma, suicides) may result from myths about masturbation, body image, erectile dysfunction, illegitimate pregnancy and sexual problems (eg. Premature Ejaculation). In addition, most adolescents lack relevant information and skills to practice safe sex. This situation has its impact not only on adolescent/young individual but also on their families and the society.

Adolescents are “exposed” to sexual imagery and messages in today’s media but lack accurate and “useful” information concerning sexuality and reproductive health.

7.1 Implications of Early Sexual Involvement in Adolescence:

- Adolescents who start having sex early are more likely to have sex with :
 - high risk partners, or
 - multiple partners.
- They are less likely to use condoms.
- Contraceptive usage is likely to be low.

7.2 Consequences of Unsafe Sexual Behaviour among Adolescents

- Early pregnancy and Parenthood (early marriage and sometimes ‘out of wedlock’)
- Higher percentage of low birth weight (LBW) babies and increased infant morbidity and mortality
- Abortions and its related complications
- RTI/STI including HIV/AIDS
- Consequence that are more in adolescents even if it has been ‘safe sex’
- Emotional impact - guilt, stress, anxiety, suicide
- Social impact - Stigma (especially if unmarried)
- Economic impact - hindrance to academic and career progression
- Emotional, social and economic impact may be more in case of adolescents (even if it is safe sex) because they are not mature enough to handle these consequence.

7.3 Negative Impact due to lack of Awareness and Skills related to Sexuality and HIV:

Whether they are married or unmarried, adolescents can face potentially serious physical, social and economic consequences from unprotected sexual relations such as: unintended and too early pregnancy and childbirth, ‘unsafe abortions’ and STIs including HIV. These events can also cut short educational and job opportunities; and negatively affect social and cultural development - especially of adolescent girls. For boys too, early fatherhood can disrupt educational plans and increase economic responsibilities.

Adolescents, both male and female belonging to most countries of South East Asia, need to deal with multiple issues arising out of these areas to lead a healthy, responsible, safe, joyful and guilt free sexual life. Psychologists have termed this to be one of the main developmental tasks of healthy adolescence. Not having achieved comfort with sex and sexuality as adolescents could lead to a number of serious problems not only in adolescence but also in adulthood.

Adolescent Sexuality, if not dealt with properly, has serious repercussions. The lack of accurate information regarding sexual anatomy and physiology may lead to sexual ill-health. In many cases, adolescents are ignorant about sexuality largely because they have a negative emotional attitude toward sex organs and matters related to sexuality. It is not uncommon for adolescents to perceive their sexual organs as dirty and to refrain even from looking at them. Such negativism is particularly common among females, but males, too, may have negative feeling about sex organs. The innumerable myths attached to the organs and their functioning are usually picked up early in childhood and adolescence from peers or available, unscientific literature and may lead to irreparable harm later in life.

Lack of sexual health education (i.e. Information PLUS Skills) contributes to the health and psychosocial problems of the adolescents. They are likely to be curious yet ill-informed, bold yet vulnerable and have numerous myths related to sexual anatomy and functioning. Many adolescents adopt high risk behaviour due to the numerous myths and lack of skills - especially ability to negotiate and to deal with peer pressure effectively.

The anxiety attached with masturbation, "small" penis or breasts, can lead to negative body image, premature ejaculation and complex problems related to sexual functioning. Ignorance about sexual functioning and STI, curiosity about sex, peer pressure and lack of appropriate skills may facilitate transmission of STI/HIV and lead to unwanted pregnancy. Alternatively it may lead to primary "infertility" purely because of ignorance regarding physical aspects of sexual intercourse. Many of these factors / determinants are linked and feed on each other.

Adolescence is the "Last Chance" to catch up on lost growth and development due to childhood malnutrition

8. Vulnerability of Adolescents

- Adolescents are Vulnerable by virtue of:
 - Normal Developmental Processes.
 - Family/ Peer/ Environmental Influences that may be positive (protective) as well as negative (e.g. broken family, alcoholism in family members or peers).
 - Life style Patterns that they choose;

and are "At Risk" because of Certain Behaviours.

Some adolescents are more Vulnerable and need special attention.

Special Attention Groups of Adolescents are:

- "Out of school" adolescents and street adolescents.
- Sexually abused adolescents.
- Commercial sex workers.
- Adolescents with mental and physical disabilities.
- Orphan Adolescents, those in foster care and institutions.
- Adolescents in conflict with the law.
- Working Adolescents.

The adolescents who fall in the special attention groups are more at risk of identity crisis and low self esteem, guilt, frustration and mental problems. They are also the group who can be moulded and helped to change their erratic behaviours to more responsible ones to improve their self worth and

esteem.

Given the turbulent period and the multiple challenges it is not strange that adolescents have unmet needs in many areas: regarding nutrition, sexuality, reproductive health, managing emotions and stress, mental health, substance abuse, etc. They require appropriate information and skills to negotiate adolescence safely. Adolescents need to be empowered with correct, age appropriate and current information and skills in all these areas to develop and practice responsible behaviours to protect themselves from risks as well as to help them seek appropriate services.

Information for parents, teachers and social workers is equally important as they play key roles in adolescent health and development.

The various issues related to adolescence, growing up, body image etc. have not only a huge socio-economic impact but also impact the National Health Indicators.

9. Role of the Health System to help Adolescents attain and maintain optimum health

- Provide accurate information to adolescents, families, media
- Address groups of adolescents/teachers/parents, schools, colleges, clubs
- Provide needed services in a friendly manner (AFHS)
- Utilize the media
- Facilitate the provision of “Life Skills education”, help postpone early marriage and early pregnancy

Remember health sector alone cannot achieve all this. It has to enable other sectors like departments of education, youth, women and child, social work etc., political and religious leadership and media etc.

10. Summary

Growth and development during adolescence is a biopsychosocial process characterized by physical, psychosocial and cognitive changes taking place together but at a different pace. These changes may not occur at the same chronological age in different adolescents and this may cause concern in them. The clinician should be well aware of normal range and variations in these rapid changes so that appropriate counseling can be done and timely referrals can be made.

Puberty occurs 2 years earlier in females. Accordingly the growth spurt occurs earlier in females but the amount of growth (peak height velocity) is more in males. Thus, females may appear taller in the beginning of puberty but their ultimate adult height is shorter than their male counterparts. In male, peak gain in weight coincides with peak gains in height whereas in females peak gain in weight occurs about 6 months after the peak gain in height.

Body composition also changes. Males gain more lean body mass and lose fat mass. Females gain more fat mass and actually lose lean body mass. There may be variations in stages of development in breast/genitals and pubic hair development in the same individual.

Early adolescents think concretely and are not aware of (or do not care for) the consequences of their actions. This may lead to risk taking behavior. Abstract reasoning begins in middle adolescence but feelings of “nothing will happen to me” persist and add to risk taking behavior. By the late adolescence, sense of perspective is established with enhanced ability to weigh options and take appropriate decisions. They also develop ability to compromise and set limits. The environment in family and community, and the media have major bearings on development of these behaviors. Understanding the developmental levels of an individual adolescent helps the clinician in framing questions, explanations and instructions.

It is important to understand implications of these normal growing up processes and the perspectives of adolescents and of significant others. Health care providers have to take into account these issues in order to promote adolescent friendly health services.

11. References:

- *Nelson Textbook of Pediatrics, Saunders-Elsevier, 19th Edition, 2011.*
- *Agarwal KN, Agarwal DK, Seth A. (Eds). The Growth Infancy to Adolescence, CBS Publishers and Distributors, New Delhi, 2nd Edition, 2007.*
- *IAP Growth Monitoring Guidelines for Children from Birth to 18 Years. Indian Pediatrics 188 VOLUME 44 MARCH 17, 2007; 187-197.*

12. Annexure I: Group Exercise

Changes during adolescents	Health Implications

Annexure 2:

Self-Assessment Tool (SAT)

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

(i)

(ii)

(iii)

2. What are the implications of these 'normal' changes on adolescents' health?

(i)

(ii)

(iii)

3. What are the health related concerns of adolescents in your work area?

(i)

(ii)

(iii)

4. How health system can help adolescents to attain and maintain optimum health?

(i)

(ii)

(iii)

Handout IV

Adolescent-Friendly Health Services

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1. Introduction

Services for adolescents must demonstrate relevance to the needs and wishes of young people. This handout looks at how to implement and make health services adolescent-friendly. It keeps in view the adolescent needs, perspectives of different stakeholders, characteristics and approaches to making health services more adolescent-friendly.

2. Why should health services be Adolescent – friendly?

Adolescence is a unique phase of life where along with changes in body, changes do occur in mind i.e. thinking process also changes. Family, school and community environments also have effects on the development of adolescents. Thus, needs of adolescents are also in transition from that of child-like needs to independent adult like needs. Health care providers need to assess these needs and bring some changes in their handling adolescents. This is different than handling a 6 year old child or a 36 year adult.

For completion of psychosocial history, we need information from both adolescent client and parents. Adolescent may have some information which she/he would not want to share with parents or is not sure whether it should be shared with parents/guardian. Similarly, unlike children, adolescents need privacy during physical examination and in in-patient services. Thus, a delicate balance is needed while dealing with adolescent clients.

You will understand this more when you read about clinical interaction with adolescent client.

3. What health services do Adolescent 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 too 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, however, it must be ensured that services are appropriate and effective, and they must be affordable and acceptable for the community.

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 and develop positive life skills.

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.

4. Principles of Adolescent Health Care Services

The basic principles of adolescent health care have emerged from results of several surveys conducted on adolescent and youth regarding their views about health services and what will encourage them to use the services. These are 6 As –

1. **Availability**

The adolescent health services should be available in community and at every health care facility to every adolescent.

2. **Accessibility**

The services should be near to the residences and at a time when adolescents can avail them without compromising their studies or work.

3. **Approachability**

The health services and the staff should be such that adolescent feels welcomed there. The young person should feel comfortable while interacting with health care staff.

4. **Acceptability**

Health care services should be provided in a manner which is acceptable to adolescents. Young persons should be respected and be involved in decision making process related for their health care.

5. **Appropriateness**

Health care providers should be able to provide the care needed or should be able to identify the need of referral. Adolescent JobAid is an important handy tool for their needs.

6. **Affordability**

The care extended to adolescents should be affordable to adolescent and/or their parents. User charges may be waived off if adolescent is not in a position to pay. This may be the situation when they seek confidential care and can not ask their parents for health care exposures.

5. Barriers that prevent utilization of services by adolescents

5.1 Barriers related to clients (adolescents):

- Discomfort with real or perceived clinic conditions
- Discomfort with real or perceived attitudes of providers
- Belief that the services are not intended for them
- Concern that the staff will be hostile or judgemental

- Fear of medical procedures
- Concern over lack of privacy and confidentiality
- Embarrassment at needing or wanting RH services
- Shame, especially if the visit follows coercion or abuse
- Fear of being examined by provider of opposite sex
- Stigma for availing mental health services or counseling services
- Ignorance or lack of information about health risk and services available
 - Poor understanding of their changing bodies and needs.
 - Insufficient awareness of pregnancy and STI/HIV risks
 - Lack of information of what services are available and location of services
 - User charges

5.2 Barriers related to health providers and policy :

A) Provider factors:

- Untrained providers and staff for adolescent health and development issues
- Providers and staff not sensitive to adolescents' needs
- Judgemental and/or unempathetic attitude of providers and staff towards adolescent needs and concerns
- Providers and/or staff refuse services to adolescents (this factor may be more in government health settings as compared to private settings)
- Providers unwilling to provide sufficient time to the adolescent client for interpersonal communication and psychosocial history taking
- Provider attitude biased towards boys versus girls

B) Policy factors:

- Discrimination against adolescents, sometimes by requiring minimum age or parental consent.
- Unclear laws and policies regarding adolescents, both married/unmarried and boys/girls
- Not involving adolescent boys and girls during formulation of policies related to their needs and concerns
- Cost of services is high and unaffordable by adolescents

C) Barriers related to health facility:

- Lack of designated or special health services for adolescents at the facility
- Lack of privacy and confidentiality
- Unfriendly environment
- Timings are not suitable and convenient to adolescents
- Cost of services is high and unaffordable by adolescents

6. Characteristics of Adolescent-Friendly Health Services

6.1 Adolescent-friendly programmes

Adolescents are involved in programme design and continuing feedback. It is fundamental to ensure participation of young people in identifying their needs and preferences for meeting those needs. Involving youth in the planning of the facility / programme and in continuous feedback will enhance their “ownership” of the programme. This feeling of ownership will motivate young people to recruit their peers and to advise on needed adjustments.

Both boys and girls (married/unmarried) are welcomed and served quickly: We are quite used to drop-in clients arrangement, which does not need prior appointments. It is very good because the adolescents are present-minded and rarely plan ahead to seek prior appointments for receiving services. With young people, it helps to “seize the opportunity” when they show up for getting Health care. However, when requested an early appointment should be made available.

No overcrowding and short waiting times: Having to wait for a long time to be served in a clinic, particular adolescent clients. A long wait dissuades them and they tell this to the peers-the prospective clients and this gives a bad reputation to the facility.

Affordable fees: Cost can be a significant barrier to potential adolescent client. The services should be free or affordable. Some studies have shown that adolescents want to pay something for services or else they will not value what is provided. User charges should be waived off especially when adolescents visits health centre alone.

Publicity: The adolescents must be informed about the existence of the clinic and other service programmes and also what services are provided. They must be reassured that they are welcome and will be served respectfully and confidentially. Provision of privacy and confidentiality should be prominently displayed.

Boys and young men welcomed and served: In case of RH care clinics it is commonly presumed that the services are meant only for females. For a young woman, the accompaniment of her boyfriend to the clinic can be an important element in the decision to seek services. This support should not be dampened by feelings of discomfort.

Wide range of services available: While it is not always possible, attempts should be made to identify and provide most needed services as “one-stop shopping”. These services should include: Nutrition Counselling, Growth and Development Monitoring, RH and sexual counselling, Contraceptive counselling and provision, Sexual abuse counselling, Substance abuse counseling, vaccination etc. and anticipatory guidance.

Necessary referrals available: Effective working arrangements should be established to ensure that youth receive the services they are referred to and assure that referral sites provide appropriate, youth friendly treatment. Referral centers should be pre-identified.

Parental involvement is encouraged: Many younger adolescents may be accompanied by parents and they are a good support system for adolescents in any case. However, the services should not be denied in the absence of parent or care-giver.

Services are well promoted in areas where adolescents gather: Information exchange in the form of group discussion with peers can be quite useful. It helps adolescents realize that they are not unique in their fears and can provide peer support to obtain needed care or seek solutions to problems. Schools, AWCs and other congregation should be used.

Linkages are made with schools, youth clubs and other adolescent-friendly institutions:

Clinics can increase their reach by other means of contact with clients. Telephone help lines can be operated by trained counsellors from the clinic site. Clinics can also set up smaller branches or satellite clinics closer to where young people congregate or that are linked to schools. School health services and RBSK mobile clinics are the feeder services for adolescent friendly health clinics.

Alternative ways to access information, counselling and services are provided: Some young people prefer to learn about sensitive issues on their own by using written or audio-visual materials. Such material can be used while clients are waiting to be seen. Some materials should be available to take home, too, so that they can refer to them later when needed. Modern means of communication like SMS, mobile phone, social networking sites, institutes websites or dedicated websites should be used judiciously.

Peer counsellors: Evidence shows that many young people prefer talking with their peers about sensitive issues. It is, therefore, useful and effective to have peer counsellors available as alternatives or supplements to some aspects of counselling activities. HCWs should help in training peer-counseling.

6.2 Adolescent-friendly service provider(s) (Medical officers and ANMs/LHVs)

Trained and empathetic staff on adolescent issues: Having specially trained staff at the clinic is the single most important condition for establishing youth friendly services. Acquired skills must include familiarity with adolescent physiology and development, interpersonal skills, attitude and performance of all the staff.

Respect for adolescents: Some providers bring to their job deeply entrenched biases against sexual activity of adolescents and find it difficult to relate to adolescents in a respectful way. Given this reality, clinic managers should carefully consider such attitudes as they select their staff to work with young persons. They should be non-judgemental, considerate, easy to relate and trustworthy. They welcome and interact with all adolescents irrespective of age, gender, socio-economic background or other considerations.

Maintains privacy and confidentiality: Privacy and confidentiality rank very high among the young people. Privacy must be arranged for counselling sessions and physical examinations. Young people must feel confident that their important and sensitive concerns are not retold to other persons. A common fear expressed by young people is that the nurse, doctor or other staff will tell their parents or acquaintances that they came to the clinic for Health care.

During first interaction with adolescent client, the issue of privacy and confidentiality should not only be discussed but the client should be issued of privacy and confidentiality in all situations. One exception should always be discussed. The adolescent client should be told that confidentiality may be breached in case it is found that some information can cause severe harm to adolescent or a life threatening situation is discovered during interaction. The adolescent the adult care giver (parents) will be contacted such situations also include abuse or coercion of the adolescent client.

Adequate time for client and provider interaction: The young people need more time than adults to open up and to reveal very personal concerns and require strong reassurances and active encouragement to speak freely. Time is needed to bring myths to the surface, to discuss them, and to dispel them. In addition to responding to client concerns provider should be able to cover questions about body image and development, sex, relationship, condom negotiation and contraceptive method options. HEADS approach should be used. You will find details in JobAid. Therefore, an adequate time should be allotted for each client. Providers should inform and support adolescent clients to enable them to make free choices for his or her need.

6.3 Adolescent-friendly health centre

Separate space and special time set aside: Creating separate space, special times, or both for adolescent clients appears more important for certain clients such as young teenagers, first time clinic users, non-sexually active clients and marginalized young people. A separate service can also facilitate provider's efficiency in arranging specialized youth friendly features.

Convenient hours: Having clinics open at times when young people can conveniently attend is fundamental to effective recruitment. Such times include late afternoons (after school or work), evenings and weekends.

Convenient location: New facilities can easily be planned with this requirement in mind. Young people do not want to or cannot travel too far to reach service sites. Sometimes, they desire to go out of their neighbourhoods. In any case, the location should be in safe surroundings and, ideally, should be approachable by public transport.

Adequate space and sufficient privacy: Adequate space is needed to assure that counselling and examinations can take place out of sight and sound of other people. This requires separate rooms with doors and policies that support minimal interruptions and intrusions. Both audio and visual privacy should be ensured.

Comfortable surroundings: The service environment may vary in important details with the specific target audience to be served. In general, young people prefer a setting that is comfortable, has posters or décor that relate to their taste and interests, and does not present an overlay

Required supplies are available: Adequate supply of medicines, equipment are available for basic services and necessary procedures. Educational material is also available on site.

7. Adolescent Immunization

Vaccines have controlled several killer diseases for children. Vaccines have been successful in eradicating small pox and possibly the poliomyelites. These successes have led to a picture that vaccines are for children only. However, vaccines are now being recognized as very important public health interventions for prevention and control of diseases of adolescents and adults.

Vaccinating adults with pertussis vaccine is regarded as an important step in control of childhood pertussis. Similarly, antenatal tetanus toxoid administration is used for prevention of neonatal tetanus. Now, antenatal administration of Tdap (Tetanus and reduced doses of diphtheria toxoid and acellular pertussis) is being advocated to control neonatal tetanus and pertussis and diphtheria. Certain vaccines specific to adolescent and adult age groups have also been licensed.

7.1 Reasons for vaccinating adolescents

Need of vaccination to an individual is determined by risk of getting infection or by probability of spreading infection to others. Adolescents continue to be susceptible to various infectious agents and can get the disease too. Generally, childhood infectious diseases occurring in adolescents or adults are more severe with more complications (eg. Chicken pox).

Considering the coverage of children with adequate immunization in India, it is very likely that an adolescent remain susceptible to infectious diseases. Notion that by this age natural infections (clinical or sub-clinical) provide enough exposures to get protective immunity is not true in cases of all adolescents. In today's over protective environment to some adolescents & children. It may keep them susceptible to infectious diseases.

In certain cases (e.g. pertussis) antibody levels may fall below the protective levels. This necessitates booster doses.

Adolescence is the age where susceptibility to new infections begin because of natural risk taking behaviours. This makes it necessary to continue protection against tetanus and to have protection against diseases like human papilloma virus infection. Adolescents also move out of home to hostels or dormitories for higher education. This further makes them vulnerable to diseases like meningococcal meningitis. They may travel to some disease prone areas and thereby needing specific vaccines (eg. Yellow fever for African countries, OPV for Haj Pilgrims)

Some adolescents carry one or other chronic illness (eg. Asthma, cancer survivor, etc.). Their vaccination needs are entirely different because of enhanced susceptibility to infections and their complications.

At the end, some adolescent might have missed one or other childhood vaccine thereby putting themselves in an increased risk of getting diseases. Catch-up vaccinations are needed for these adolescents.

7.2 Vaccination Schedule for Adolescents

National Immunization Program has major emphasis on childhood vaccination. For children older than five years. DPT can be given till 7 years as second booster. If the child has received it then TT is recommended at 10 years of age and at 15-16 years of age. National Immunization Program does not have any other vaccine which can be used during adolescence. Hepatitis B is provided during infancy and upto 5 years of age, however this can be used at any age.

Administering Hepatitis B in Pentavalent vaccine will preclude use of Hepatitis B vaccine alone at any age. MMR too can be used in adolescents. Indian Academy of Pediatrics has specific recommendations for adolescent immunizations.

Indian Academy of Pediatrics recommendations for adolescents

TT	Booster at 10 and 16 years
Rubella	As part of MMR vaccine or (Monovalent) 1 dose to girls at 12-13 years of age, if not given earlier
MMR	1 dose at 12-13 years of age. (if not given earlier)
Hepatitis B	3 doses (0, 1 and 6 m) if not given earlier
Typhoid	TA, Vi or Oral typhoid vaccine every 3 years
Varicella	1 dose upto 12-13 years and 2 doses after 13 years of age. (if not given earlier)
Hepatitis A	2 doses (0 and 6 months) if not given earlier

IAP Recommendations for vaccination of travelers

Vaccine	Place of Travel	Dose Recommended
Meningococcal Vaccine	USA/UK/endemic areas Saudi Arabia and Africa	1 Dose
Yellow fever	Yellow fever endemic zones	10 days before travel
Oral Cholera vaccine	Endemic Areas or area with an outbreak	2 doses 1 week apart
Japanese B encephalitis	Endemic areas for JE	Single dose (upto 15 years)
Rabies Vaccine (Pre exposure Prophylaxis)	For adolescents going on trekking	0, 7, 28

7.3 Special issues related to Adolescent Immunization

Safety of vaccine administration is of paramount importance. Although, all vaccines are very safe, adolescents may face some adverse events more commonly. Syncope following vaccination is more common in adolescents and adults. For this reason and to monitor other immediate serious adverse events like anaphylaxis, all vaccine recipients should be monitored closely for 15 – 30 minutes after vaccination.

Pregnancy is the condition where vaccines should be used carefully. However, data related to adverse outcome to fetus is available for small pox vaccine only. Risk to fetus by vaccine to mother seems to be theoretical. In addition to TT, Td or Tdap vaccines can be used during pregnancy. Influenza and Hepatitis – B vaccines can also be used safely. Other vaccines should better be avoided if pregnancy status is known.

Prescribed interval between 2 vaccines or between subsequent doses of same vaccine should be followed. In case of shorter or longer duration between 2 consequent doses, the effects of vaccine may remain suboptimal. In cases where a shorter (>4 days short) duration between 2 doses could not be avoided, the dose should be repeated after a recommended period between invalid dose and this additional dose.

Simultaneous administration of different vaccines is generally safe. Interval between administrations of 2 different vaccine need not be 4 weeks except after measles containing vaccine (MMR) and when Tdap is to be given after Meningococcal vaccine (MCV4). Measles vaccine is known to suppress the immune response transiently. MCV4 vaccine contains very high concentration of diphtheria toxoid (6 times the levels in Tdap vaccines). So, administering Tdap vaccine within 1 month of receiving MCV4 vaccine may lead to increased risk of local reactions including deposition of immune complexes at the injection site (Arthus Reaction).

8. How are services best delivered to adolescents?

Adolescent-friendly health services can be delivered in hospitals, at health centres, in schools, or in community settings. They may be planned from above or started by groups of dedicated healthcare professionals who see that the needs of adolescents are not being met, and who believe that services can be more effective. This section gives examples in a range of different settings.

A judicious mix of different (but complimentary to each other) delivery models and settings may be required to cover all groups of adolescents in a geographic area, e.g. a district.

8.1 Services at health centres or hospitals

Basic health services are usually delivered at ordinary health centres 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 and 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.

8.2 Services located at other kinds of centres

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 periodically 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 particular group of the adolescent population, being used mainly by boys or by girls or by one age group.

8.3 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 come to health centres. 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. Mobile teams of Rashtriya Bal Suraksha Karyakram (RBSK) can extend some of the services to adolescents. Peer leaders will be instrumental in providing services in community.

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. Here too, peer leaders and their mentoring health workers will be key to extend services to these adolescents.

8.4 Health services linked to schools

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

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.

Table

Community level assistance for awareness, enabling environment and marketing of services:	
Schools	Saas-Bahu groups (eg. in Chittor)
Anganwadi Workers (AWWs)	Parent groups
Self-help Groups (SHGs)	Nehru Yuvak Kendra (NYKs)
Mahila Mandal	National Service Scheme (NSS)
Youth clubs	Scouts and Guides
NGOs working in their area	National cadet corps
Literacy programmes (continued education)	Media to create awareness and an enabling environment
	Websites and social networking sites

9. Life Skills: Role of Health Sector

9.1 Background

Adolescents have numerous concerns and problems. Numerous such issues (Tobacco and Alcohol use, Early initiation of Sexual activity, Depression) are linked and may have common origins and driven by common “Risk Factors” (WHO). Most of these problems and concerns not only impact the adolescents as individuals but also have a significant Public Health Impact. Many national indicators like TFR, MMR, IMR etc have a significant component contributed by the adolescent age group. Adolescents have certain well-defined needs to negotiate adolescence and its attendant issues. It is increasingly being recognized that, since the problems may have common origins, we need to address the identified risk factors and holistically address the needs of the adolescents to make a dent on these and other public health indicators. It is important to recognize that many of the identified risk factors can be understood and their impact reduced or even neutralized by the skillful and well-informed adolescents.

9.2 Adolescents require Information and Skills

There is growing evidence that access to age and sex appropriate information and health and counseling services is necessary, but information alone is not sufficient to prevent the problems. In addition to these they need skills to use this information in order to remain healthy.

There is a growing body of research focusing on protective factors and resiliency to deal with the prevailing risk factors (WHO) experienced by the adolescents. The research emphasizes the importance of caring and supportive adults in the lives of adolescents, connectedness with parents, safe and supportive learning environments, community support and opportunities for community service, values and a spiritual element to their lives. Resiliency and protective factors that are present in the community, become an important aid to the healthy adolescent development and wellness when the adolescents and the communities are able to learn and practice life skills like Self Awareness, Critical thinking, Empathy, Coping with stress and emotions and practice improved Inter-personal relationship and Effective Communication among others.

9.3 Core life skills (WHO Model)

1. Self awareness is recognition of 'self', our character, our strengths and weaknesses, and desires and dislikes.
e.g: I get angry very soon/ I feel nervous when I have to talk to any authority/ I curse a lot/ I am always confident/ I must win in every game or I get upset etc.
Self –awareness is critical for developing a positive attitude towards life. Being aware of their weaknesses will make adolescents build a sense of self-esteem and self-confidence and be willing to learn more. This also helps them utilize the opportunities available to them in relation to their abilities.
2. Empathy is the ability to be sensitive to another person's situation, to understand his/her concerns, worries, fears and needs and how they feel.
Empathy is not sympathy e.g: In case of people living with AIDS, or people with mental illnesses, if you show sympathy, you feel sorry for them. If you show empathy, you will ensure that they are not stigmatized or discriminated.
3. Critical thinking is the ability to analyze information and experiences in an objective manner. It can help us recognize and assess the factors that influence our attitude and behaviour, such as media and peer pressure influences. e.g: When your friends ask you to try a drug, you think of the consequences objectively and make a decision to refuse the offer.
4. Creative thinking is the ability to generate new ideas by combining, changing, or reapplying existing ideas. It helps us to look beyond our direct experience, and to respond adaptively and with flexibility to situations in our daily lives. It helps us to look beyond our direct experience, and to respond adaptively and with flexibility to situations in our daily lives e.g: when your boy friend insists on intimacy, more than you are ready for, you think of a creative answer to get out of the situation. 'my mother will be here any minute', 'I have periods' etc.
5. Problem solving enables us to deal with constructively with problems that arise in our lives. e.g: When your friend demands sex, you think of the consequences of the various choices you have and consequences of each of the choice and arrive at a decision.
6. Decision making is choosing the best one out of the available choices and must or when one is trying to make up his/her mind as to what one wants and what is best. e.g: When you face peer pressure for risky behaviour, (to smoke/use drugs/alcohol/unsafe sex) you think of the consequence and make the best choice that can help you to be safe.
7. Inter personal relationship means being able to make and maintain friendly relationships, which can be of great importance to our mental and social well being. It may also mean being able to end relationships constructively. e.g: You like to go to the same shop/restaurant or any other due to personal service and friendly environment.
8. Effective communication is the ability to express the views, thoughts and feelings, both verbally and non verbally, in ways that are culturally acceptable. e.g: When your friend insists on your going to a movie without informing your mother, you can assertively communicate that you do not want to do that.
9. Coping with Emotions is being aware of the predominant emotion that preoccupies the mind at any point of time, how emotions influence behaviour and being able to respond to emotions appropriately e.g: some people have heart attack when they hear a very happy or sad news.
10. Coping with Stress means recognizing the sources of stress in our lives, recognizing how this affects us and acting in ways that help us control our levels of stress, by changing our environment or life style and learning how to relax. e.g: you are stressed because you do not like the way your father decides all the issues for you, without consulting you.

9.4 Principles of life skills

- Life skills are inherently present in all of us. They need only to be sharpened/ polished regularly.
- Life skills are for 'self' and not for others.

This is because it is 'I' who, not being able to be positive & adaptive, can not face the opportunities and challenges of life effectively ! Others are not experiencing the same misery.

It does not mean that life skills do not benefit others. Whosoever acquires them, is going to benefit from them

- Self awareness is the mother of all life skills
If one acquires self awareness, all other life skills follow.
- Life skills work in pairs
That is why they are usually written in pairs
- Life skills are always used in combination
- Life skills are interdependent .They assist each other
- Life skills can be used positively as well as negatively. A thief also uses life skills to befool the people and steal the things! Often other people use life skills to take advantage of us while we do not use them at all or do not use them effectively.
- Different set of life skills is chosen to address the same situation by different people. That is why we find variations in decisions and diversity in outcomes
- One need to practice the life skills to acquire them
- Life skills are not the solution for all problems. It is only one of the ways. One needs to be educated, take care of his/ her need through livelihood options

9.5 How one develops Life Skills

Skills are learned best when students have the opportunity to observe and actively practice them. Listening to a teacher describes skills or read or lecture about them does not necessarily enable young people to master them. Learning by doing is necessary. Teachers need to employ methods in the classroom that let young people observe the skills being practiced and then use the skills themselves.

9.6 Methods for building skills and influencing attitudes include the following

- Class Discussions
- Brainstorming
- Demonstration and Guided Practice
- Role play
- Small Groups
- Educational Games and Simulations
- Case studies
- Story Telling
- Debates
- Practicing Life Skills Specific to a Particular Context with Others
- Audio and Visual Activities, E.G., Arts, Musing, Theatre, Dance
- Decision Mapping or Problem Trees

Summary

1. Health services can help to meet adolescent needs, only if they are part of a comprehensive programme. Adolescents need:
 - A safe and supportive environment that offers protection and opportunities for development; such as education, nutrition physical development, mental/emotional development, vocational training;
 - Information on growing up process, and skills to understand and interact with the outside world;
 - Develop life skills for problem identification, decision making, problem solving and negotiation skills;
 - Health services and counselling - to address the health problems and deal with personal difficulties.
2. Health service providers cannot meet all these needs alone. They can join or create networks that act together and maximise resources. Inter sectoral approach is best - Education and Health to work together.
3. There is no single “fixed menu” suitable for every region. Each district/ state must develop its own package, according to economic, epidemiological and social circumstances.
 - A package of basic health services must be tailored to local needs,
 - Reproductive health services and counselling are a high priority in most places,
 - Information and counselling are important elements to support adolescents.

10. ‘Quality of Care’ and Quality Implementation in AFHS**10.1 What do we mean by ‘quality’?**

To provide good ‘quality’ adolescent health services, we first need to define what quality means - that is, identifying the particular aspects of service provision that we need to address in order to provide the best possible outcome for adolescent patients. Quality is conformance to specifications - specified standards or expectations of a certain level of performance.

Dimensions of quality health services are related to recipient (user), provider and system in which the service is provided.

10.2 Dimensions of Quality:

- a) Quality Dimensions Relating to the Recipients of Services
 - Accessible: Individuals who need the services, are able to obtain them
 - Acceptable: Individuals who need the services, are willing to obtain (i.e. it meets their expectations)
 - Equitable: Different population groups in the area who need the services are able to obtain them (No discrimination)
- b) Quality Dimensions Relating to the Providers of Services
 - Appropriate: The required services are provided; services that are not needed (even if harmless) as well as harmful services are not provided

- Comprehensive: The services cover all the needed aspects (i.e. bio-medical as well as psycho-social aspects)
- Effective: The services bring about positive changes in health status
- c) Quality Dimensions Relating to the System in which Services are provided
 - Efficient: The services are provided at the lowest possible cost.

Although dimensions of quality are similar for all age groups, for adolescents **the two A's- Accessibility and Acceptability - are the aspects equated with "adolescent friendliness"**. **Criteria for adolescent friendliness** have been identified in many surveys and are specified in the Global Consultation document (WHO 2001). Not all aspects of the two A's are of equal importance to adolescents.

Adolescents of both sexes rated criteria indicative of client-provider attitudes as most important, with the highest importance scores given to listening, friendliness, and aspects, followed by understanding of the counsellor, freedom to ask questions and privacy. Confidentiality was ranked slightly lower and was less important to young men than to young women. Criteria for "accessibility: (subdivided into geographic, economic and administrative) scored rating by sex and residence (urban/rural). These findings suggest that **changing provider attitudes should be a first priority**. It may be feasible to structure the Quality improvement process so as to prioritize areas for improvement rather than giving equal weight to all dimensions of quality.

It is assumed that accomplishment of **the three E's - Equity, Effectiveness and Efficiency - is best determined at the level of the network** although it would also be important to determine how different organizations contribute to their attainment. **To measure the three E's requires management information systems for generation of routine data on service outcome indicators.** These have been only partially defined for adolescent services and are of three main types: (a) process measures (e.g. level of participation of organizations within the network, range of services offered, protocols developed etc. (b) those relating to utilization, such as who comes, for what, when, how often, to which facility (c) intermediate outcome measures which relate to the health outcomes that the overall strategy seeks to improve (e.g. contraceptive/condom uptake vaccination rates, treatment compliance etc.). Targets for some rates (e.g. contraceptive uptake) could be set in order to help identify weak links in the network and to signal a need for action to address underlying problems. The cost of the Quality Improvement process should be measured in relation to intermediate indicators and eventually, health outcomes.

10.3 Quality implementation:

Quality implementation process involves these steps: Choose an element of service - define standards - define criteria for meeting the Standard - identify gaps in implementation - improve implementation to remove gaps.

- **'Standard' of Quality:** Standard is a statement of required quality - an expectation of a certain level of performance. It gives a basis of achieving a particular level and also for assessing the performance. A gap between actual performance and stated level (standard) represents the scope of improvement. National standards in respect of adolescent friendly health services under RCH-II ARSH strategy have been laid down by means of a national consultation process.
- **'Criteria' to meet the laid down standards:** Criteria are the actions that need to be taken at the levels of input, process and output to achieve the laid down standards. These actions need to be specified and must be achievable within the constraints of the local setting.

By focusing on the input, process and output (the elements of criteria to meet standards) of services within each broad definition of the 'dimension' or quality we can go some way to achieve good quality health services for adolescents.

The input of care refer to features to the setting in which services are delivered, such as the building/rooms policies outlining clients rights or clinical guidelines, the staff available or the type of equipment used.

The process of care relates to the activities and experience of delivering and receiving care, such as registration and referral procedures, history taking and physical examination procedures and adolescent patient's or client's experience of receiving care.

The agreed procedures and practices then have to be carried out consistently and reliably by staff- this is part of the process of provision.

The output of care are the impact that the use of health services has on the adolescent patient, that is, on their physical and psychological health, their satisfaction with the service or their quality of life.

- **Means of Verification:** We need to use tools for assessing whether the criteria at the level of input, precess and output are in place.

We can really only achieve better health for adolescents if we focus on the input, process and output of care together. If we address the process and input of service provision without looking at the output, we won't be able to tell whether the process and input changes we have made have had any impact on the quality of services or on adolescents' health in general. For example, one way of trying to improve adolescents' access to sexual and reproductive health services (SRHS) could be to set up 'teen centre' based services, in which specially trained staff provide services and information and lively printed information materials are given out (i.e. the input and process aspects of provision). By looking at overall utilization rates (one of the output of services provision) and any differences between the rates of use by girls and boys, and by asking the views of the adolescents who use and don't use the services, we can then get some idea of whether our strategy has worked. We may find that utilization has increased only amongst adolescent boys and that girls don't use the service because they feel uncomfortable going to a place where large groups of boys go to socialize or that their parents forbid them from going there. Looking at outputs in this way will tell us that a more effective approach to improving the access and equity of services for adolescent boys and girls might be to provide a broader range of service delivery points.

10.4 Quality Implementation Process:

Quality implementation process involves the following steps:

- Select issues for quality improvement.
- Identify the relevant standards.
- Deciding criteria to meet the standards related to input, process and output.
- Verify the quality/improvement by measuring appropriate indicators.

This process is explained in Annexure I - 'Making Health Services Adolescent Friendly -Using a 'Quality of Care' Framework'.

Annexure 2 describes the seven national standards and criteria related to input process and output at the level of service delivery point and district as well as national/ state level.

Annexure I: Quality Implementation Process Session 4, Activity 2

Making Health Services Adolescent Friendly

Using a 'Quality of Care' framework

Dimensions of quality health services for adolescents

Accessibility, acceptability and equity

- Adolescent friendly policies:
- Adolescent friendly procedures:
- Adolescent friendly health care providers:
- Adolescent friendly support staff.
- Adolescent friendly health facilities.
- Adolescent involvement.
- Community involvement.
- Provision of outreach/peer-to-peer services.

Appropriate and comprehensive

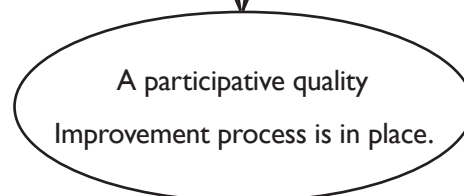
- Adolescents are addressed as individuals not just as cases of a health problem.
- A comprehensive package of health services and other relevant services are provided or secured through referral

Effectiveness

- Health workers have the required competencies.
- Provider practices are guided by evidence-based protocols and guidelines.
- Health facilities have the required equipment, supplies and functioning basic services.

Efficiency

- Management information system and a system to utilise the information generated from this is in place.
- A system by which the cost of services for adolescents can be monitored is in place.



Quality Implementation Process

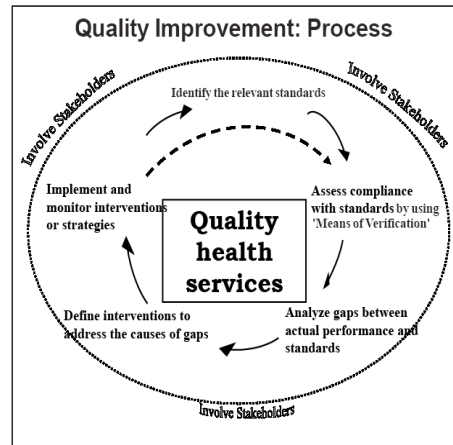
- Select an issue for quality improvement: Identify which dimension of health service provision is inadequate
- Identify the standard: Specify the desired quality to be achieved
- Formulate the Criteria: Specify what needs to happen for the standard to be compiled with
- Verify the quality/improvement by using 'means of verification'.

Criteria

- **Input**
Features of the Clinic Area: Staff, equipment, procedures followed in the clinic
- **Process**
The activities of providing and utilizing services: Clinical exam of client, referral etc.
- **Output**
Impact of services on the clients - their physical & mental health; satisfaction level

Means of Verification for the above 3 criteria/actions

- What data is to be gathered?
- How is the data to be gathered? (When, from where, from whom?, by whom)
- How will the data be analysed & put to use ?



Example: Quality Implementation Process

- Select an issue for quality improvement: Adolescents in our Community are not aware of what health and counselling services are available.
- Identify the standard: Adolescents are well informed about the availability of good quality health services from the service delivery points (SDPs).

Formulate the Criteria/Actions:

Input

- SDP will have a signboard welcoming adolescents & informing them about the availability of good quality health services.
- SDP staff will have visited educational institutions to inform adolescents about the availability of quality health services.
- Organizations (e.g. NGOs working with children/adolescents on the street) will have informed the adolescents they come into contact with about the availability of quality health services.
- Local performing groups will have provided information about the availability of quality health services for adolescents, through folk media.
- Information about the availability of quality health services will have been posted in pharmacies and shops in the area.
- Information about the availability of quality health services will have been provided through the media.

Process

- SDP staff are visiting educational institutions to inform adolescents about the availability of good quality health services.
- Organizations which come into contact with adolescents are briefing them about the availability of quality health services.
- Local performing groups are providing information about the availability of quality health services through folk media.

Output

- Adolescents are well informed about the availability of good quality health services

Criteria	Means of Verification
Input <ul style="list-style-type: none"> • SDP will have a signboard welcoming adolescents & informing them about the availability of good quality health services. 	<ul style="list-style-type: none"> • Observation
<ul style="list-style-type: none"> • SDP staff will have visited educational institutions to inform adolescents about the availability of quality health services. 	<ul style="list-style-type: none"> • Report of the SDP.
Process <ul style="list-style-type: none"> • SDP staff are visiting educational institutions to inform adolescents about the availability of good quality health services. 	<ul style="list-style-type: none"> • Interviews with SDP staff.
<ul style="list-style-type: none"> • Organizations which come into contact with adolescents are briefing them about the availability of quality health services. 	<ul style="list-style-type: none"> • Observe selected sessions.
Output <ul style="list-style-type: none"> • FGD with adolescents in Adolescents are well informed about the the catchment area of the availability of good quality health services 	<ul style="list-style-type: none"> • FGD with adolescents in the catchment area of the SDP.

For complete table refer to Annexure 2 (Standard 2)

Quality Improvement: Principles

- A continuous, cyclical process - NOT a one-time activity
- Applicable to all levels of health services and systems
- Focuses on processes, structures and systems - NOT people (staff) - as the root of health service delivery problems
- Participatory: Involves key stakeholders (e.g. clinicians, patients, managers, policy makers) to ensure that multiple perspectives of quality are addressed
- Evidence-based and appropriate: Uses local data to identify local solutions to local problems
- Requires continuous, committed and active leadership

Quality Improvement

- QI methods & tools have been successfully applied in reproductive health & child health service provision.
- They can be useful in our efforts to make health services friendly to adolescents.

Annexure 2

Table: Role of Programme Managers and Other Stakeholders

Stakeholders	Communities	Panchayati Raj Institutions and Urban Local Bodies	Peer Leaders Female and male Multipurpose Workers, AWWs and ASHAs	District/State Programme Manager	Elected Representatives
Role	Primary stakeholders (may rightfully demand that:)	Catalysts and watch agents	Mobilisers and basic service providers at community level	Manager of decentralized RCH programme responsive to local needs	Mobilizers and advisors
Responsibilities	Priority needs of the poor and the vulnerable well addressed through local representatives and government authorities Female and male health workers are available to all community members, including the poor and the vulnerable Service providers remain accountable for the coverage and quality of services Better household practices especially for caring of newborn children and seeking care for women during pregnancy and childbirth	1. Communities are adequately consulted while finalizing plans for maternal and child health 2. Programme inputs reach groups who are the most needy and poorest groups 3. Communities continue as key decision makers throughout the project cycle 4. Provision of RCH services meet the local client needs	1. Gather needs of the beneficiaries and views of communities about the program 2. Ensure the feedback is relayed to decision makers through monthly reports and other M&E instruments 3. Counsel communities on appropriate health care requirements 4. Deliver basic RCH services following the standard protocols to ensure quality and responsiveness 5. Establish rapport between communities, local governments and other stakeholders of the programme	1. Prepare comprehensive district plans building on PHC plans 2. Form comprehensive district/ state program teams ensuring adequate delegation and accountability. 3. Improve financial management as per programme requirement and ensure timely submission of statements of expenditure and maintain accounts as per finance manual. 4. Ensure timely supply of programme inputs and funds 5. Monitor programme performance and results.	Mobilise public opinion about the programme Participate in consultations to finalise district/state plans Monitor the reach of services to the poorest and vulnerable groups and provide feedback to Programme Managers Participate in social mobilization activities

Annexure-3: Standards for Quality and Adolescent-friendly Health Services for Adolescents

Standard 1. Health facilities provide the specified package of health services that adolescents need

Criteria	SDP*	District level	National / state level	Key partners	Means of verification
Input Criteria					
1. SDP provide the defined package of health services to adolescents or make them available through referral: <ul style="list-style-type: none"> • Promotive Services • Preventive Services • Curative Services • Referral <i>(Note: The services to be provided at the sub-centre, primary health centre, community health centre and district hospital will need to be specified).</i>	Provide the health services.	Inform all SDP about the package of health services that they need to deliver.	Specify the package of health services to be delivered at each level (i.e. sub-centre, primary health centre, community health centre and district hospital).		<ul style="list-style-type: none"> - Report of the SDP - Interviews with SDP staff.
2. Mechanisms are in place to ensure effective referral to other SDP which provide services not provided on the spot (where applicable).	Work to build/ strengthen referral linkages	Assist SDP in developing referral linkage		Other SDP in the public and private sector	Report of the SDP Interviews with SDP staff
Process criteria					
Health services are provided on the spot in line with the package. If services are not available on the spot, patients are referred elsewhere. Both these actions are carried out in line with standard operating procedures.					Record review. Interviews with managers and service providers
Output criteria					
The specified package of health services are provided to adolescents					

*SDP = Service Delivery Point (Health facilities).

Standard 2. Health facilities deliver effective health services to adolescents.

Criteria	SDP	District level	National / state level	Key partners	Means of verification
Input Criteria					
1. Services providers are in place	-	Work with the national authorities to ensure that staff are deployed in line with the profile	Define the staffing profile for each SDP, and communicate this to the districts Deploy staff to the SDP in line with the defined profile.	-	Report of the SDP Observation of SDP
2. Services providers are clearly aware of their roles and responsibilities in relation to the functioning of the SDP	Ensure that every staff member has his/her respective job description	Ensure that the SDP has the job descriptions	-	-	Report of the SDP Interviews with SDP staff.
3. Service providers have the competencies required to provide the specified health services effectively	-	Implement the competency building plan	Develop a competency building plan that addresses competencies relating to both clinical management as well as interpersonal communication Note: The competency building plan should include elements of self learning, training, follow up after training, mentoring, and continuous learning to address gaps that have been identified Develop materials to implement the plan. Make materials and resource persons available to the districts to implement the competency building plan.	-	
4. Clinical management guidelines and standard operational procedures are in place for the provision of the specified health services.	-	- Distribute the tools to the SDP	- Develop the tools. - Distribute them to the districts.	-	- Observation of the SDP

Criteria	SDP	District level	National / state level	Key partners	Means of verification
5. Supplies, equipment and basic amenities (e.g. water, sanitation and electricity) required to provide the specified health services are in place.	<ul style="list-style-type: none"> - Work with the district authorities to ensure that the supplies, equipment and basic amenities are in place. - If/when needed, try to find local solutions to problems such as equipment breakdown, erratic supplies, and water supply interruptions. 	<ul style="list-style-type: none"> - Work with the national authorities to ensure that the equipment, supplies and basic amenities are in place. 	<ul style="list-style-type: none"> - Specify the supplies, equipment, and basic amenities that need to be in place in each type of SDP, and communicate this to the districts. - Make resources available for the above mentioned items to be in place. 	<ul style="list-style-type: none"> The government departments responsible for this. 	<ul style="list-style-type: none"> Report of the SDP Observation of the SDP
6. Information/ educational materials directed at adolescents are available.	<ul style="list-style-type: none"> - Display and/or distribute informational materials. 	<ul style="list-style-type: none"> - Distribute them to the SDP. 	<ul style="list-style-type: none"> - Develop partnerships with NGOs to provide informational materials. - Develop the materials and send them to the districts. 	<ul style="list-style-type: none"> NGOs producing educational materials for adolescents. 	<ul style="list-style-type: none"> -
Process criteria					
Service providers manage adolescents who seek help effectively.	-	-	-	-	<ul style="list-style-type: none"> - Record review. - Observation of service provider-patient interaction.
Output criteria					
Adolescents receive effective promotive, preventive and curative services.	-	-	-	-	Exit interview with adolescent patients.

Standard 3. Adolescents find environment at health facilities conducive to seek services.

Criteria	SDP	District level	National / state level	Key partners	Means of verification
Input Criteria					
1. SDP will have a signboard welcoming adolescents & informing them about the availability of good quality health services.	-	<ul style="list-style-type: none"> - Develop sign boards. - Put up the sign boards. 	<ul style="list-style-type: none"> - Design logo and text for the sign board and have it approved. 	<ul style="list-style-type: none"> - Businesses could be invited to contribute to this work. 	<ul style="list-style-type: none"> - Observation.
2. At a minimum, the following amenities will be in place: <ul style="list-style-type: none"> • clean premises, • drinking water; • functional toilet, • seating in the waiting area, • attractive posters and informational materials 	Carry out improvements to the SDP as per the guidelines.	<p>Orient SDP managers on the guidelines.</p> <p>Support SDP in developing plans and in carrying out follow up action.</p> <p>Distribute posters and informational materials.</p>	<p>Develop guidelines for making the surroundings making the surroundings appealing to adolescents and send them to the districts.</p> <p>Develop posters/ informational materials, and send them to the districts.</p>	-	<ul style="list-style-type: none"> - Observation.
3. Services are provided to adolescents at specified days/ timing convenient to them; in addition they are free to obtain services at any other time.	Provide services.	Work with the SDP to develop a plan for this.	-	-	<ul style="list-style-type: none"> - Observation - Report for the SDP manager
4. SDP staff are fully aware of national policies and recommended procedures on respecting the privacy and confidentiality of their adolescent (and other patients).	Discuss the policy statement and procedures with SDP staff and work as a team to apply them.	<p>Orient SDP managers on the policy statement and the standard operating procedures.</p> <p>Support SDP in applying the procedures.</p>	<p>Develop the policy statement and the standard operating procedures and send them to the districts.</p> <p>Note: The standard operating procedures will cover actions that relate to registration, the waiting area, the examination area, record keeping and referral.</p>	-	<ul style="list-style-type: none"> - Report of the SDP. - Interviews with SDP staff.

Criteria	SDP	District level	National / state level	Key partners	Means of verification
Process Criteria					
1. Services are provided on the days/times that they are meant to be.	-	-	-	-	<ul style="list-style-type: none"> - Observation - Interviews with SDP staff.
2. SDP staff apply the standard operating procedures on respecting the privacy and confidentiality of other adolescent patients.				-	<ul style="list-style-type: none"> - Observation - Interviews with SDP staff.
Output Criteria					
Adolescents feel comfortable with the surroundings and procedures when they visit SDP			-	-	<ul style="list-style-type: none"> - Exit interviews with adolescent patients.

Standard 4. Service providers are sensitive to the needs of adolescents and are motivated to work with them.

Criteria	SDP	District level	National / state level	Key partners	Means of verification
Input Criteria					
1. Service providers are fully aware of national policies and procedures on the dealing with their adolescent patients with understanding and empathy.	Heads of SDP should discuss the policies and procedures with SDP staff.	Distribute them to the SDP.	Develop a policy statement (on the need to deal with all adolescents with understanding and empathy) and the corresponding standard operating procedures, and send them to the districts.	-	- Report of the SDP. - Interviews with SDP staff.
2. A mechanism is in place to recognize and reward good performance.	Apply the mechanism.	Orient SDP managers to the mechanism	Develop the mechanism, have it approved and sent it to the districts.	-	- Report of the SDP. - Interviews with SDP management.
Process Criteria					
1. Service providers apply the procedures in their dealing with their adolescent patients.			-	-	- Observations. - Interviews with SDP staff.
2. Good performance of service providers is recognized and rewarded.			-	Panchayati Raj institutions could be involved in this.	Observation of completed performance assessment forms. Individual interviews with SDP managers/ staff
Output Criteria					
1. Service providers feel motivated to provide services to young people.			-	-	Individual interviews with SDP staff.
2. Service providers feel valued by their colleagues & supervisors.			-	-	Individual interviews with SDP staff.

Quality Implementation in Adolescent-friendly Health Services

Standard 5. An enabling environment exists in the community for adolescents to seek the health services they need.

Criteria	SDP	District level	National / state level	Key partners	Means of verification
Input Criteria					
All adult patients visiting SDP will have been informed about the value of providing adolescents with the health services they need.	Communicable with all adult patients about the rationale for providing health services to adolescents.	-	Ensure that communicating about the value of providing adolescents with the health services they need is addressed in teaching/learning materials.	-	Interviews with the SDP staff.
Community members will have been briefed about the rationale for providing adolescents with the health services they need.		Identify key institutions and networks that need to be engaged to influence public opinion. Identify other players (e.g. other government departments/NGOs) best suited to reach out to these institutions/networks. Brief them about the rationale for providing adolescents with the health services they need.	Develop a tool that district officials could use to communicate on this matter key institutions and networks that need to be engaged to influence public opinion.	-	Interviews with heads of key institutions/networks
Information about the rationale for providing adolescents with the health services they need will have been communicated through the mass media.			Develop messages and have them approved. Conduct a national/state level publicity campaign.	-	- Articles in the print media. - Programmes on radio and television.

Criteria	SDP	District level	National / state level	Key partners	Means of verification
Process Criteria					
Service providers communicate effectively about the rationale for providing health services to adolescents in their interactions with adult patients.	-	-	-	-	- Observe selected interactions.
The rationale for the provision of health services to adolescents is discussed in community meetings.				-	- Observe selected meetings.
Output Criteria					
Community members are aware of the value of providing health services to adolescents.	-	-	-	-	- Interviews with gatekeepers.
Community members support the provision of health services to adolescents.	-	-	-	-	Interviews with gatekeepers.

Standard 6. Adolescents are well informed about health services

Criteria	SDP	District level	National / state level	Key partners	Means of verification
Input Criteria					
1. SDP will have a signboard welcoming adolescents & informing them about the availability of good quality health services.	-	<ul style="list-style-type: none"> - Develop sign boards. - Put up the sign boards. 	Design logo and text for the sign board and have it approved.	Local businessmen could be engaged to participate in this.	Observation.
2. SDP staff will have visited educational institutions to inform adolescents about the availability of quality health services.	Make a plan to visit educational institutions. Visit them according to the plan.	Send a letter to heads of educational institutions about the initiative. Send a list of educational institutions SDP.	Send a letter to the district educational officer about the initiative.	-	<ul style="list-style-type: none"> - Report of the SDP. - Interviews with SDP staff.
3. Organizations (e.g. NGOs working with children/adolescents on the street) will have informed the adolescents they come into contact with about the availability of quality health services.		Organize meetings to brief organizations which come into contact with adolescents. (Note: Particular efforts will need to be made to establish linkages with NGOs working with adolescents at greatest risk.vulnerability).		-	<ul style="list-style-type: none"> - Interviews with heads of selected organizations.
4. Local performing groups will have provided information about the availability of quality health services for adolescents, through folk media.			Identify and engage performing groups. Develop a plan for their performances. Support them in conducting their performances.	Performing groups.	-

Criteria	SDP	District level	National / state level	Key partners	Means of verification
5. Information about the availability of quality health services will have been posted in pharmacies and shops in the area.		-	Select the pharmacies and shops in which posters are to be displayed. Send out the posters for display.	-Develop posters and send them to the districts. -Voluntary organizations such as Rotary of Lions could be engaged in this work.	- Observation.
6. Information about the availability of quality health services will have been provided through the media.		Brief media persons periodically about the initiative.	Develop messages and have them approved. Conduct a national/state level publicity campaign.	-	- Articles in the print media.
Process Criteria					
1. SDP staff are visiting educational institutions to inform adolescents about the availability of good quality health services.				-	- Observe selected sessions.
2. Organizations which come into contact with adolescents are briefing them about the availability of quality health services.				-	- Observe selected sessions.
3. Local performing groups are providing information about the availability of quality health services through folk media.				-	- Observe selected performances.
Output Criteria					
Adolescents are well informed about the availability of good quality health services.	-	-	-	-	- FGD with adolescents in the catchment area of the SDP.

Standard 7. Management systems are in place to improve/sustain the quality of health services.

Criteria	SDP	District level	National / state level	Key partners	Means of verification
Input Criteria					
1. Mechanisms are in place to monitor the performance of SDP (including SDP staff) and to identify needs for corrective/ameliorative actions.	Weekly assessment carried out.	Distribute the self-assessment tools to the SDP and orient the SDP manager/staff to it. Develop a plan to visit the SDP. Provide supportive supervision.	Develop a monitoring system that includes the following elements: weekly self-assessment by SDP managers, monthly external assessment by district coordinators, six monthly external assessment by the state level coordinators. Develop monitoring tools and distribute them to the districts.	'Resource institutions' (e.g. departments of community medicine in medical colleges) could be engaged to make a valuable contribution to this.	Observe monitoring plan. Interviews with SDP manager/staff.
2. State and district coordinators have the competencies needed to provide facilitative & supportive supervision in a respectful manner.		Participate in competency building.	Develop a competency building plan (which includes: Self learning, training, follow up after training and ongoing learning). Implement the competency building plan.	-	Observe monitoring plan. Interviews with SDP manager/staff.
3. A mechanism is in place for service providers to participate in discussions/actions aimed at discussing how they could deal with challenging situations in their work with adolescents, more effectively.	Apply the mechanism.	Orient SDP managers to the mechanism.	Develop the mechanism and sent it to the districts.	-	Observe monitoring plan. Interviews with SDP manager/staff.
4. Strengthened management information system is in place that gathers information on the following issues: • Age, • Sex • Reason for visit (i.e. the presenting issue/problem)	Apply the revised system.	Distribute the revised format to SDP. Orient SDP managers to their use. Monitor their use.	Review the existing management information systems. Develop ways and means of strengthening it. Orient district coordinators to the revised format, and distribute it to them.	-	Observe monitoring plan. Interviews with SDP manager/staff.

Criteria	SDP	District level	National / state level	Key partners	Means of verification
Process Criteria					
Assessments are carried out as specified.				-	Observing an assessment exercise. Reports of the SDP. Interviews with SDP managers/staff.
Service providers participate in problem identification and solving activities.				-	Interviews with SDP managers/staff. Minutes of meetings held to discuss the implications of the findings for the work of the HSDP.
Output Criteria					
Data are collected, analyzed and used to make health services more adolescent friendly.				-	Interviews with SDP managers/staff.

Summary

- Adolescents need health services that are somewhat different than the routine services.
- Six As (Availability, Accessibility, Approachability, Acceptability, Appropriateness and Affordability) determine the utilization of health services by adolescents.
- Some modifications can make existing health services adolescent friendly.
- All adolescents should be assessed for need of vaccinations
- Life skills education can potentially act as vaccine to empower adolescents to face real life situations.
- Quality of adolescent friendly health services be maintained according to national standards.

Handout V

Nutrition and Anaemia in Adolescents

CONTENTS

1. Nutrition during Adolescence
2. Nutritional Anaemia
3. Role of Healthcare Providers
4. Annexures

1. Nutrition during Adolescence

Adolescence is a significant period for physical growth and sexual maturation. Nutrition being an important determinant of physical growth of adolescents is an important area that needs attention.

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

Increased nutritional needs at this juncture relate to the fact that adolescents gain upto 50% of their adult weight, more than 20% of their adult height, and 50% of their adult skeletal/bone mass during this period. Adolescent girls also additional requirement of iron to compensate for menstrual blood loss and calcium which gives strength to bones. Sub-optimal nutrition slows the growth process and the rate of sexual maturation.

More than two thirds of the adolescent girls suffer from anaemia. Two thirds suffer from Chronic Energy Deficiency of the third degree with Body Mass Index (BMI) below 16. Married women aged 15-49 are also reported to have BMI below 18.5 (NFHS 3). Iodine Deficiency Disorders can lead to growth retardation and retard mental development. Only half of the households are using iodised salt for cooking in India (Multiple Indicator Survey (MICS) 2000). Meal missing, junking and food fads are equal in rural and urban girls. Boys also have food fads which affect their health adversely. This is driven by fancy towards role models and publicity from the media.

1.1 Balanced Diet

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

Recommended Dietary Allowance of Nutrients for adolescents in 24 hours

	Male			Female		
	10-12Yr	13-15Ys	16-18Yr	10-12Yr	13-15Ys	16-18Yr
Energy (Kcal)	2200	2500	2700	2000	2100	2100
Protein (gms)	54	70	78	57	65	63
Calcium (Mg)	600	600	500	600	600	500
Iron (Mg)	34	41	50	19	28	30

Source: ICMR (1998)

You will find more information on “Healthy Eating” in Annexure

1.1.1 Eating right and nutritious food during adolescence

- Helps in achieving rapid growth and full growth potential
- Helps in timely sexual maturation
- Ensures adequate calcium deposition in the bones and helps in achieving normal bone strength and in avoiding osteoporosis in later life
- Establishes good eating habits and sets the tone for a lifetime of healthy eating. Prevents obesity, osteoporosis, heart disease and diabetes in later life.

Food availability and utilization of available food determine nutrition at community and family level. Following factors need consideration in understanding the determinants of nutrition

1.2 Factors influencing Nutrition of Adolescents**Conditioning factors:**

- Infectious diseases are important factors responsible for malnutrition, particularly in children and adolescents. Diarrhoea, intestinal parasites, malaria and tuberculosis all contribute to malnutrition.
- Poor environmental sanitation also leads to repeated bouts of infections.
- Girls lose a considerable amount of iron (average 1 mg daily) during menstruation. Therefore, they require additional iron rich foods and supplements.
- Boys too need iron for building muscles during adolescent. They need even more iron than that in girls.

Cultural factors:

- Food habits, customs, beliefs, traditions and attitudes: Food habits are among the oldest and most deeply entrenched aspects of any culture. The family plays an important role in shaping food habits and these habits are passed on from one generation to the other.
- Rice is the staple cereal in eastern and southern India, whereas wheat is the staple cereal in the north. Papaya is avoided during pregnancy because it is believed to cause abortions. There are also beliefs about hot and cold foods, light and heavy foods.
- Religion: Religion has a powerful influence on food habits. Hindus do not eat beef, while Muslims do not eat pork. Orthodox Hindus and Jains do not eat meat, fish, eggs and certain vegetables like onions. These food taboos prevent people from consuming nutritive iron-rich foods.
- Food fads: Personal likes and dislikes influences us in selection of foods and consistent faulty habits may lead to nutritional deficiencies.
- Cooking practices: Practices like draining away the rice water at the end of cooking, prolonged boiling in open pans and peeling of vegetables influence the nutritive value of foods.
- Social customs: In some communities, men eat first and women eat last and poorly.

Socio-economic factors:

Malnutrition and anaemia are largely a by-product of poverty, ignorance, insufficient education, lack of knowledge regarding nutritive value of foods, large family size, etc. These factors largely determine nutritional status of an individual. Malnutrition because of lack of food is quite uncommon now.

Gender issues:

In some families and communities, girls and young women are discriminated against in both quantity and quality of food. On top of this, they are married early have early pregnancy and child birth and this further compromises their nutritional status.

1.3 Factors specific to adolescents

Adolescents have a world of their own and have a different eating pattern that influence their nutrition

Typical Eating Pattern of Adolescents

- Adolescence is a period of emergence of an individual into a more independent phase of life, and this influences food behaviour also
- There is a lack of a sense of urgency regarding future health as they have limited future perspective
- Family meals become less important
- They break away from family eating patterns into improper dietary habits
- They succumb to unbalanced diets under influence of peers, mass media, socio cultural norms in their friends
- Personal self esteem and body image guide the eating behaviour
- Missing meals especially breakfast is extremely common. SHAHN Survey-2002 among Delhi school students reveals that 30% boys and 40% girls skip one meal everyday and breakfast is the commonest casualty (54%)
- Snacks are eaten by over 75% of adolescents and provide them a fourth to a third of their calorie intake (Jenkins, 1987). SHAHN Survey-2002 reveals that 40% girls and 50% boys recall having consumed junk food in last 24hours.
- Fast food joints are mainly patronized by adolescents - with soft drinks, burgers and pizzas being the favourite foods. These spoil the appetite for regular meals and are high on calories and low on nutrients.
- Food selection is based mainly on availability, convenience and time, rather than food value

1.4 Clinical Management of Nutrition during adolescence

Very often adolescents present with one or more issues related to nutritional status. This can be an easy and neutral entry point to develop a good rapport with adolescent and his/her family. All adolescents should be assessed for nutritional adequacy and managed using the algorithm, "I am too thin/too fat" (Please see Annexures) At times, adolescents present with vague complaints like not doing well, I feel tired". There can be various reasons for such presentation. Use algorithms for "I am tired all the time" for management of these adolescents.

1.4.1 Nutrition Assessment and Counseling in adolescents

Nutritional assessment is an important part of evaluation of an adolescent. A stepwise approach should be adopted.

Step 1- History

History about foods and feeding habits should be taken primarily from the adolescent alone, and from parents also but separately. This is important as adolescent may not reveal some of eating behaviors in front of parents. It should be clarified to the adolescent that the purpose is to find out problem areas and not to find faults of adolescents or not to scold, punish or intimidate the adolescent, and the honesty and completeness are essential if the problem is to be solved

Nutritional history in adolescence

Food

- Current daily food intake (24 hour recall, 3-7 day food consumption record, or filling a questionnaire)
- Reasons for consumption (hunger, peer pressure, family meal time etc.)
- Perception (of adolescent and parents separately) about adequacy of diet
- Any supplements taken e.g. vitamins, tonics, herbal foods etc.
- Foods served and eating pattern of family
- Childhood nutritional adequacy
- Eating pattern over last 6 months – 12 months
- Past or present efforts of gaining or losing weight
 - Method used
 - Food products used
 - Any medicines taken

Growth and Development

- Available records for past height, weights and blood pressures
- Past history of underweight or obesity and methods used to correct the same
- Age of onset of puberty and rate of growth
- Menstrual history in girls

Past or present illness interfering with nutrition

History of tuberculosis, diabetes, liver or kidney diseases or celiac disease.

Genetic risk factors

Family history of hyperlipidemia, heart attack, stroke, hypertension, obesity, cancer and osteoporosis, especially the death or disability in younger (< 45 years of age) because of coronary artery disease, or stroke.

Self esteem and Body image concepts

- How is the self esteem
- Satisfied or not satisfied with body
- Interested in change
- Any plans for change

*Intake of tobacco, alcohol**Physical Exercise*

- What activity
- How long
- How strenuous

Step 2 – Physical Examination

It is important to take weight, height and skin fold thickness (not required in routine). Weight should be taken in minimum clothes, height with a measuring scale and skin fold thickness over middle part of the back of arm (between shoulder and elbow). Skin fold should be measured by special calipers if available or by pinching skin between thumb and index finger; obesity is indicated when thickness is greater than 2.5 cm.

Weight and height should be plotted on the charts and interpreted accordingly. It should be remembered that weight and height depend on the pubertal stage of adolescent and at the same age but at advance stage of puberty these parameters will be higher. So, the pubertal (SMR) stage should also be recorded. It is also important to calculate Body Mass Index (BMI) to detect significant underweight or overweight. Use the charts in Annexure to find z-score and nutritional status of adolescents.

Other signs of vitamins and other deficiencies may be found. One should look for pallor (anaemia) also.

Step 3 – Laboratory Test

Generally no laboratory tests are required if only mild inadequacies are noted. For severe malnutrition (under or overweight) the adolescent should be referred to an expert. However, annual screening can be done for hemoglobin concentration.

Step 4 – Nutritional Counseling

All points noted in history and examination should be reviewed carefully and good habits or not so good habits and harmful habits related to nutrition should be identified and shared with adolescent and parents (with permission of the adolescent client). Adequacy of diets should be assessed by total intake over time.

Need to change, if any should be discussed. For this it is important to find a motivational key (any point having immediate significance. For example, physical appearance and attractiveness will improve with certain diets, or certain food pattern will improve skin – glow etc. and preserve it over time, etc. Decide on such motivational keep and guide the adolescent accordingly.

At times, a written agreement between adolescent and counselor help a lot in both motivating adolescent and in following the progress of dietary plans. Other factors like poor intra family relationships or lack of food or when adolescents are working then lack of time and money should also be assessed. Cultural and ethnic backgrounds are important for determining food habits.

Counseling should take into consideration all such points. Very often the whole family has to change their dietary habits.

2. Nutritional Anaemia

Anaemia during adolescence may have long lasting consequences as cognitive changes due to iron deficiency anaemia may lead to poorer academic performance and some lost opportunities. Thus, anaemia has several facets and physicians looking after adolescents should be well versed with these issues.

2.1 Adolescence – A period of Acute Stress on Erythropoiesis!

Adolescence is a period of growth in height, weight, muscle mass, bones etc. This heightened growth during puberty increases demand for oxygen and hence oxygen carrying capacity and the body respond by increase in red blood cell (RBC) mass. Hemoglobin (Hb) concentration and size of RBCs also increase and Mean Corpuscular Volume (MCV) reaches adult values by the time puberty ends. Boys have more androgens and more increase in muscle mass and activity. These stimulate greater release of erythropoietin and thus a higher Hb concentration in boys than that in girls. Post menarche girls also lose blood every month and further reducing the Hb levels.

Developing behaviours may result in lack of iron, folic acid and other vitamins in diet further leading to inadequate erythropoiesis and anaemia in adolescents. Autoimmune disorders (systemic lupus erythematosus, autoimmune haemolytic anaemia, etc) may manifest first time during adolescence.

All these changes put acute stress on erythropoiesis during adolescence and this fact should be considered while evaluating an adolescent for anaemia. This would mean an increase in demand for hematinics and other nutrients, hence this justifies iron prophylaxis in adolescents.

Adolescents should be encouraged to consume iron rich foods (green leafy vegetables, jaggery, meat) complemented with a Vitamin C source like Citrus fruits (oranges, lemon) and Indian gooseberry (Amla).

2.2 The ill effects of anaemia can be seen as:

- Reduced capacity to work and thus decreased productivity
- Increased risk to pregnant girls/women. (In India, 20-40% of maternal deaths are due to anaemia). Miscarriage, low-birth weight babies, premature labours, Ante-partum Haemorrhage/Post-partum Haemorrhage (APH/PPH) and Puerperal Sepsis

Anaemia may increase susceptibility to infections by impairing the immune functions

2.3 Risk Factors for Anaemia in Adolescents

Various risk factors have been associated with anaemia. Lower socioeconomic status, having less educated or illiterate parents, low BMI, having chronic illness, poor dietary intake, and living in malaria endemic area are some important risk factors. Any adolescent with one or more of these risk factors should be looked carefully for presence of anaemia.

2.4 What is anaemia?

Anaemia is the decreased oxygen carrying capacity of the blood due to deficiency of hemoglobin in the red blood cells for particular age and sex. During adolescent hemoglobin below 12 gm % is considered anaemia and hemoglobin below 7 gm/dl is severe anaemia.

Iron deficiency anaemia is a major nutritional problem in adolescent boys and girls in India. There is increasing evidence for deficiency of folic acid and vitamin B12 too.

2.5 Etiology of Anaemia in Adolescents

Most common cause of anaemia in adolescents is nutritional deficiency (mostly of iron, followed by deficiency of folate and vitamin B12). Adolescents presenting with mild anaemia will most commonly have iron deficiency anaemia whereas severe anaemia can also be because of iron deficiency but other deficiencies like folate and B12 should not be ignored. Other more serious causes of anaemia should also be looked for in an adolescent with moderate or severe anaemia. Acute or chronic blood loss should be looked for in adolescents showing features of iron or folate deficiency anaemia and not responding to hematinics. Such adolescents should also be assessed for important non-nutritional causes of anaemia including acute or chronic inflammation, parasitic infections, and inherited or acquired disorders that affect hemoglobin synthesis, red blood cell production or red blood cell survival.

2.6 Clinical Presentation of Anaemia in Adolescents

The clinical manifestations depend on the degree of anaemia and the rate of development of anaemia. Insidiously developed mild to moderate anaemia may be asymptomatic and may be an incidental finding clinically in hemogram.

Mild to moderate reduction in haemoglobin (below normal to >7 gram per decilitre) may cause non-specific features like fatigue, irritability, short attention span, poor exercise tolerance, and poor school performance, etc.

When the Hb falls below 7 g/dl, several additional features may appear like pallor, paresthesias, and increasing weakness (impaired work performance and endurance). When Hb further falls below 5-6 g/dl, tachycardia, hypotension, congestive cardiac failure and shock may develop.

Patients will also have features suggestive of etiology of anaemia.

Nutritional anaemia develops insidiously over a period of weeks to months or years, with symptoms appearing only when anaemia becomes severe. Iron deficiency is usually associated with cognitive dysfunction and generally its severity correlates well with severity of anaemia and degree of iron deficiency. Adolescents with megaloblastic anaemia may present with severe anaemia or predominantly with gastrointestinal or neurological symptoms (peripheral neuropathy, posterior spinal neuropathy, dementia or depression from B12 deficiency). Knuckle hyperpigmentation and may have pancytopenia are also found frequently in these adolescents.

Evidences of involvement of leucocytes (recurrent infections, fever) and platelets (easy bruising, petechiae or echymosis) indicate involvement of a more pervasive bone marrow process, either its suppression or malignant infiltration. Features of other chronic conditions like renal failure, connective tissue disorders (SLE, Rheumatoid Arthritis, etc) would point anaemia being a result of that chronic disease.

A thorough general and relevant systemic examination is important to confirm or rule out features of etiological condition causing anaemia. Enlargement of lymph node, hepatosplenomegaly, petechiae or bruising would necessitate investigations for serious haematological conditions including malignancy. Pallor with splenomegaly may indicate towards haemolytic process including autoimmune haemolytic anaemia. Recurrent malaria should be ruled out in endemic areas. Mild splenomegaly may be there in megaloblastic anaemia also.

2.7 Management Issues

A simple algorithm “(I am too pale)”, describes clinical management of anaemia (Annexure).

Treatment of anaemia depends on the severity of anaemia and rapidity of its development. Significant acute blood losses in trauma or surgery need to be replaced. Treatment can be divided in treatment of anaemia and treatment of etiological condition causing anaemia.

Mild to moderate anaemia needs treatment of etiological condition primarily. Severe anaemia causing heart failure needs transfusion of packed red cells. (Table- Management of severe anaemia in adolescence)

Whole blood is used when acute blood loss is there otherwise component therapy should be given. Some patients with very low haemoglobin levels may be very well preserved clinically and in such situations RBC should be given only after collecting appropriate samples.

For iron deficiency iron therapy is needed in the dose of 3-6 mg per kilogram per day in 2-3 divided doses in between meals. Various compounds can be used depending on tolerance by patient. Ferrous sulphate and ferrous fumarate are widely used compounds. A small dose of folate should also be given with iron as when erythropoiesis occurs demand for folate increases. Iron should be continued until 3 months after the hemoglobin has become normal. Deworming once in 6 months also help in maintain hemoglobin levels.

For B12 and folic acid deficiency anaemia, we use 1000 microgram of B12 stat followed by 250-500 microgram weekly for 3 months. Folic acid is also given 5 mg per day. These patients will need iron also for erythropoiesis.

Management of 'secondary' anaemia includes control/treatment of the conditions causing anaemia.

2.8 National Iron Plus Initiative

This new initiative includes

- Biweekly iron supplementation for Preschool children, for 6 months to 5 years.
- Weekly supplementation for
 - i. Children from 1st to 5th grade in Govt. and Govt. aided schools
 - ii. Out of school children (5-10 yrs) at Anganwadi centres.
 - iii. Adolescents (10-19 yrs).
 - iv. Pregnant and Lactating women.
 - v. Women in reproductive age group.

Table –supplementation interventions of Iron folic Acid

Age group	Intervention/Dose	Regime	Service delivery
6–60 months	1ml of IFA syrup containing 20 mg of elemental iron and 100 mcg of folic acid	Biweekly throughout the period 6–60 months of age and de-worming for children 12 months and above.	Through ASHA Inclusion in MCP card
5–10 years	Tablets of 45 mg elemental iron and 400 mcg of folic acid	Weekly throughout the period 5–10 years of age and biannual de-worming	In school through teachers and for out-of-school children through Anganwadi centre (AWC) Mobilization by ASHA
10–19 years	100 mg elemental iron and 500 mcg of folic acid	Weekly throughout the period 10–19 years of age and biannual de-worming	In school through teachers and for those out-of-school through AWC Mobilization by ASHA
Pregnant and lactating women	100 mg elemental iron and 500 mcg of folic acid	1 tablet daily for 100 days, starting after the first trimester, at 14–16 weeks of gestation. To be repeated for 100 days post-partum.	ANC/ ANM /ASHA Inclusion in MCP card
Women in reproductive age (WRA) group	100 mg elemental iron and 500 mcg of folic acid	Weekly throughout the reproductive period	Through ASHA during house visit for contraceptive distribution

2.9 Prevention of Anaemia in Adolescents

Prevention of anaemia is important in adolescents or in adults too. Good balanced diet will certainly prevent anaemia. However, diet of Indian adolescents often deficient and they need supplementation by hematinics. Weekly administration of iron (100 mg) and folic acid (5mg) during adolescence will prevent the occurrence of anaemia. It can treat also mild anaemia which remains undetected clinically. These tablets can be 'prescribed' as a weekly drug to ALL adolescents both girls and boys. Ministry of Health and Family Welfare, Govt of India recommends this weekly supplementation under the national program Weekly Iron Folic acid Supplementation (WIFS).

2.10 Other deficiency states

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

3. Role of a healthcare provider

The health care provider holds a key position in advising the adolescent about good nutrition. He should promote healthy lifestyle, physical exercise and eating practices. Activities like individual nutritional assessment, detection and treatment of micronutrient deficiency, management of severe under-nutrition, antenatal nutrition education and management of clinical condition should be undertaken in an adolescent clinic or even in schools and communities.

Remember that the nutrition of an adolescent is a major determinant of the future health of the societies in which they live.

3.1 Role at community level

Healthcare providers must educate the community to provide education on importance of adolescent nutrition and influence the adverse socio-cultural practices. Please, refer to the information on eating Healthy in Annexures

Education regarding balanced diet for both boys and girls:

- Provide education on the importance of nutrition for adolescents themselves and on their offsprings
- Promote good food selection and safe cooking practices
- Promote concept of kitchen garden where green leafy vegetables etc. can be grown at a very low cost
- create awareness in community to factors contributing to malnutrition and nutritional anaemia, especially in girls
- Involve other functionaries like AWW, Schoolteachers, ASHAs, counselors and peer leaders to identify and tackle nutritional problem.

- Create awareness in community about role of malaria and hookworm infestation in causing and aggravating anaemia

3.2 Role in Individual Counseling

Following tips can be used for counseling parents and adolescents themselves:

- Food should be attractively served, with variety in colour, shape, flavour, size and texture.
- Likes and dislikes of the adolescent should be kept in mind.
- Impress upon them that the growing bodies of the adolescents need balanced and wholesome diet; missing meals is deleterious for health and breakfast is very important for a good beginning of the day.
- Snacks should be wholesome and nutritious.
- Most of whole pulses should be included in diet.
- Occasional consumption of 'Junk food' may be allowed.

Annexure I: Case Study

Handout V

Case Study 1

Sheela

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

Discuss:

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

Case Study 2

Raju

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

He has an upset stomach most of the time and has loose motions.

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

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

His mother brings Raju to the Medical Officer.

Discuss:

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

Annexure 2: Role Play

Scenario 1

A 13 year old boy, Rajiv, is brought by his mother to your clinic with a respiratory infection. On examination you note that he is of thin built, looks short for this age and pale. He is at the early stage of puberty. They belong to lower middle class family.

How do you manage this case? “ (I am too Thin)*

Scenario 2

A 16 year old girl, Neha, is brought to your centre by her mother who complains that Neha does not eat enough even after repeated requests, which angers her. The mother says that Neha needs to be given some tonic. Neha herself is very quiet.

How do you handle this situation? (I am too pale)*

Scenario 3

The principal of a nearby government school has come to see you. She would like to begin some nutrition education in her school. She requests you to help her in this activity.

How would you help her? “(Eating healthy , Physical activity)”#

* See the algorithms in Physician's Chart Booklet.

See these two in Module-VI.

Annexure 3 : Self-Assessment Tool (SAT)

1. Why is nutrition important during adolescence?

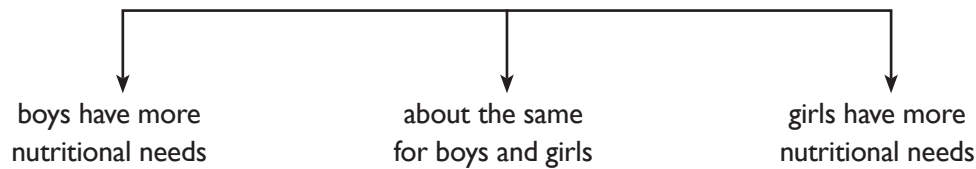
- i. _____

- ii. _____

- iii. _____

2. Are the nutritional needs of boys more than that of girls?

(please mark your answer with a cross (×) anywhere along the line)



3. What diseases can be caused by lack of proper nutrition?

- i. _____

- ii. _____

- iii. _____

- iv. _____

4. What are the consequences of nutritional anaemia?

- i. _____

- ii. _____

- iii. _____

- iv. _____

5. What can be done to improve the nutritional status of adolescent girls?

- i. _____

- ii. _____

- iii. _____

- iv. _____

6. How nutritional anaemia be prevented in adolescents?

- i. _____

- ii. _____

- iii. _____

Handout VI

Non-Communicable Diseases and Adolescents

CONTENTS

1. Introduction
2. Risk Factors for NCDs
3. Why adolescents are important in control of NCDs
4. Management of Risk factors for NCDs
5. Unintended injuries

1. Introduction

Non Communicable Diseases (NCDs) are leading cause of death worldwide including India. So much so that about 52% of deaths in our country are because of NCDs including trauma; 38% include deaths due to communicable diseases, maternal, neonatal, and child diseases, and nutrition related deaths all combined and remaining 10% due to other causes. Compared to developed countries, NCD related deaths occur earlier in developing countries.

Disease adjusted life years (DALY) measures overall disease burden expressed as the number of years lost due to ill health, disability or early death. In India, cardiovascular diseases and injuries (road accidents, burns, etc) account for 20% of DALY each, whereas, neuropsychiatric (mental health) illnesses account for 19% of DALY, respiratory diseases for 7%, cancers for 6%, diabetes for 2% and others for 26% of DALYs. Thus, NCDs are a very significant group of diseases for our country.

Majority of NCD related deaths are attributed to four groups of diseases, cardiovascular diseases, cancers, diabetes, and chronic respiratory diseases. Mental illnesses can also be added to this list. All these combined are estimated to cost the developing world US dollar 21 trillion in next two decades.

This handout focuses on risk factors for NCDs and their management.

2. Risk Factors for NCDs

Nearly half of the premature deaths because of NCDs are preventable. Focusing on risk factors for NCDs and reducing the risk can lower the burden of NCDs significantly. NCDs have 4 main behavioral risk factors-

- Tobacco use
- Harmful use of alcohol
- Insufficient physical activity
- Unhealthy diet/obesity.

Other risk factors for NCDs include high blood pressure, high cholesterol levels, high blood glucose levels, and genetic susceptibility (history of premature (<45 years of age) death or disability due to coronary heart disease or stroke, diabetes, and hypertension).

3. Why adolescents are important in control of NCDs

Treating NCDs bears a huge cost in terms of money and productive lives lost. Hence, it is wise to prevent NCDs by all means. Focusing on prevention of even risk factors in young people is likely to be more effective. Adolescence is probably the last best opportunity to build positive health habits and to limit the harmful behaviors. Adolescence is an age of developing brain and the time of habit formation. Habits adopted during this time are likely to persist in adult life. Hence, it is important to detect and manage harmful behaviors related to NCDs early. Tables 1 and 2 describes important aspects of NCDs in adolescents.

These risk factors can be less damaging if identified early in life when habits are still forming. This offers for better health, more years of productivity and certainly a lesser cost of health care to nation.

3.1 Prevalence of Risk Factors for NCDs in Indian adolescents

Various studies have revealed different prevalence of these risk factors in Indian children and adolescents. A Central Board of Secondary Education (India) survey of students of 8th, 9th, and 10th class found 10/8% students overweight and 2.1% obese. Only 30.2% students were found to have sufficient physical activity (at least 60 minutes per day on all 7 days during last 7 days). Students

spending time (>3 hours per day) on sedentary activities like watching television, using computer or mobile phones, or doing activities while sitting constituted 23.2%. Cigarette smoking on one or more days during past 30 days was found in 1.2% students, while use of tobacco other than cigarette on one or more days during last 30 days was found in 3.7% of students of 8-10th classes.

Global Youth Tobacco Survey (of students of 8-10th classes) in India found 6.1% students who have ever smoked cigarette and 14.6% were currently using one or other tobacco product. Many of them (26.4%) had one or more parents who smoke. Good thing is that nearly 2/3 of them wanted to stop smoking.

Another survey of students in India found that 22% of students did not consume fruits and 3.2% did not eat any vegetable during last 30 days. Carbonated soft drinks were consumed by 42% and 31.3% had fast foods. Only 39.3% student had at least 60 minutes of physical activity each of 7 days in a week. Only 9.7% attended physical activity classes on 5 or more days in a week. Time spent on sedentary activities was 1-2 hours in 45% and 3-8 hours in 23%. Family history of hypertension, heart disease, and diabetes was found in 23.1%, 13% and 11.3% students respectively. High blood pressure was detected in about 2% of the students.

Table 1 Main Behavioural risk factors in adolescent for NCD

Risk Factor	Current status	Implications on Health
Tobacco use	Most (90%) of adult smokers begin smoking before age of 18 years. One in four adolescents who smoke start using tobacco before the age of ten.	Exposed young people have two to three times the risk of asthma and lower respiratory conditions. Smoking by teen girls as adverse effect on fertility as well as morbidity and mortality in the fetus, newborn, infant and toddlers.
Physical inactivity / or lack of exercise	Insufficient physical activity and unhealthy sedentary behaviors are on rise. Rapid urbanization is also a driving force behind these risks	Inactivity may lead to high blood pressure and overweight/obesity, which can trigger NCDs such as cardiovascular diseases, diabetes, and cancers in adulthood.
Poor eating habits / unhealthy diets	Foods containing high levels of saturated fats, trans-fats, sugar and salt lead to weight gain and adverse metabolic changes. Unhealthy diet also leads to over weight /obesity and various nutritional deficiencies	Overweight and obesity are important determinants of health, increases in blood pressure, unfavourable cholesterol levels and increased resistance to insulin. They raise the risks of coronary heart disease, stroke, diabetes mellitus, and many forms of cancer
Alcohol consumptions	Adolescents who begin drinking earlier are more likely to become dependent on alcohol within 10 years than those who begin drinking at an older age.	Major risk factor for premature death and disability. There is a direct relationship between harmful levels of alcohol consumption and NCDs such as cancers and cardiovascular disease. This also increases risk of road traffic accidents, unprotected sex, intentional and unintentional injuries, poor mental health, and gender-based violence.

Table 2 - Why is Adolescent period important for prevention of NCD's

Best period to begin	Factors influencing	Interventions needed	Policies
Adolescence is the last best opportunity to build positive health habits and limit harmful ones.	Adolescence is a time when the influence of peers is extremely important	To lower the likelihood of youth smoking and chewing tobacco, protect against alcohol use, and support healthy diet and physical activity.	Some of the most cost-effective strategies to combat tobacco use and harmful use of alcohol include raising taxes and enforcing bans on advertising especially targeted to adolescents.
Unless prevention is done from the adolescent, age habits are very hard to change once they get established as a life style.	Parental influence of being role model for healthy or unhealthy life styles is maximum during this period.	Communities must also work together to promote physical activity and healthy eating habits based on cultural appropriateness, especially within schools.	Public promotion of what constitutes a healthy diet and the appropriate amount of physical activity, specifically 60 minutes a day for adolescents, is important.
Some risks, such as poor nutrition, begin in childhood and are a clear precursor for later health problems.	Media influence and the targeted marketing of unhealthy products and lifestyles for adolescent are on rise.		National and local governments can do more to ensure their communities are eating healthier by encouraging clear food labels; managing food taxes and subsidies; promoting healthy eating in schools and workplaces; restricting marketing of junk food and sugary beverages to children and adolescents; and providing incentives for the food industry to prepare foods with less sodium, trans-fat, and saturated fat.

3.2 Identification of the risk factors in adolescents

As stated above many of the risk factors might have already started in the adolescents. Thus it is better to identify them as early as possible. It is important to look for the risk factors in all adolescents and if found then 'selective screening' by some blood tests can be added to clinical screening.

3.2.1 History

It is important to include some questions related to unhealthy diet, physical activity or inactivity, smoking and substance (including tobacco and alcohol) use/misuse, and then family history of diabetes, hypertension, coronary heart diseases, stroke or early (<45 years of age) death or disability due to acquired heart disease or stroke in parents or grand parents. These questions can be incorporated in HEADSS review of psychosocial interview. Some questions are given below for illustration.

- Do you exercise or participate in outdoor games atleast five days a week?
- Do you watch T.V. / computer or spend time on mobile for more than two hours per day?
- Do you consume fruits, fruit juices or green leafy vegetables in your routine diet atleast five days a week?
- Does anybody in your family (parents, siblings, grandparents or maternal grandparents etc) have high blood pressure, diabetes, or any heart disease?
- Do you consume any kind of tobacco (Bidi, Cigarette, Hookah, Gutkha etc.)?
- Do you consume any kind of alcohol (Beer, Whisky, Vodka etc.) or drugs (Ganja, Charas etc.)?

A thorough physical examination should include assessment of weight and BMI, blood pressure, and systemic examination. We must identify whether unhealthy diets, overweight or obesity, hypertension, inadequate physical activity or sedentary behaviors are present.

Adolescents having one or more risk factors should be considered for targeted screening blood tests. Clear guidelines are not available for adolescents, however, whenever one or more risk factors are identified especially family history as above then in such cases screening for risk factors for atherosclerosis may be advised using serum cholesterol and very low density lipoprotein estimation along with fasting blood sugar level. Some studies have used HbA1C as screening for diabetes. Other tests may be required depending on the history and examination of an individual adolescent.

Whenever these screening tests are abnormal then a thorough physical examination and detailed laboratory evaluation is required and such adolescents should be referred to experts' evaluation.

4. Management of Risk factors for NCDs

Behavioral risk factors like smoking, alcohol intake, inadequate physical activity and sedentary activities, and unhealthy diets can be managed by appropriate counseling of parents and adolescents. Healthy habits are likely to be followed when the whole family is ready to change and adopt healthy habits. Barriers to healthy habits should be identified and managed accordingly. Algorithm (I am too thin/too fat) can be used for management of overweight and obesity.

It is important to identify genetic risk factors like enhanced susceptibility in view of family history as described above. Such adolescents and family should be advised to adopt healthy diets, regular physical activity, and less (<2 hours per day) of sedentary activities (screen time like television, video games and mobile phones).

Smoking and other tobacco use should be managed by counseling techniques. Following texts from WHO Job Aids can be used to educate parents and adolescents for promoting healthy eating and physical activity, for prevention of unintentional injuries and for preventing use of tobacco, alcohol and other substances.

4.1 Healthy eating

Adolescents need a healthy diet to grow and develop, and to function optimally. A healthy diet consists of:

- a variety of foods balanced across the major food groups;
- a sufficient amount of food to meet an adolescent's needs.

4.1.1 *There are five basic food groups:*

- starchy foods such as rice and other cereals, potatoes, noodles and pasta
- fruit and vegetables
- milk and dairy products such as yogurt and cheese
- meat, fish, poultry, eggs, nuts and legumes
- foods and drinks high in fat and/or sugar.

4.1.2 *Balanced food intake*

A young person should eat a diet balanced across the five food groups. They should eat:

- plenty of fruit and vegetables
- adequate quantities of rice and other cereals, potatoes, noodles and pasta
- some milk and dairy products such as yoghurt and cheese and
- some meat, fish, poultry, eggs and/or nuts and legumes.
- The relative proportion of the five groups is depicted in the diagram 1.
- In addition, they should:
 - choose foods that are low in salt and
 - limit foods that contain a lot of fat or sugar.

4.1.3 *Adequate food intake:*

If adolescents do not have enough to eat, they will be underweight. Being undernourished will affect their physical growth and development as well as their ability to learn and to work. Young women who are underweight tend to have babies who are smaller and more liable to health problems. If adolescents have too much to eat, particularly foods high in fat and sugar, this can lead to them becoming overweight. Being overweight can lead to health and social problems during adolescence and later in life.

4.1.4 *Messages for adolescents*

1. Eating a sufficient amount and a wide variety of healthy foods is important for you to grow and develop normally.
2. While it is important that you eat enough food for your body to grow and develop normally, it is important to remember that eating too much food can make you overweight; this is not good for your health.
3. Eating healthily means having regular meals and avoiding unhealthy snacks (especially those that contain a lot of fat or sugar).

4.1.5 *Messages for parents*

What you should know:

1. Your son or daughter needs to eat a wide variety and a sufficient amount of healthy foods to grow and develop normally.
2. If your son or daughter develops healthy eating habits during their adolescent years, these habits are likely to continue for the rest of their lives.

What you should do:

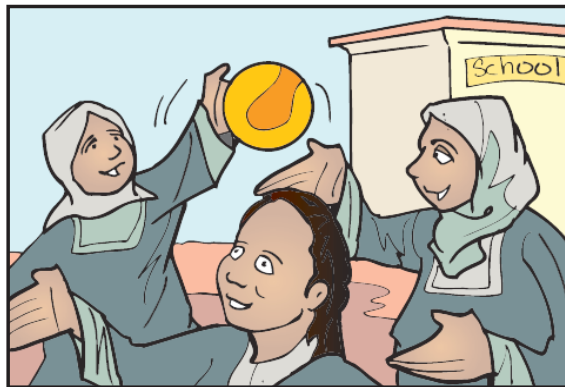
1. Talk to your son or daughter about healthy foods and healthy eating.
2. Support your son or daughter to develop healthy eating habits.
3. Provide your son or daughter with a good role model by eating healthily yourself.



Diagram 1: Balanced food intake across food groups

4.2 Physical activity

Regular physical activity has important physical, mental and social benefits both during adolescence and later in life. Physical activities include sports such as football and exercise such as jogging. They also include regular daily activities such as walking to school and work done at home (e.g. cleaning the floor) or at work (e.g. painting a room).



4.2.1 Messages for adolescents

Around sixty minutes of physical activity on most, if not all days, can provide you with the following benefits:

Physical benefits

- It will help your bones and muscles grow and develop.
- It will help you remain (or become) fit and trim.

4.2.2 Mental benefits

- It can help to build your self-confidence and self esteem.
- It can help you study and work better.
- It can help you calm down when you are anxious, sad or angry.

4.2.3 Social benefits

- Participating in sports can help you meet people and develop a sense of camaraderie.
- It can also help you learn how to play by the rules, how to cooperate with members of your team, and how to deal with both victory and defeat.

Too little activity can lead to overweight and associated health problems. Too much activity, not balanced with an adequate diet, can lead to poor growth and development.

4.2.4 Messages for parents

What you should know:

1. Many adolescents need to be encouraged to build in some regular physical activity in their daily lives.
2. Developing this habit in adolescence and maintaining it into adulthood will help them prevent health problems that inactivity contributes to such as high blood pressure and diabetes.

4.2.5 What you should do:

1. Encourage your son or daughter to engage in regular physical activity for around 60 minutes on most, if not all days. Encourage them to match their physical activity with an adequate diet.
2. Provide incentives and opportunities for your son or daughter to engage in regular physical activity.
3. Provide your son or daughter with a good role model, by engaging in regular physical activity yourself.

4.3 The use of tobacco, alcohol and other substances

Adolescence is a time of curiosity and experimentation. Many adolescents experiment with tobacco, alcohol and other substances. They do this for different reasons - to feel and act older, to fit in with friends, to challenge adults, or to relieve stress.



The use of tobacco, alcohol and other substances can lead to negative health consequences both during adolescence, and into adulthood.

1. Tobacco use stains fingers, lips and teeth. It also causes bad breath. Smokers tend to be less fit and get short of breath more easily. Tobacco also causes problems later in life - notably cancer and heart disease.
2. The consumption of alcohol, even in small amounts, can impair judgement. The consumption of large quantities of alcohol in a short period of time can cause neurological and liver damage.
3. Using cannabis, heroin, amphetamines or cocaine can cause damage to the brain, liver, kidney and lungs both in the short and long terms. Injecting substances with shared needles and syringes greatly increases the likelihood of getting HIV.
4. Substances such as tobacco, heroin, amphetamines and cocaine can induce dependence. Being dependent on these substances impairs the ability of people to carry out everyday activities and can lead to tensions with family members, friends and others. Most people who develop dependence on substances do so during their adolescence.
5. While under the influence of alcohol or other substances people do things that they would not normally do, such as: driving dangerously, being verbally or physically violent, or having unprotected sexual activity. Many adolescents die from motor vehicles crashes under the influence of these substances.

4.3.1 Messages for adolescents:

1. Do not be pressured into using tobacco, alcohol or other substances by people around you, or by images on television etc.
2. Talk to your friends, parents or other trusted adults if someone offers you substances to use. They could help you avoid using them.
3. If you have started using alcohol or other substances, seek help from your friends, parents or other trusted adults. They could help you give up their use.
4. If you do use alcohol or other substance that impair judgement, do so with someone you trust and in a safe place. You are more likely to suffer an overdose if you consume substances on your own, and are more likely to be a victim of crime or violence if you are alone and in an unsafe place.
5. If you do use alcohol or other substances that can impair your judgement, avoid driving a car, motorcycle or bicycle while under their influence.

4.3.2 Messages for parents

What you should know:

1. Increasing the awareness of your son or daughter about the dangers of substance use, and helping them become aware of the influence that peers and the media can have, can help them avoid substance use.
2. Early detection of substance use, followed by counselling by health workers, has been shown to be effective in motivating adolescents to give up their use or to reduce the harm it could cause them.

4.3.3 What should you do:

1. Talk to your son or daughter about the dangers of using tobacco, alcohol or other substances. Do this in early adolescence. Do not wait until their use has started.
2. Discuss with your son or daughter the influence that their peers and images in the media could have in persuading them to initiate substance use. Explain to them the importance of deciding what is best for themselves.
3. Make clear what your expectations regarding their behaviour are. Provide a good role model through our own behaviour.
4. **Be watchful for signs of substance use by your son or daughter. If and when you notice them, discuss the matter, and together seek help from a health worker.**

Handout VII

Adolescent Injuries, Aggression and Violence

CONTENTS

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3. Injuries
4. Prevention of Injuries
5. Road traffic injuries
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7. Management of injuries in clinics
8. Anticipatory guidance
9. Adolescent aggression and violence
10. Specific Issues
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1. Introduction

Every year, millions of children all over the world die from preventable causes. Injuries and violence are responsible for a large majority of these causes causing more than five million deaths every year. Violence and injuries account for 9% of global mortality and as many deaths as HIV, malaria, and tuberculosis combined (Peden et al. 2008). Injury death rates are significantly higher in low- and middle- income countries, which already account for more than 95% of the world's deaths from injuries and violence.

Young people are among the most vulnerable. Apart from the high death toll, injuries during childhood and adolescence are also associated with high morbidity: for every injured child who dies, several thousand more survive with varying degrees of disability. The impact on the society is tremendous: every day, thousands of families are robbed of their children and thousands of children have to learn to cope with the consequences of their injury, which, in some cases, can be both long-lasting and profound.

2. Magnitude of the problem

Worldwide, 8 of the 15 leading causes of death for people aged 15 to 29 years are injury related, including road traffic injuries, suicides, homicides, drowning, burns, war injuries, poisonings, and falls. According to findings of 2010 Global Burden of Disease Study, injuries cost the global population some 300 million years of healthy life every year, causing 11% of disability-adjusted life years (DALYs) worldwide. Road-traffic crashes were the number one killer of young people and accounted for nearly a third of the world injury burden—a total of 76 million DALYs in 2010, up from 57 million in 1990.

Injuries account for 9-10% of total mortality in India. As per national data from National Crimes Record Bureau (2010), New Delhi, a total of 5,03,932 people were injured and 3,84,649 accidental deaths were reported in the country during 2010, showing an increase of 7.7% as compared to previous year. In the decade from 2000 to 2010 the accidental deaths increased by 32.4%, corresponding with population growth of 18.3%. The common causes of unnatural accidental deaths are- road traffic injuries (37.2%), poisoning (7.8%), drowning (7.8%), railway accidents and rail-road accidents (7.7%), and fire related deaths (6.8%). Age-wise, 6.9% of such victims were up to 14 years of age while 53.0% were in the age-group of 15- 44 years, rest were in age more than 45 years.

Deaths in 'Road Accidents' in the country have increased by 5.5% during 2010 compared to 2009 and 26.5% victims of Road Accidents were occupants of 'Two Wheelers'. The month-wise distribution of 'Road Accidents' has shown maximum number of accidents during May (39,821) and least in the month of September (32,898). Maximum 'Road Accidents' (69,282) were reported during 6 p.m. to 9 p.m. Rate of Accidental Deaths per thousand vehicles was highest in Arunachal Pradesh at 6.3, followed by Bihar and Sikkim at 2.4 each. Delhi city accounted for 25.1% deaths of bicycle riders, 18.8% deaths of pedestrians, 16.6% deaths of two-wheeler riders and 9.2% deaths of three-wheeler riders in 35 mega cities.

Violence is commonly witnessed by adolescents. A study in school adolescents in Chandigarh found that

- 2/3 of adolescents witnessed violence in life
- 80% witnessed someone being bullied.
- 28% witnessed serious violence being caused by objects like roads/sticks (13%), chains (47%) helmet/belts (10%) and hockey sticks bats (16%).
- Different types of violence witnessed by adolescents included physical fights (slaps, punches, kicks), fights with objects, robbed or mugged, shot or stabbing and killed.

- Nearly all were exposed to Media violence
- 27% of subjects were victims of violence
- 13% of subjects were perpetrators of violence
- Those having exposure to violence had poorer school performance.

National study on child abuse (2007) found that nearly every other boy and girl faced sexual abuse at least once. Another study in Delhi found $\frac{3}{4}$ of children reporting physical abuse.

2.1 Understanding injury, aggression and violence

An injury consists of unintentional or intentional damage to the body that results from acute exposure to thermal, mechanical, electrical, or chemical energy, or from the absence of such essentials as heat or oxygen. Injuries can be classified based on the events and behaviors that precede them, as well as the intent of the persons involved. Aggression is intense behavior to achieve some goals.

Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or a group or community that either results in or is likely to result in injury, death, psychological harm, mal-development, or deprivation.

3. Injuries

Injuries can occur in various ways and it is important to understand types of injuries and factors related to causation and prevention of injuries.

Classification of Injuries

- | |
|--|
| <p>I. Intentional injuries</p> <ul style="list-style-type: none"> a) Self inflicted injuries (suicide) b) Interpersonal violence (homicide, sexual, child abuse) c) Collective violence (war) d) Other intentional injuries (legal intervention) <p>II. Unintentional injuries</p> <ul style="list-style-type: none"> a) Road traffic injuries b) Drowning c) Poisoning d) Falls e) Burns f) Other unintentional injuries(firearm injuries) |
|--|

Both intentional and unintentional injuries can also be categorized according to the place where they occurred, i.e. on the road, at home, at a leisure/sport facility, at school or in the workplace, or according to the circumstances in which they occurred, e.g. during working hours (occupational injury) or during leisure time.

3.1 Why are adolescents at risk from injuries?

Overall rates of injury and death increase dramatically from childhood to late adolescence. Due to developmental and social factors, such as time spent without adult supervision and increasing

independence, adolescents are more likely to engage in risk-taking behaviors than either younger children or adults.

Developmentally, research over the past decade has found that parts of the frontal lobe – in particular the prefrontal cortex which governs judgment, decision-making, reasoning and impulse control – appears not to fully mature until the age of 20 or 25 years making adolescents more likely to engage in risk-taking behaviors.

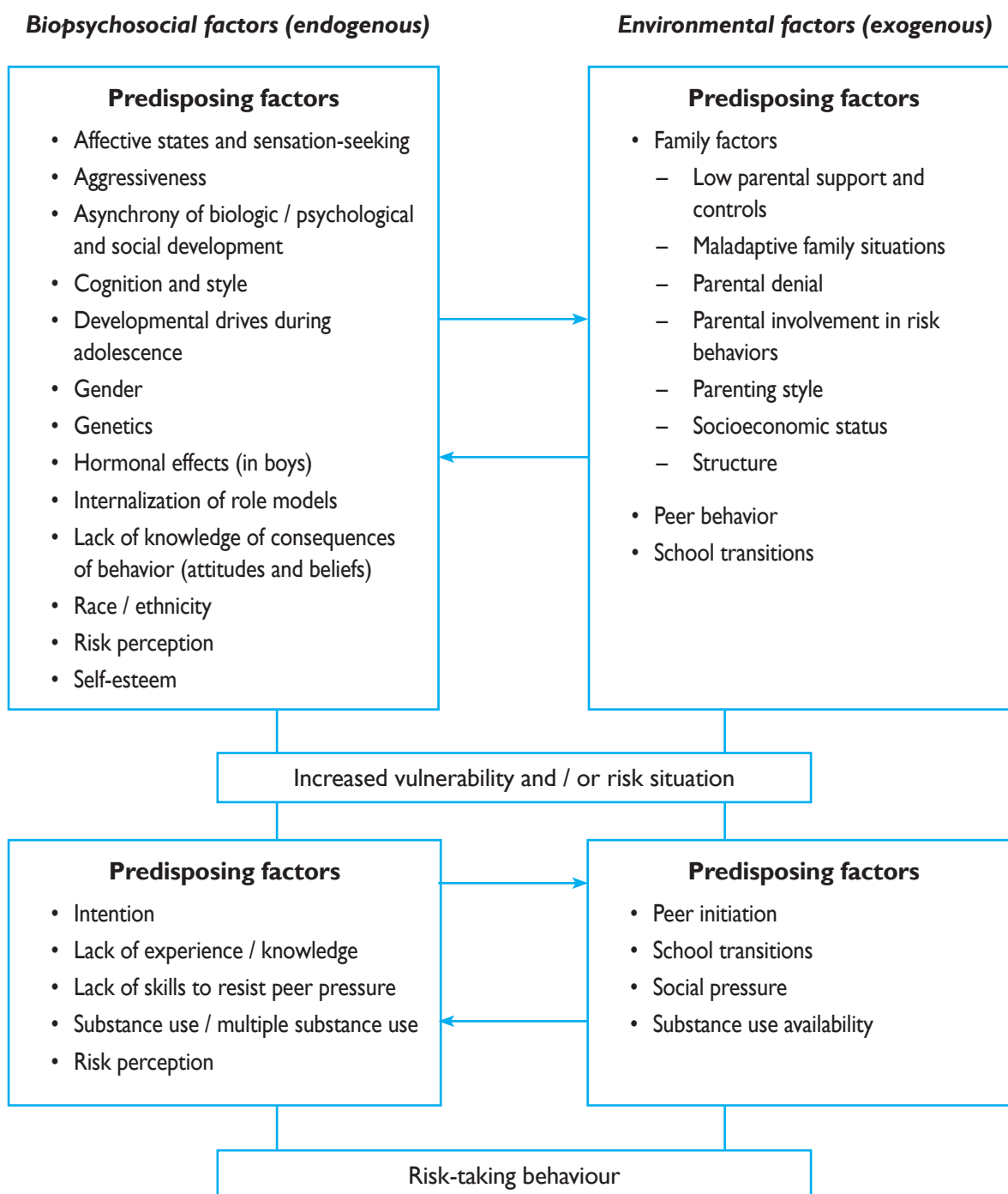


Fig. 1: Principal factors in risk-taking behaviors
(adapted from Igra v etal, *Social Pediatrics*, New York, 1995)

3.2 Risk-taking behavior

The primary causes of injury, illness and disability in adolescents are behaviorally generated. Nearly 50% of the morbidity and mortality in adolescents stems from four behaviors: sexual activity, substance use and abuse, motor vehicle use, and interpersonal violence. These behaviors have their origin in adolescence, and is common among all age ,socioeconomic and ethnic groups (Figure 1). All of these behaviors have a probability for negative outcome and share one common thread i.e. risk taking tendency of the adolescents. Moreover, these behaviors continue in adult life and are responsible for some of the major causes of morbidity and mortality and are largely preventable. While young children may inadvertently take risks because they lack appropriate skills to do otherwise, older children and adolescents may actively seek out risk. Risk-taking behavior may allow adolescents to feel a sense of control over their lives or else to oppose authority. Research shows that there are high levels of sensation-seeking behavior among young adults and that there exists a need to maintain a heightened level of physiological arousal. Young people consequently seek new situations and experiences to maintain this level, irrespective of the risks inherent in the experience.

Such sensation-seeking frequently focuses on risky behaviors, including driving a vehicle or crossing a road. Sensation-seeking has been shown to rise between the ages 9 and 14 years, peaking in late adolescence or in early adulthood, and declining steadily with age . Risk-seeking behavior is a significant predictor of involvement in road traffic injury among child pedestrians as well as it is for young adolescent drivers aged 16–17 years Across all ages and particularly among the young, sensation-seeking is more common among boys than among girls. Boys as young as 11 years have a greater affinity for speed, risk-taking and competitive behavior; all of which place them at an increased risk of road traffic injury. But it is also pertinent to remember that though injuries are a frequent and sometimes devastating outcome of risk taking but risks are also inherent in the environment in which adolescents live, work, and play.

3.2.1 Peer influence on risk taking

As young children become adolescents, they enter a phase where the influence of their parents is reduced, and they begin to discover and assert their independence. This transition can be expressed in their lifestyle, and in an increasing conformity with certain social norms, that in turn influence their behavior and decision-making. For many young people, peers are of significant importance and can be the primary source of the social norms with which they strive to conform. Social norms, including peer pressure and the emphasis placed on rebellion in the culture of young people, can affect the manner in which young people drive a vehicle. Direct peer pressure may be exerted on the driver's behavior through the influence of a passenger. Research has shown that young drivers experience higher peer pressure than older drivers to commit traffic violations such as speeding, driving under the influence of alcohol and dangerous overtaking. There is a close link between the presence of similarly aged passengers in the car and increasing risk levels. A number of studies have shown that young drivers, both male and female, drive faster and with a shorter following distance at road junctions if they have young passengers in the car.

3.2.2 Effect of gender on risk taking

There is evidence of a strong relationship between gender, road safety behavior and road traffic injury. Most studies conducted show a strong male bias, with the male-to female ratio ranging between 3:1 and 5:1. This relationship holds true across different regions of the world and applies to fatal and non-fatal injuries. A part of the predominance of boys in road traffic injury statistics can be accounted for by differences in exposure. Research on 10–12-year-old boy pedestrians has found that the amount of exposure, together with nature of the road environment, influences injury rates among this group, particularly those from poorer areas. However, exposure does not account for the entire difference.

Among young drivers, men have more fatal crashes per kilometer driven than do young women, even taking into consideration their increased exposure levels. Factors thought to contribute towards this difference include increased risk-taking and sensation-seeking.

4. Prevention of injuries

It is important for the medical officer to have broad knowledge about the prevention of injuries as many of these factors are interlinked. It might help the MO while counseling the adolescents and their parents in their clinic and in the community as well.

4.1 Approaches to prevent injuries

Child and adolescent injuries can be considered as a major health problem. The traditional model of injury prevention and control rests on managing three Es ie enforcement, education and engineering. A multipronged strategies are required to control injuries and these strategies complement each other thereby amplifying the final effect. It involves changing the environment, individual behavior, products, social norms, legislation, policy, and ecology related to injury.

4.1.1 Structural Approaches

Structural strategies involves product modifications (such as machinery guards) and environmental changes (such as adding lifeguarding to pools and recreational water bodies, and building bike lanes, pool fencing) often afford the greatest protection to the population. But the adolescent's individual choices and behaviors can often override these protections and in the end they do not have a desirable effect. Moreover these measures are costly or may not be feasible to implement.

4.1.2 Behavioral Approaches

Injury prevention education is the process of changing people's health - directed behavior to reduce unintentional injuries. It is a very important component of the effective structural, automatic, environmental, or engineering protections. For example, bicycle and motorcycle helmets protect against head injury, but they must be fitted properly and used consistently. Seat belts can prevent injuries, but they must be worn even when it is not mandatory or otherwise. Driver must abstain from over speeding and drunk driving even if there are penalties for them. Effective injury prevention always involves both behavioral (active) and environmental (passive) countermeasures—it is never an either/or proposition. However, behavior education has its limitation as it is difficult to bring about a desired change and the successful outcome is difficult to measure.

4.1.3 Legislation and Policy Approaches

Although adolescent behaviors can be changed by introducing a law or policy that mandates compliance—such as requiring protection when operating industrial machinery or requiring helmet use - legislation must be supported by the public and enforced by local authorities. Enforcement of legislation indicates state awareness of the importance and urgency of problem. However in LMICs laws around the injuries are inadequate and rarely proactive.

Other policy approaches that have proven effective for preventing motor vehicle injuries among adolescents as well as other drivers include primary seat belt use laws (where one can be cited for nonuse as a primary offense), enhanced police enforcement, blood alcohol level laws, minimum legal drinking age 21 laws, sobriety checkpoints, and zero tolerance laws for young and inexperienced drivers. Policy changes that discourage early adolescent driving, such as rising insurance costs, expensive driving schools, and GDL laws, have already reduced the proportion of 16-year-olds who hold a driver's license from nearly 43.8% in 1998 to 29.8% in 2006 in US.

4.1.4 Ecological Approaches

The most effective injury prevention efforts are structured within an ecological framework, focusing on individual modifiable factors and family, peer group, work site, and community and socio cultural factors simultaneously. For example, legislation requiring bicycle helmet use should be accompanied by an educational campaign for children and parents, police enforcement in the community, and discounted sales of helmets by local merchants. Programs addressing the safety of employees can also be extended to focus on the safety of other family members such as adolescents on and off the job. Ecological approaches emphasize tailoring specific interventions to the cognitive and physical skills of adolescents and to the social world in which they live. Local enforcement of laws designed to protect adolescents is an important ecological factor in prevention. Significant overlap exists among these strategies. Ecological changes have an influence on legislation and behavior; structural changes have an effect on behavior and ecology. Legislative changes affect behavior, structures, and ecology. There is no single strategy to resolve this problem. Strategies work best when combined.

In addition, to hasten recovery and limit disability an efficient rehabilitation services (including immediate post trauma management services) are essential.

Road traffic injuries and drowning are the two important preventable cause of injury in adolescents and will be discussed in detail.

5. Road traffic injuries

The high incidence of adolescent traffic-related injury is due in part to lack of experience and lack of maturity. Although teenagers drive less than most other drivers, they are involved in a disproportionately high number of crashes. The likelihood that children and adolescents will suffer fatal injuries in motor vehicle crashes increases when they do not use seat belts or when a driver transporting children or adolescents has been drinking and when new and inexperienced drivers transport other teenage passengers. The fatal crash rate per Km driven for 16–19-year-olds is three times the risk for older drivers (age 60+), and fatal crash risk is highest at age 16. Crash risk for both males and females is particularly high during the first months of driving and drops as young drivers accumulate more experience behind the wheel.

One has to understand that many years of experience may be needed for adolescents to become proficient in driving. For example, young drivers may also lack experience to recognize, assess, and respond to the situation or hazards. They may be willing to accept higher levels of risks while walking, riding a bike, or driving a car or motorcycle. These risks may be fueled by emotions, peer pressure, and other adolescent stressors.

In addition, adolescence is characterized by increased independence from parents and social pressure from peers. Moreover, distracted driving, the use of cell phones while driving, the presence of teen passengers, and the increased use of in-vehicle technologies present additional safety concerns. Other factors, that may divert the attention of adolescents and has potential to impact the safe driving are not well understood. The list includes, cell phones, texting, in-vehicle internet use, and on-board navigation systems. These problems are further compounded by adolescent alcohol use.

5.1 Road traffic injuries and risk factors

Research has shown that , speeding , drink-driving, non usage or improper usage of helmets , seat-belts and child restraints are the five most important risk factors that is consistently associated with fatalities and are largely preventable. An examination of the factors that contribute to injuries reveal that alcohol may be the single most important factor. Drinking and driving increases the risk

of being involved in a crash, as well as the severity of resulting injuries. Driving starts to be impaired at very low levels of alcohol consumption, with the risk of crash involvement growing rapidly as consumption increases. Young and novice drivers who drink and drive have a greatly increased risk of a crash compared to more experienced drivers. The effects of alcohol impairment are magnified when combined with fatigue.

The other factors which might affect safe driving are consumption of other intoxicants, sleep deprivation, use of mobile or other gadgets. Use of mobile telephones while driving, increases the risk of crash four-fold. The risk is similar for both the hand held and hands free mobile set. Helmets and Seat belts. Two wheeler drivers (motorcyclists and bicycle drivers) are increased risk of severe head injuries resulting from traffic injuries. Motorcyclists comprise a third of all road traffic deaths in the South-East Asia. Head and neck injuries are the main cause of severe injury, disability and death among motorcycle users.

5.2 Preventing Road Traffic Injuries

As per the Global action plan for road safety, 2013 designed by UN general assembly, the five pillar that guide national road safety plans and activities over the decade of action are :

- Road safety management
- Safer roads and mobility
- Safer vehicles
- Safer road users
- Post-crash response

Basically the strategies described under prevention of injuries will be applicable in preventing road traffic injuries as well.

5.3 Delivering Care after Crash

A significant proportion of patients who sustain a road traffic injury incur permanent disability, through amputation, head injury or spinal cord injury. Access to pre-hospital services and quick evacuation and transport to hospital can save many lives and limit disability, since majority of these who die do so before they reach a hospital.

Moreover, health care providers should be appropriately trained in emergency medical care, which is not the case in many LMICs including India

5.4 Evidence based strategies to reduce road traffic injuries in adolescents

A number of effective strategies would, if implemented, reduce motor vehicle-related injuries in adolescents. Among the most important strategies are graduated licensing and safety belt and helmet use.

5.4.1 Seat Belts and Helmets

Wearing a standard, good quality motorcycle helmet can reduce the risk of death by 40% and the risk of serious injury by over 70%. Seat belt usage protects the driver and the occupants from severe crash injuries. It reduces the risk of a fatal injury by up to 50% for front seat occupants, and up to 75% for rear seat occupants. Proper use of bicycle helmets can eliminate 65%–88% of bicycle-related brain injuries and 65% of serious injuries to the face. Peer pressure, negative modeling of the

future challenges. Legislation mandating seat belt and helmet use, together by family members, and community climate are some of the factors related to nonuse. Building a culture of safety for seat belts and helmet-wearing among adolescents will be one with enforcement and education has proven to be the most effective strategy.

5.4.2 Graduated Driver Licensing

One proven method for helping teens to become safer drivers is graduated driver licensing (GDL) which is prevalent in many developed countries.. GDL systems work because they directly target the risk factors by giving newly licensed adolescent drivers experience under low-risk driving conditions. Many of these strategies have been successfully implemented within the context of parent management of teen driver intervention conducted within driver education.

6. Drowning

Drowning is the process of experiencing respiratory impairment from unintentional submersion/ immersion in liquid. Apart from mortality it may also result in non fatal injury which may lead to brain damage and long term disability. Around 96% of unintentional drowning deaths take place in low- and middle-income countries. China and India have particularly high drowning mortality rates and together contribute 43% of the world's drowning deaths and 41% of the total global DALYs (disability-adjusted life years) lost related to drowning. In India, the drowning deaths could be due to boat capsizing, swimming, recreational (during picnics and other outing). Males is especially at risk of drowning, with twice the overall mortality rate of females. Studies suggest that the higher drowning rates among males are due to increased exposure to water and riskier behavior such as swimming alone, drinking alcohol before swimming alone and boating. Increased access to water is another risk factor for drowning.

6.1 Prevention of Drowning

Victims of drowning have a very slim chance of survival after immersion. The victim loses consciousness after approximately 2 minutes of immersion and irreversible brain damage can take place after 4-6 minutes. Therefore, prevention strategies are more important.

Drowning prevention strategies should be comprehensive and include: and engineering methods which help to remove the hazard, legislation to enforce prevention and assure decreased exposure, education for individuals and communities to build awareness of risk and to aid in response if a drowning occurs.

Availability of properly-fitted and appropriate personal flotation devices non consumption of alcohol while boating and swimming appear to be effective drowning prevention strategies. Individual and community education on drowning awareness, risks associated with drowning and learning waters survival skills appear promising strategies to prevent drowning. Similarly, ensuring the presence of lifeguards at swimming areas also appears to be a promising strategy to prevent drowning. Ensuring immediate resuscitation by increasing the capability of first responders to provide first aid in cases of drowning can decrease the potential severity of outcomes.

7. Management of injuries in clinics

In routine practice the MO may either come across adolescents who has come to the clinic with some degree of morbidity associated with injury or violence or during routine screening MO perceives that there are certain risk taking behaviors in the client which makes him at risk to injuries or violence. In any setting, a complete evaluation of the adolescent should incorporate the following:

(1) an assessment of psychosocial factors placing the youth at greater or lesser risk for health-damaging behaviors; (2) a detail of current and anticipated behaviors; (3) an assessment of the consequences of those behaviors on health status, general functioning and psychosocial development; and (4) a physical examination and, laboratory tests if necessary.

The next step is to inquire about the nature and extent of participation in all health risk behaviors. It is important to remember that an adolescent may be indulging in more than one risk taking behavior at a time. These behaviors may be more dangerous and need to be explored specifically. The MO should take note of any adverse medical consequences arising out of these behaviors. He should also interview the adolescents and their parents about the adolescent's functioning in areas of family, peers, and school or work to find out how is she meeting the expected development outcomes in these contexts. While doing physical examination, one should look for physical signs of trauma like lacerations, ecchymosis, or other musculoskeletal injuries, which may be a pointer towards unintentional or intentional injuries. Manager such injuries appropriately. If coercion nature is suspected use algorithm "I have been attacked" given in Annexure.

8. Anticipatory Guidance

The clinical setting, primary prevention or anticipatory guidance is the mainstay focusing mainly on education of the clients. For adolescents who are actively engaging in some risk behaviors but have neither shown any signs of escalation of these activities nor experienced any developmental impairment or adverse consequences, management should consist primarily of counseling.

Realistic goals for counseling should not focus on convincing the youth to cease all risk behaviors, but rather encouraging the adolescent to modify the behaviors so that, he or she is protected from the most harmful outcomes. The discussion should focus on the normative nature of some exploratory activities, the risk factors increasing participation, and the adverse consequences of specific activities. For example, parents can be informed that their own behavior, such as the use of tobacco or the wearing of seat belts, serves as a powerful message to their children.

Because adolescents appreciate the present more than the future, any discussion of adverse effects of behavior should emphasize immediate, -short-term results, such as bad odor or compromised athletic performance with cigarette smoking, rather than the risk of lung cancer. A discussion of those aspects of normal development that encourage risk taking also may assist families in balancing the parents' needs for supervising and monitoring activities with the adolescent's needs for increased autonomy and independence through age-appropriate responsibilities and activities. Discussion of alternative activities that serve developmental needs but do not have adverse consequences is another useful strategy. The clinician also may engage the parents in a discussion of how negative or positive risk factors may be minimized or enhanced.

9. Adolescent Aggression and Violence

Violence results from aggressive behavior. When intensity of behavior increases and impact becomes more severe, aggression become violence. Relationship between normal behavior and violent behavior is shown in figure 2. It is important to understand that not all aggressive behavior is antisocial/criminal and not all antisocial behavior is violence. But, any violence is antisocial. Aggressive and violent behavior are in a continuum (Figure 3).

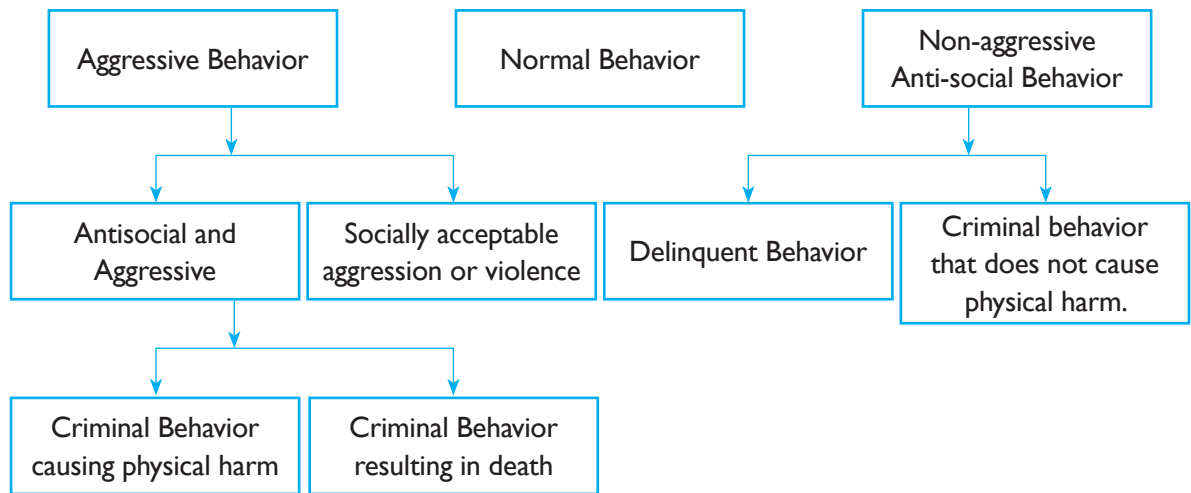


Figure 2: Relationship between normal behavior, aggression and violent behavior. Adapted from Ref. 4

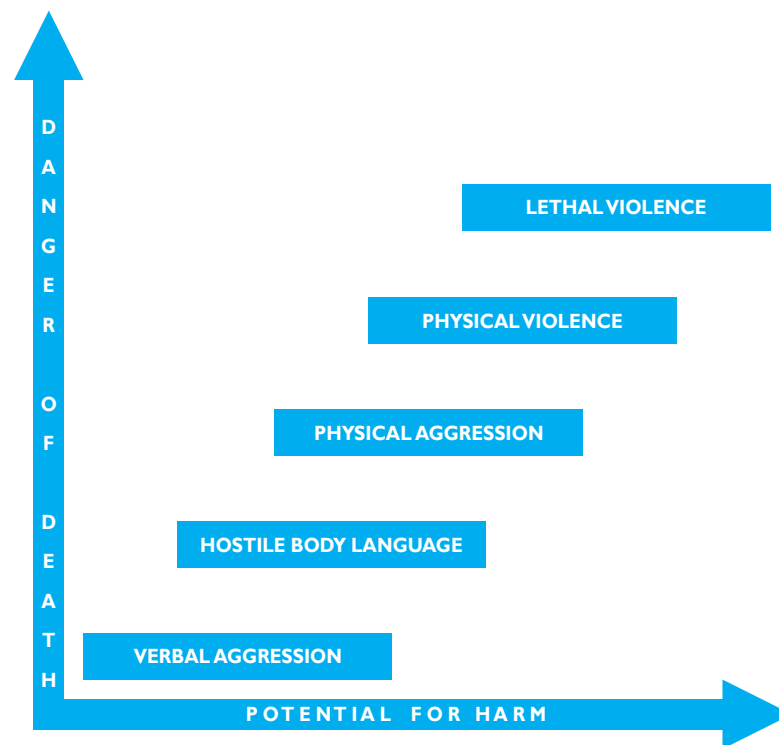


Figure 3- Continuum of aggression and violent behavior

9.1 Factors related to aggression and violence in adolescents.

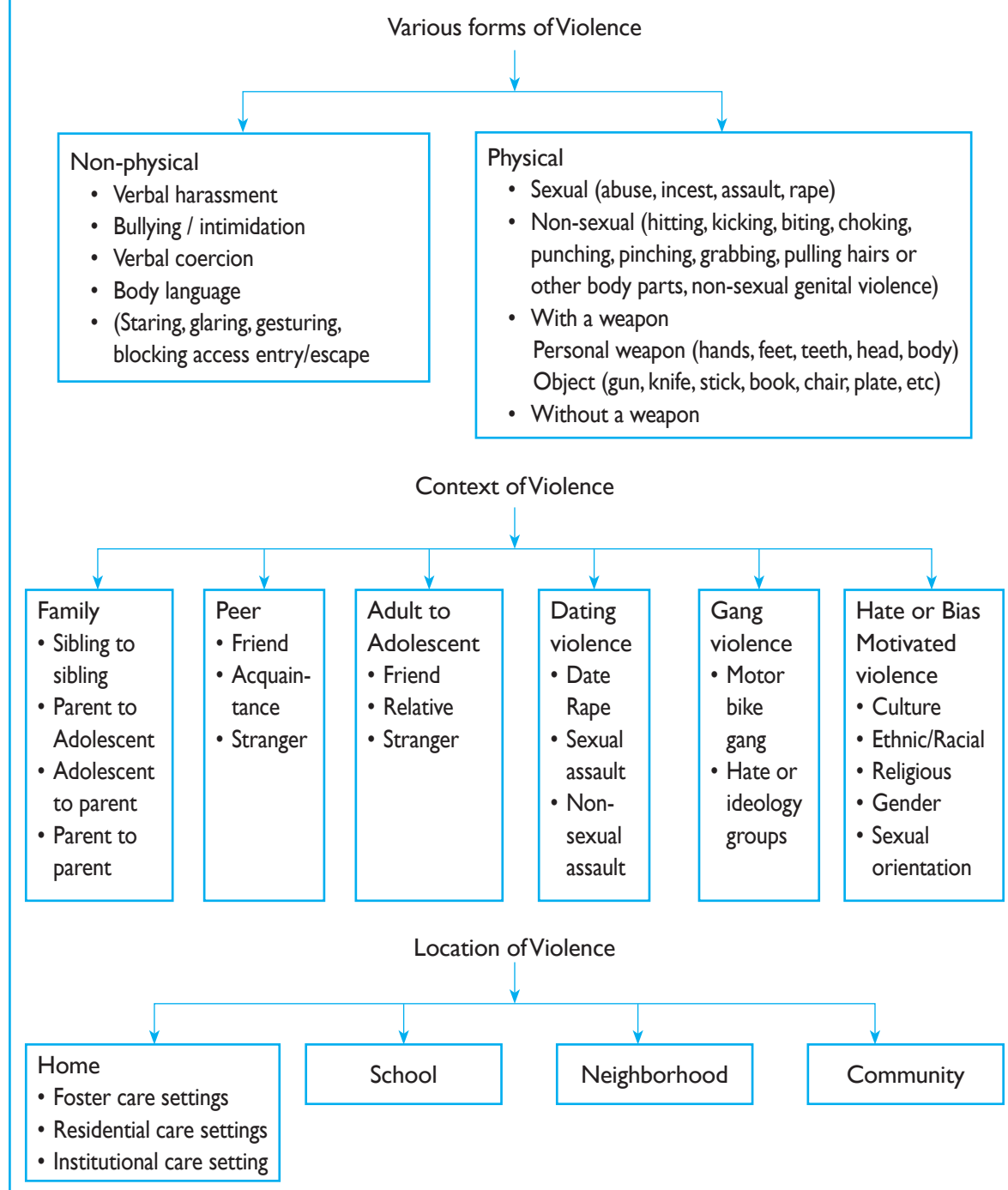
Violence is a learned behavior and exposure to violence at home teaches adolescent how to use violence to exert social control over others and to resolve interpersonal conflicts. Substance misuse is associated with an increased risk of exposure to violence. Adolescents with mental illness are at risk of becoming violent and adolescents with opposition defiant disorder, conduct disorder or intermittent explosive disorder often resort to heightened aggressive and to have 'killer instinct' to win./ sometimes, this behavior continues on side the sport too. Hate crimes including terror acts are not uncommon and sometimes adolescents are forced to participate in it. Easy access to weapons

including five arms increases chances of violence. Box 2 illustrates some more risk factors.

Violence is often glorified in the entertainment programmes on the television and in the movies. The visual and print media give extensive coverage to incidents related to violence. The children are also exposed to the scenes of domestic and community violence. All these are bound to have its impact on the adolescent minds. On a slight provocation a fight and exchange of abusive language erupts in playgrounds and in the streets.

Usually it is a combination of factors that predict violent behavior. The combination of factors should be looked for both in the adolescent and the adolescent's environment, and only the adolescent's aggressive tendencies should not be blamed.

Box 1: Violence in Adolescents (Adapted from Ref. 4)



Box 2: Factors contributing to violence in adolescence

- Boys
- Out-of-school adolescents
- Broken families
- Unemployment
- Low IQ
- Mass media exposure (modeling)
- Witnessing domestic and community violence
- Gang membership
- Access to weapons
- Belief that violence of aggression is normal
- Alcohol substance use
- Emotional, psychological, or social problems
- Childhood physical/sexual abuse
- Affective states and sensation-seeking behavior
- Uncontrolled anger
- ADHD
- Conduct disorder (CD), Oppositional defiant disorder (ODD), Anti-social personality disorder

Box 3: Factors protecting adolescents from violence

- Good support system in family
- Consistent supportive environment
- Being socially competent being caring for others
- Competent in Life Skills
 - Empathy
 - Critical thinking
 - Decision making
 - Communication
- Impulse control
- Having mental behavioral and emotional flexibility
- High self-esteem
- Ability to plan and set goals
- Belief in futures

Box 4: Predictors of witness, victims and perpetration*Predictors of witness of violence*

- Male sex
- Low maternal education status
- Nuclear family
- Family h/o substance abuse

Predictors of victims of violence

- Female sex
- Low socio-economic status
- Witness of violence

Perpetrators of violence

- Predictors of perpetrators of violence
- Low socio economic status
- Victims of violence
- Low maternal educational status

9.2 Medical officer's Role in Managing Aggression and violence in adolescents.

Medical officers have several roles to play in making a violence free society. MO gets opportunities to intervene at various levels. First, they should equip themselves with skills like patience, problems solving and negotiation skills. MOs should be aware of factors promoting violence and protecting from violence. They should have enough resources in their clinics (information material as given in Annexure)

HEADS screening should include questions about school status, drug use or alcohol use, injuries and fighting. Details of peers and immediate environment at home school and community should be assessed. An ability to initiate and maintain social relationships with age-appropriate friends is an indicator of good psychosocial health of adolescents. If violence is suspected then determine (a) if adolescent was a victim or perpetrator or witness of violence and (b) nature, context, and location of violence. Find out motivators or pre-disposing factors for violence. Assess for presence of any mental health illness. Understand the limitations of health services in preventing violence and involve other agencies like Child Line, Child Welfare Committees and police appropriately. Use algorithm "I have been attacked" in cases of victims of violence.

Encourage parents of 'adolescents experiencing violence' in supportive parenting in the form of effective supervision, setting limits and having consistent behavior by themselves. Parents should encourage, protect and support adolescents in managing their world.

Medical officers can promote protective factors by supporting teachers, counselors and peer-leaders in promoting protective factors in school and community. Life skills education of all adolescents in or out of school is likely to reduce effects of violence on life of adolescents.

10. Specific issues

10.1 Dating violence

Violence during the time spent together with a friend is not uncommon. During HEADS screening questions about friendship and dating should be asked especially on excessive possessiveness, substance use, fights or violence.

Dating violence can take many forms including physical abuse (i.e., hitting, slapping, biting, punching); psychological abuse (for example: constant criticism, threats, insults, emotional outburst, etc), sexual abuse (i.e., unwanted touching, kissing or fondling, sexual intercourse, date rape, use of date drugs to obtain sexual contact, etc).

Parents and teachers are required to teach adolescents about the dating violence and how to cope with it. Parental monitoring is also required. Awareness and educational programs should be organized to create awareness and facilitate learning appropriate skills for dealing with dating violence. The adolescent girls should be equipped with assertive skills required to say “no” to sexual advantages of the boyfriend. Information to be provided to parents and adolescents can be found in Annexure.

10.2 Co-ercion and abuse

Abuse or maltreatment constitutes all forms of physical, sexual and/or emotional ill-treatment, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity, in the context of a relationship of responsibility, trust or power.

Child abuse is widely prevalent irrespective of caste, religion, socioeconomic status, regional, and other factors. While sitting in our chambers we tend to overlook the glaring signs /symptoms of child abuse because of shortage of time but the high index of suspicion should always alert the concerned doctor to look deeper in a sympathetic and child friendly manner and whatever may be the reasons enough time and attention should be devoted on this child.

The role and responsibilities of the attending clinician in cases of child abuse broadly has two aspects; (1) to provide immediate medical care and (2) to ensure the future safety and welfare of the child but most often we either fail or choose to ignore the second aspect because of lack of knowledge / experience of handling such situations or fear of getting involved in the legal situations. But the truth is by avoiding we invite more problems for ourselves and always carry guilt of not acting in a justified manner to save the life /dignity of a child. Use algorithm “I have been attacked” whenever needed.

Immediate goal should be to take care of the medical condition and provide him/her with the best that center can offer. In case of any life threatening injuries, recent sexual assault or potentially grievous injuries police has to informed immediately and meanwhile medical care should be continued and if the child needs to be referred best available first aid treatment should be instituted before transporting the child. In other conditions, depending upon the situation, either the family or the care taker or the child welfare committee of the district or the child helpline (telephone number - 1098) or the NGOs dealing with the welfare of the children can be contacted.

Precautions should be taken while dealing with an adolescent who is likely to be a victim of violence (including sexual violence). A detailed verbatim hand written history taken and recorded separately from the child and the accompanying person including the date, time, place, witnesses, family history, immunization status, behavioral changes, eating habits, socioeconomic background, previous illnesses, psychological background, etc. should be recorded. For medical examination the written consent

from the parent, or the accompanying person, and the child should be taken and the examination should preferably be done by the doctor of the same sex. Diagrammatic representation of anatomical parts and the injuries should be recorded besides performing and recording the detailed general examination. Appropriate samples should be collected depending on the form of violence/abuse. The records should be kept confidential and in a secured place. The cases of sexual abuse should preferably be dealt by the specially trained team. MO should be very well aware of new law POCSO given in Annexure 3.

11. Summary

- Injuries (both unintentional and intentional) have important contribution in morbidity and mortality in adolescents.
- All adolescents should be screened for risk of unintentional injuries, exposure to violence (victim or victimizer).
- Health services and Medical Officers can act in various ways to prevent and control injuries, aggression, and violence in adolescents and in community.
- Care should be taken to follow all rules and regulations while dealing with a victim of violence.
- Involving various agencies (Child Line, Welfare Committees, NGO and Police) should be considered at every level.

12. Further Readings

1. Accidental deaths and suicides in India; 2010; National crime records bureau; Ministry of home affairs, Government of India.
2. World report on child injury prevention. World Health Organization 2008.
3. Global status report on road safety 2013: supporting a decade of action. World Health Organization 2013.
4. Pratt HG, Greydanus DE. Adolescent violence; Concepts for a new Millennium. Adolescent Medicine; State of the art reviews – Hanley and Belfus, Inc., Philadelphia; Vol 11, No. 1, 2000.
5. MunniR, MalhiP. Adolescent violence exposure, gender issues and impact. Indian Pediatrics; 43, 2006, 607 – 612.

13. Annexure

1. Algorithm “ I have been attacked” (See Physician Chart Booklet)
2. Information to be given to parents and adolescent
 - i. Violence and abuse
 - ii. Unintended injuries
3. POCSO ACT
4. Self Assessment Test

Annexure 2: Unintended injuries

Injuries are a leading cause of death and disability among adolescents. Many adolescents die or are seriously hurt as a result of road traffic crashes (including as riders of bicycles and motorcycles, as drivers of cars, as passengers and as pedestrians). Many adolescents also lose their lives through drowning and falls. Injuries can occur anywhere - in homes, places of study and work, on the roads and elsewhere in the community. They can, and should be, prevented.



5.1 Messages for adolescents

There are several things that you could do to reduce the chance that you will be hurt or even killed as a result of an injury:

Road traffic crashes:

1. Learn and respect the traffic rules as a bicycle or motorcycle rider or a car driver.
2. Pay attention to the traffic when you are walking on a footpath or a dirt track alongside a road.
3. When driving a car always use a seat belt. When riding a motorcycle or bicycle, always use a helmet. They may feel uncomfortable and may not look attractive to you, but they can save your life.
4. Both as a driver/rider and as a pedestrian, be particularly attentive when it is dark, or if visibility could be hindered by rain or fog. If available, use bright clothing or reflective materials to alert drivers of your presence.
5. Never drive or ride if you are ill or very tired, or if you have been consuming alcohol or other substances that affect your thinking.
6. Never get into a car or on a motorcycle if the driver/rider has been consuming alcohol or other substances.

Drowning:

1. Learn to swim, if there are opportunities to do so.
2. Avoid getting into water above your waist if you do not know how to swim.
3. Even if you are an able swimmer, do not swim when you have consumed alcohol or other substances.

5.2 Messages for parents

What you should know:

1. You could help your son or daughter avoid injuries by discussing the risks of this with them, and by teaching them how to avoid injuries to themselves and to others.
2. Ensuring that they know how to respond if and when someone is injured - including where to seek help - could save lives.
3. Working with family and community members to make your home and community - including places of study and work - safe, will reduce the likelihood of your son or daughter, as well as others, being injured.

5.3 What you should do:

1. Discuss with your son or daughter, the risks and consequences of injuries.
2. Teach them what they could do to reduce the likelihood of injuries, and how to respond when someone is injured.
3. Clarify your expectations of their behaviour, and provide a good role model through your own example.

Road traffic crashes:

1. Emphasize to your son or daughter the importance of driving safely and respecting traffic rules. Also, ensure that the vehicles they drive are in good condition.
2. Talk to them about the importance of paying attention to traffic as a driver or as a pedestrian, especially when poor light, rain or fog hinder visibility.
3. Talk to them about the importance of not driving/riding if they are feeling very tired or unwell, or if they are under the influence of alcohol or other substances. Help them make a plan for what to do in case the driver of their car/rider of their motorcycle has consumed alcohol or other substances.

5.4 Drowning:

Encourage your son or daughter to learn to swim. Insist that they do not get into water above their waist if they do not know how to swim. Stress to them that they should never swim if they have consumed alcohol or other substances, even if they are able swimmers.

Annexure 3

POCSO Act

As you may be aware, the Protection of Children from Sexual Offences Act 2012 (POCSO) has come into force from 14th November, 2012. The Protection of Children from Sexual Offences Act, 2012 has been drafted to strengthen the legal provisions for the protection of children from sexual abuse and exploitation. For the first time, a special law has been passed to address the issue of sexual offences against children. The salient features of the landmark act are appended below :

1. The Protection of Children from Sexual Offences Act, 2012 defines a child as any person below the age of 18 years and provides protection to all children under the age of 18 years from the offences of sexual assault, sexual harassment and pornography.
2. The Act provides for stringent punishments, which have been graded as per the gravity of the offence. The punishments range from simple to rigorous imprisonment of varying periods. There is also provision for fine, which is to be decided by the Court
3. An offence is treated as “aggravated” when committed by a person in a position of trust or authority of child such as a member of security forces, police officer, public servant, etc.
4. Punishments for Offences covered in the Act are:
 - Penetrative Sexual Assault (Section 3) on a child – Not less than seven years which may extend to imprisonment for life, and fine (Section 4)
 - Aggravated Penetrative Sexual Assault (Section 5) – Not less than ten years which may extend to imprisonment for life, and fine (Section 6)
 - Sexual Assault (Section 7) i.e. sexual contact without penetration – Not less than three years which may extend to five years, and fine (Section 8)
 - Aggravated Sexual Assault (Section 9) by a person in authority – Not less than five years which may extend to seven years, and fine (Section 10)
 - Sexual Harassment of the Child (Section 11) – Three years and fine (Section 12)
 - Use of Child for Pornographic Purposes (Section 13) – Five years and fine and in the event of subsequent conviction, seven years and fine (Section 14 (1))
5. The Act provides for the establishment of Special Courts for trial of offences under the Act, keeping the best interest of the child as of paramount importance at every stage of the judicial process. The Act incorporates child friendly procedures for reporting, recording of evidence, investigation and trial of offences. These include:
 - Recording the statement of the child at the residence of the child or at the place of his choice, preferably by a woman police officer not below the rank of sub-inspector
 - No child to be detained in the police station in the night for any reason.
 - Police officer to not be in uniform while recording the statement of the child
 - The statement of the child to be recorded as spoken by the child
 - Assistance of an interpreter or translator or an expert as per the need of the child
 - Assistance of special educator or any person familiar with the manner of communication of the child in case child is disabled
 - Medical examination of the child to be conducted in the presence of the parent of the child or any other person in whom the child has trust or confidence.

- In case the victim is a girl child, the medical examination shall be conducted by a woman doctor.
 - Frequent breaks for the child during trial
 - Child not to be called repeatedly to testify
 - No aggressive questioning or character assassination of the child
 - In-camera trial of cases
6. The Act recognizes that the intent to commit an offence, even when unsuccessful for whatever reason, needs to be penalized. The attempt to commit an offence under the Act has been made liable for punishment for upto half the punishment prescribed for the commission of the offence.
 7. The Act also provides for punishment for abetment of the offence, which is the same as for the commission of the offence. The Act makes it mandatory to report commission of an offence and also the recording of complaint and failure to do so would make a person liable for punishment of imprisonment for six months or / and with fine.
 8. For the more heinous offences of Penetrative Sexual Assault, Aggravated Penetrative Sexual Assault, Sexual Assault and Aggravated Sexual Assault, the burden of proof is shifted to the accused. This provision has been made keeping in view the greater vulnerability and innocence of children. At the same time, to prevent misuse of the law, punishment has been provided for making false complaint or proving false information with malicious intent. Such punishment has been kept relatively light (six months) to encourage reporting. If false complaint is made against a child, punishment is higher (one year) (Section 22).
 9. The media has been barred from disclosing the identity of the child without the permission of the Special Court. The punishment for breaching this provision by media may be from six months to one year (Section 23).
 10. For speedy trial, the Act provides for the evidence of the child to be recorded within a period of 30 days. Also, the Special Court is to complete the trial within a period of one year, as far as possible (Section 35).
 11. To provide for relief and rehabilitation of the child, as soon as the complaint is made to the Special Juvenile Police Unit (SJPU) or local police, these will make immediate arrangements to give the child, care and protection such as admitting the child into shelter home or to the nearest hospital within twenty-four hours of the report. The SJPU or the local police are also required to report the matter to the Child Welfare Committee within 24 hours of recording the complaint, for long term rehabilitation of the child.
 12. The Act casts a duty on the Central and State Governments to spread awareness through media including the television, radio and the print media at regular intervals to make the general public, children as well as their parents and guardians aware of the provisions of this Act.
 13. The National Commission for the Protection of Child Rights (NCPCR) and State Commissions for the Protection of Child Rights (SCPCRs) have been made the designated authority to monitor the implementation of the Act.

Annexure 4: Self-Assessment Tool for Injuries and Violence

1. Enumerate the types of injuries in adolescents

Intentional

Unintentional

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. How common (%) abuse with sexual intent (atleast once in life) in Indian Children and adolescents?

Boys _____

Girls _____

3. What is the role of health services in protection of adolescents from injuries and violence?

Handout VIII

Common issues in adolescents

CONTENTS

1. Introduction
2. Adolescent with school problems
3. I have abdominal pain
4. I have a headache
5. I have a skin problem
6. I cannot see very well

1. Introduction

Adolescents commonly presents with problems related to school and academic performance, headache, pain in abdomen, skin problems, and difficulty in vision. At times, adolescent may not have any physical disease related to these presenting features and various psychosocial problems can present with one or more of these symptoms. Several of these symptoms may arise because of scholastic performance of adolescents which may not be as good as desired by adolescents, their parents and teachers. Such adolescents may present as poor scholastic performance. Hence, it is very important to differentiate between psychosocial issues and physical illnesses for appropriate management.

This chapter includes clinical approach on the following issues:

- I have problem related to school / studies
- I have abdominal pain
- I have a headache
- I have a skin problem
- I cannot see very well

The last four algorithms are included in Physician Chart Booklet.

2. Adolescent with school problems

Very often an adolescent presents with falling grades / marks in school, under achievement, refusing to attend school, etc. Parents and teachers complain of adolescent having poor attention in class, day dreaming, disrupting the classroom, frequently truant, and using drugs or alcohol in school.

Such adolescents may have one or more of a number of causal factors (Table I) alone or in combination. Finding real problems and managing them provide challenges. This algorithm presents a simple method of evaluation of such an adolescent and suggests treatment modalities.

Step 1

Establishing rapport with an adolescent who has been branded unsuccessful or failure by parents and teachers will be difficult but it is the most important first step. These adolescents may be resentful and uncooperative in the beginning but will follow the instructions if faith “that you are to help him” is established.

Begin the evaluation by giving more importance to adolescent and take a thorough history using HEADS. This may take one or more sessions. Parents and teachers can add more information to the history, but later and separately.

Table 1. Causes of school problems in Adolescents

1. Physical Illnesses <ul style="list-style-type: none"> • Deficits in vision • Deficits in hearing • Chronic illness • Neurologically derived problems <ul style="list-style-type: none"> - Delayed development - Learning disorders (Dyslexia, dyscalculia, dysgraphia) - Delayed cognitive maturation - Temperamentally difficult child 	2. Mental Health Issues <ul style="list-style-type: none"> • Depression • Anxiety Disorder • Oppositional Defiant Disorder • Conduct-Disorder • Bipolar Disorder • Psychosis
3. Psychosocial Issues <ul style="list-style-type: none"> • Adjustment Reaction (intra family conflict, stressful adolescence, conflict with close friends, recent or imminent loss, actual or possible pregnancy or paternity) • Drug or alcohol use • Juvenile delinquency / gang membership 	4. Other issues <ul style="list-style-type: none"> • School Derived problems <ul style="list-style-type: none"> - Poor training / education in earlier classes - Troubled class with overcrowding and large number of unmotivated students.

Step 2

Knowing adolescent's point of view is the next goal those adolescents would do better if they could somehow find a way to solve their problems. They generally have a self-justifying defensiveness and getting past this is essential in the beginning.

Begin by reasoning that you are genuinely interested in helping them to do better in school and life. Ask what is going on at school and what is his or her point of view about the issues. Empathic projective techniques are fruitful in breaking the ice.

Step 3

Parents' and teachers' views are also equally important. Interview parents separately. Reconfirm the information provided by adolescents. Do maintain adequate privacy and do not disclose any sensitive information to parents unless it is very necessary to avoid harm to adolescents.

Step 4

Perform physical examination to rule out any physical illness. Look for vision, hearing and neurological signs. Depending on the information obtained laboratory investigations may be done. However, these will be required very infrequently.

Intelligence and mental screening is an important part of the evaluation of an adolescent with school problems especially with poor academic performance. Several check lists are available for use (ADHD checklist, Mental Health Checklist (PSCY), KSCH Adolescent Health Checklist, etc.). Specific tests for intelligence; self-image, developmental delay and perceptual dysfunction (Draw-a-person test); and for reading, writing and arithmetic skills. Use of tests also depends on availability and expertise of person (Counselor).

Step 5

Compiling the information

It is not easy to find all issues or real issues behind school problems. A systematic approach is needed to summarize the issues identified in above steps.

A. Assess Manifestation <ol style="list-style-type: none">1. Poor academic performance2. Underachievement3. Non participation / not going to school4. Unruly or aggressive behavior5. Truancy, etc	B. Assess Academic Information <ol style="list-style-type: none">1. Evaluate annual and other report cards2. Teachers' comments3. Report of other educational activities, IQ tests4. Report of school counselor (if any)
C. Acute adjustment reactions <ol style="list-style-type: none">1. Recent change in school2. Parental discord or dysfunctional family3. Recent loss: Death, divorce, breakup of important relationship4. Moving home5. Actual or feared pregnancy or paternity	D. Identify nature of problem <ol style="list-style-type: none">1. Academic2. Classroom behavior3. Truancy4. Physical illness (Missed school due to illness)5. Mental illness (ADHD, Developmental delay, learning disorders, seizure disorder etc.)6. School policies related issues7. Behavioral conflict with peers, teachers, parents8. Anger/defiance9. Depression, substance abuse10. ADHD

Step 6

Managing adolescents with school problems

It is challenging to manage an adolescent having school problem(s). Clinician should ascertain whether this is a problem continuing from childhood or a new one, and should identify all the issues whether physical, mental, behavioral, socio-economic environmental or school policy related. Detailed description of these issues is out of scope of this manual. However, some basic guidelines are presented here.

1. All concerned parents, teacher, counselor, etc) should ascertain an attitude of patience, empathy, understanding, and encouragement.
2. Acknowledge even smaller steps of achievements, and celebrate small successes to enhance adolescent's self-esteem and confidence.
3. Have faith in his or her ability to succeed.
4. Counsel for better study skills and habits
5. Improve non-academic environmental stressors at home or school or neighborhood.
6. Family therapy to address parenting issues and family conflicts
7. Treat physical or mental illness adequately
8. Improve learning environment by open schooling, distance learning, etc.
9. Counsel for managing emotional sequelae of poor academic performance.
10. Consider modification of education environment like change of school, if necessary.

2.1 *Specific issues*

2.1.1 *Learning Disorders*

Children with learning disorder may have difficulty in reading (dyslexia), mathematics (dyscalculia), or written expression (dysgraphia). They perform at levels well below the level for age, schooling and degree of intelligence. The mechanisms behind these problems are not well understood. It is estimated that nearly half of chronic underachievers at school have one or other learning impairment.

These children often have co-morbid conditions like ADHD, oppositional defiant disorder, conduct disorder, depression, anxiety, poor self esteem and learning difficulties. Use appropriate algorithm to manage these conditions.

Learning disorder should be suspected whenever parents/teachers (and adolescents) find that reading (maths and writing) has always been a problem even in primary school, despite normal or near normal Intelligence Quotient. Detailed psycho-educational testing is needed to find specific areas of disability such as phonological processing, word reading, memory, vocabulary, spelling etc. Psychologists / counselor who specialize in the area can perform these evaluations. Special educational programs (remedial teaching) are needed for these adolescents. Certain school provides these facilities. Education boards provide extra time and / or 'writer' during examination.

2.2 *Maturational cognitive Delay*

We have studied the psychological development of adolescents and know that process of thinking changes during this period from 'concrete thinking' to 'abstract thinking' around the age of 12 years. However, nearly 1/3 of adolescents do not develop this ability. Abstract thinking is needed in past-primary classes especially when algebra is introduced and examinations / tests use abstract thinking in interpretation of provided situation or facts. Students continuing to be concrete thinker find it difficult in 'middle classes' and their performance fall. They generally have good psychosocial functioning and have no co-morbid mental health issues. This is a normal development variant and appropriate modification in school program (basic rather than advanced course, tuitions, parental assistance with home work etc) and vocational training rather than chasing higher education will be beneficial. These adolescents need support from parents and teachers rather than comments like being lazy or other demeaning comments.

2.3 *Developmental Delay*

Developmental delay often becomes obvious during early school years. Sometimes mild or borderline (IQ 70-85) may not be noticed until secondary schools where more 'abstract thinking operations' are required. Such children often try to compensate this limitation by being truant or by other dysfunctional behavior. These adolescents often become member of unruly gangs or remain isolated and depressed.

These adolescents find their school work extremely difficult and parents / teachers opine that despite trying hard these adolescents do not perform up to the expected levels. IQ testing reveals low scores in all subtest units. Treatment options include tailor-made educational program matching with adolescent's abilities and supportive counseling for promoting a sense of competence and self-esteem by building on strengths. Appropriate vocational training is likely to help. Medical officers should help these adolescents and parents in finding such schools and NGO who can support these adolescents.

2.4 *Problems derived from schools*

In some cases school itself is responsible for poor (less than expected) academic performance of an adolescent. A large number of students per classroom, inexperienced less motivated teachers, higher proportion of unenthusiastic and unruly students make it difficult to have a class-room environment suitable for good learning. Very often school authorities put restrictions or take disciplinary actions in authoritarian ways. At times these actions further worsen the situation. A change to a better school, maybe in a different-locality may be helpful. Although, we must ascertain that the adolescent has no inherent problems as described earlier.

Conflicts with teachers or fellow students can also lead to under achievement. Not all teachers are good in teaching or in inter-personal relationships. Complaints of inattention in class should be looked into from the perspective of deficiency in adolescent and teacher as well. With such a teacher, students may have to learn to respond in a manner different than confrontation, power-struggle and self-justification. At times there may be some students bullying others. Such bullies may extort money and other property and may be abusive and assaultive. A change of school should be considered in such situations.

A word of caution, at times the patient / adolescent may behave like a scapegoat, selectively become center of teasing and other persecution. So, when class and school are found satisfactory and not many students have complaints then this tendency should be evaluated. Counseling is required to address psychopathology of adolescent.

Sometimes, change of school because of family moving to a new city / area can be the cause of under-achievement. Adolescent may find himself / herself in a demanding school with well performing students, or amongst the students not matching the socio-economic status. Such students need counseling for understanding the situation, encouragement and appropriate direction. Parents too should understand the situation and should extend all the support. Vocational testing or aptitude testing and career planning are often useful.

2.5 *Frequent absenteeism from school*

Academic achievement depends on academic opportunities provided to a student. When a student is not exposed to a good curriculum or learning methods, student may lag behind. This situation may arise because of non-availability of school (good schools) or frequent moves of the family and change of schools. Other intelligent adolescents might not be sent to school because they have to help parents at home or have to work for earning livelihood to family. Sometimes, frequent illness or a chronic illness may compel a student for frequent absenteeism.

Students with such problems from early school days are difficult to manage than the students with recent problems due to acute illness.

Managing such students require more attention to home work and other pending work both parents and teachers. Over whelming study requirements may be staggered and good communication and understanding between student and teacher and parents may be very helpful. Sometimes, counseling by a psychologist is needed.

Some case scenarios are given to illustrate above issues more clearly.

2.6 Case Scenario

2.6.1 Case Scenario

Pavithran 9th std 14yr

- C/o
- Decline in school performance of recent onset – 1yr
- Disturbed sleep
- Sighing frequently
- Increased palmar sweating when writing
- Unable to concentrate on studies
- Decreased confidence in facing exams especially annual exams
- Preoccupied

What are the causes for sudden deterioration in studies?

Child in Std 9 with recent deterioration of school performance indicates a recent event or a recent onset sensory deficit as cause. Sighing and palmar sweating indicate anxiety and preoccupied demeanor and disturbed sleep suggests that she is worried about something and is brooding over it.

There was a history of the father being an alcoholic and wife abuser and the marital discord had worsened over the year. By the third session he expressed desire to confess regarding something that we needed to keep a secret. He had been exposed to a pornographic CD circulation with which he became preoccupied and obsessed. Disciplining at home was lacking and there was no monitoring of his activities.

- Past history; birth history and development normal. No other significant history
- Physical examination. Within normal limits
- IQ was 107
- Assessment showed no features of Learning Disorder (LD)

Follow up—

- Three counseling sessions later boy disclosed reason for distraction
- Exposure to the pornographic CD circle that existed in school
- Intensely pre-occupied with pornography - CD and internet
- Masturbating up to 10-15 times per day
- Could not concentrate on studies, however hard he tried
- Extremely depressed and genuinely wanted to stop
- After getting his permission, parents were informed (it took few more sessions for him to consider telling his parents about this underlying problem)
- They were crest-fallen and just could not believe that this had happened under their noses

A bright student till the 9th Std had deteriorated so much in academics that his very conservative and highly religious parents were at wits end.

- Counseling sessions with the psychologist and their priest helped as the boy was also very cooperative and determined to overcome this major catastrophe in his life
- The school authorities were informed through other sources that pornographic CDs were circulating in school
- Life skill programs which were already in place in that school was strengthened with emphasis on sex and sexuality.

Learning Points

- Sudden deterioration in scholastic performance in an adolescent - consider a recent event as a cause
- Challenges posed to study habits in adolescent by
 - Media violence
 - Pornography
 - Computer – chatting, Orkut
 - Videogame
- Tragic events – loss of close one, marital discord /divorce

- Discord between caretakers, increasing alcohol abuse of father
- Substance abuse
- Sexual abuse
- Exposure to pornography
- Change of medium/school
- Illness of recent onset

Never forget

- Vision/hearing – all children with learning disorder; whatever the age, must have their sensory inputs examined

Depression, anxiety disorder developing at adolescence can cause deterioration in scholastic performance

2.6.2 Case Scenario

Anisha 11 yr – Std IV

- FTND
- No delay in early developmental milestones
- Extremely slow with academic tasks
- Repeated Std III due to difficulty in coping with academic work
- Withdrawn and lacks confidence
- Anxiety and fear of failure
- On assessment
- Poor reasoning ability, short attention span, and poor retention
- Poor motivation and work habits
- Poorly developed language and communication skills; lack of confidence
- Reduced ability to make abstractions
- Poor self-concept; and poor organization
- Lack of academic success, especially in reading; low power of retention and memory
- What do you expect her IQ to be?

Anisha 11 yr

- IQ 79
- She is a slow learner

Also has

- Communication disorder,
- Attention deficit,
- Anxiety disorder,
- Low self esteem

Slow learners

- Not SLD nor mentally retarded
- Below average cognitive abilities
- IQ range of 70 – 89

Slow learners

- Speech therapy by a speech and language pathologist
- Resource room support
- Medication for attention deficit
- Work on strengths
- Involve parents
- Use of educational games, puzzles
- Develop a positive attitude – in child, parents and all caring for child
- Encourage the child to discuss school, daily activity, TV shows she watched, things she had heard, done or planned to do through her daily work to reinforce learning

2.6.3 Case Scenario

Neethu 13yr; std IX

- C/o decline in academic performance since std V
- Hard working but results not consistent with effort
- Slow with tasks – academic and miscellaneous
- Extremely anxious – mortally scared of exams
- Tends to postpone all activities
- Stickler for cleanliness to the extent that she does not allow family to touch her or her clothes
- Spends hours in front of mirror styling hair and enquiring with mother innumerable times about finesse of the style

Assessment of Neethu 13yr; std IX

- IQ (MISIC) – 90

Academic skills assessment

English

- Reading – std IX level
- Spelling – std IX level
- Written expression and reading comprehension – std VII level

Malayalam

- Reading – std VI level
- Spelling – std V level

Maths – std IX level

Assessment of Neethu 13yr; std IX

Imp:

- SLD in writing and reading
- Anxiety disorder
- Obsessive compulsive traits

Management of anxiety

Treatment choices depend on the problem and the person's preference

Medication will not cure anxiety disorders, but it can keep them under control while the person receives psychotherapy

Management of anxiety

If not treated early, anxiety disorders can lead to:

- Repeated school absences or an inability to finish school
- Impaired relations with peers
- Low self-esteem
- Alcohol or other drug use
- Problems adjusting to work situations
- Anxiety disorder in adulthood

Management of anxiety

- Cognitive-behavioral therapy by a clinical psychologist
- Relaxation techniques
- Family counseling
- Use algorithm on anxiety

Handout IX

Sexual and Reproductive Health Concerns of Boys and Girls during Adolescence

CONTENTS

1. Sex & Sexuality
2. Definitions of sexual and reproductive health
3. Promoting sexual and reproductive health of adolescents
4. Menstruation
5. What can health-care providers do to improve adolescents' access to sexual and reproductive health information and services?
6. Annexures

Sex & Sexuality

This module on adolescent sexual and reproductive health provides an introduction to the growing up process of adolescents and addresses issues that concern adolescents on the road to adulthood, which is marked by the onset of puberty. Menstruation and initiation of sperm production are important milestones that result in development of sexual and reproductive capacity of girls and boys respectively. This module addresses the socio-cultural issues related to menstruation and masturbation while dealing with the myths and misconceptions related to them. It also explores the barriers that diminish the access of adolescents to sexual and reproductive health care information and services. This module is the backdrop in which adolescent-friendly health services in the next module are to be contextualized.

Sex

Sex is the biological difference between a man and a woman. The term 'sex' is also used commonly to refer to sexual intercourse.

Sexuality

Sexuality includes the sum total of a person's personality, thinking and behaviour towards sex.

Gender

Is the socially constructed roles and responsibilities assigned to women and men in a given culture or location and the societal structures that support them. Gender is learned and changes over time.

Sexuality means different things to different people. Many people equate mating, being able to reproduce and common sexual behaviour like romance, kissing, physical relations, provocative behaviour, marriage with sexuality. But it is more than this. Sexuality is a very broad term, which includes the sum total of a person's personality, thinking and behaviour towards sex. It includes the identity, emotions and thoughts that a person has and is displayed in the form of actions, relationships and feelings. The negative aspects of sexuality also exist and include sexual coercion, eve teasing, sexual harassment, rape and prostitution.

There are innumerable ways of being sexual ranging from looking at each other to holding hands, going for walks, kissing, fondling etc. Sexual intercourse is just one of the ways but not the only expression of sexuality. Once we understand that having a sexual dimension to our personality is normal, we can build a responsible sexual behaviour.

Sex is a basic drive upon which race preservation and personal happiness depend. If sexuality does not develop and evolve properly, the whole process of growth and development is affected adversely. Suppression of sexuality tends to impair freedom and proper functioning of an individual whereas too much freedom can interfere with normal demonstration of love and affection. Disturbances in sexual development can lead to personal and social maladjustments.

1.1 Sex has more than reproductive functions

It is an important factor in the partnership and bonding between man and woman to lead a happy life. (points given below do not appear very relevant)

- sharing interests and ideas

- mutual acceptance of responsibilities
- self realization
- love

1.2 Human sexuality is also defined as “a function of your whole personality that begins at birth and ends at death”

It includes:

- How you feel about yourself as a person
- How you feel about being a man or a woman
- How you get along with members of the same sex and the opposite sex
- Genital and reproductive processes such as intercourse and childbearing
- Communicating your needs to others and respect the needs of others.

1.3 Sexuality: Some Facts

The sexual and reproductive organs are related but not the same

- Sexual responsiveness exists throughout life
- For a simultaneous orgasm during sexual intercourse the partners have to work together
- The sexual response systems of boys and girls are different
 - Boys may be more responsive to physical stimuli.
 - Male response tends to be quicker but of a shorter duration
 - Girls may be more responsive to emotional stimuli.
 - Female response is often slower to begin but lasts longer

Expression of sexuality is influenced by the gender of a person. Gender influences the traditional roles, reproduction and parenthood, behaviour and interaction with opposite sex, language being used, work and job taken and social roles. Males are under pressure to perform, hide emotions, females are under pressure to have children, be sexually appealing and so on. Stereotyped sex hinders people from developing their natural abilities and personalities. It is best to take people as persons rather than “boys” and “girls”.

1.4 Sexuality and the adolescent

The adolescent has an awakened sexual drive, a certain restlessness of character; variable moods, difficulty in concentration sometimes decreasing their school performance.

The adolescent does not understand the physiological, psychological, emotional, moral, social and legal consequences of sex. The sex drive in adolescents is usually manifested by sexual attraction having “crushes” on people, hero- worship, dating, going steady and similar behaviour.

The goal of the sex-drive is biological sexual maturity i.e. the capacity to love, mate, reproduce and care for the young ones.

1.5 Sexual changes in adolescents

- Sexual desire increases
- Sexual activities begin
- Start of masturbation
- Heterosexual relations
- Homosexual experimentation
- Tendency to experiment and explore

Change in attitude of others to adolescent sexual behaviour ?

Attitudes may differ between: boys and girls, men and women, older and younger and urban and rural people

A sexually healthy adolescent is one who can:

- Appreciate and take care of their bodies.
- Take care of their reproductive health through checkups.
- Avoid manipulative relationships.
- Identify with one's own values and act in accordance with them.
- Take responsibility for one's own actions.
- Communicate effectively with family and friends
- Negotiate sexual limits
- Accept refusal for sex
- If indulging in sexual intercourse Protect against unwanted pregnancy and sexually transmitted diseases including HIV.
- Seek information, resources and services about sexuality as and when needed.

1.6 Key messages - Summary

- Sexuality includes the sum total of a person's personality, thinking, attitude and behaviour.
- Sexuality is a normal part of human behaviour.
- Sexuality is a positive behaviour and need not be suppressed.
- Individuals are responsible for their own sexual, health and behaviour.

[Reference: 'SHAHN' Safdarjang Hospital Adolescent Healthcare Network, New Delhi]

2. Definitions of sexual and reproductive health

2.1 Sexual health

The term sexual health is used to describe the absence of illness and injury associated with sexual behaviour, and a sense of sexual well-being. Sexuality influences thoughts, feelings, interactions and actions among individuals, and motivates people to find love, warmth and intimacy. It can be expressed in many different ways and is closely linked to the environment in which people live.

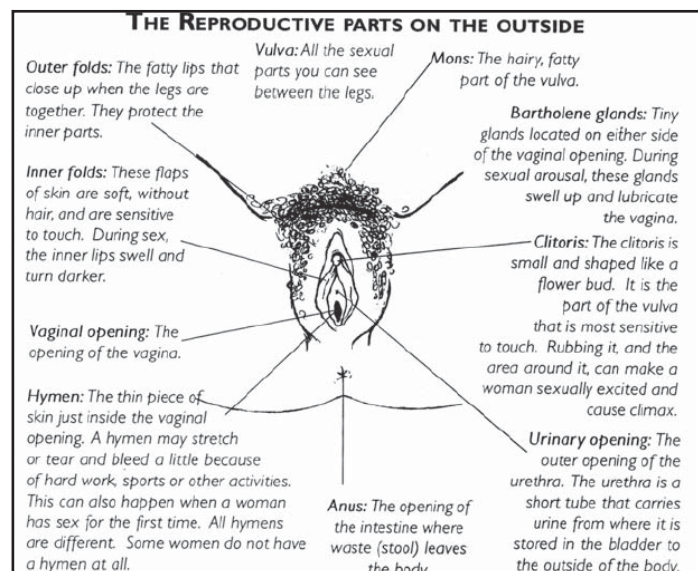
2.2 Reproductive health

Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. 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 adolescent girls and boys to be informed and to have access to safe, effective, affordable and acceptable methods for regulation of fertility which are not against the law, and the right to access appropriate healthcare services that will enable Pregnant adolescents to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

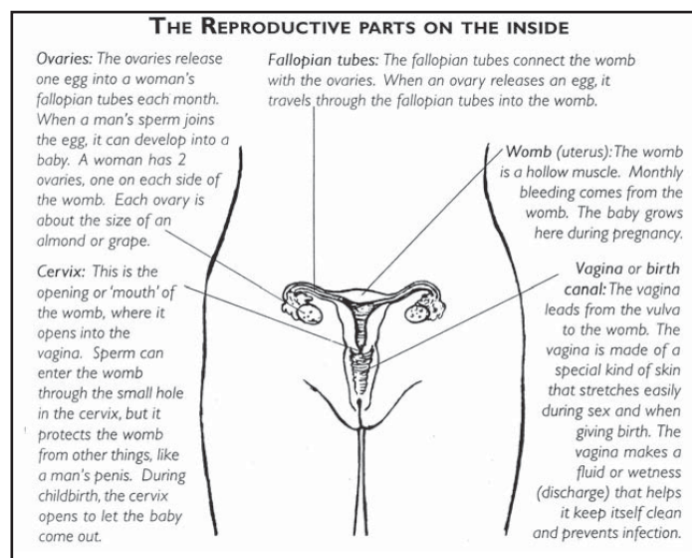
Corrections to be done in the matter written in the pictures given below

Female Reproductive System

External genitalia



Internal genitalia



3. Promoting the Sexual and Reproductive Health of Adolescents

- The concerns of different groups of adolescents may not be the same. For instance, boys and girls, married and unmarried adolescents, urban and rural adolescents may have different issues of interest and concern. The needs of adolescents 13-14 are more regarding pubertal development and menstruation, while those of 15-19 years are more regarding sex, pregnancy and contraception.
- Understanding what their interests and concerns are, and the underlying reasons for this, may help adults deal with them more effectively.
- Adolescent concerns tend to revolve around the immediate future, while the concerns of adults are for the longer term.
- 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 healthy adolescents stay sexually healthy, and ill adolescents get back to good health.
- As adolescents undergo physical, psychological and social change and development, a safe and supportive environment in their families and communities can enable them to undergo these changes in safety, with confidence and with the best prospects for health and productive adulthood.

It is worth stressing that adolescents are a diverse group. For example, a boy of 12 is at a very different stage of personal development than a boy of 18. Similarly, he is different in psychological and social terms from a girl of 12, in addition to obvious physical differences. Social circumstances can influence personal development; for example, the health and development of a boy of 12 who is part of a caring 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 a different pace. 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. The needs of those faced with unwanted pregnancies or infection, or those who have been coerced into sex are different. 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 needs.

4. Menstruation

Menstruation is a natural body process. Menstruation is a sign that her reproductive system is healthy and functioning well. The age for menarche or onset of menstruation has a wide range of normalcy. The age of onset of menarche is declining. Onset of menstruation before 10 years or the absence of menstruation after 16 years in a girl needs to be investigated. These girls are likely to be normal, but must be seen by a Medical Officer or lady doctor to rule out any serious problems.

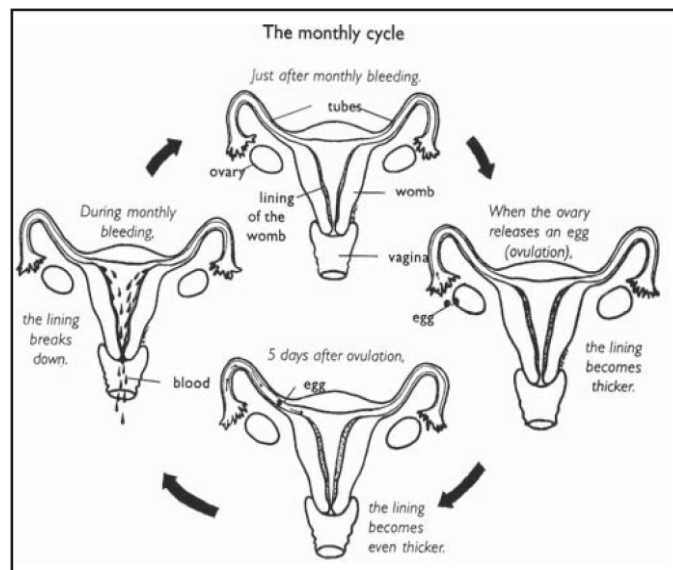
The periods usually last 5-7 days \pm 2 days but may be longer or shorter in some. A girl loses about 50-80 ml blood on an average during a period. She soaks about 3-4 pads/day in the initial 2-3 days.

It is usual that during the first few years after initiation of menstruation, the girl may skip a few cycles. This should not be of much concern unless the girl is sexually active when she may be at risk of pregnancy or she has a very heavy bleeding after missing her menstrual cycle.

It is important to talk about this normal body function since a significant number of adolescent girls have concerns related to the menstrual cycle, most of which require only reassurance or counselling. Also a number of myths and misconceptions in the society have led to it being perceived as something, which is unclean. Many traditional cultural beliefs and practices, which are followed even today, may harm the growing girls.

4.1 Menstrual Cycle

Menstruation is the periodic shedding of blood and tissue from the female reproductive organ called the uterus. Each month an egg (ovum) matures in one of the ovaries under the influence of hormones. This travels through the fallopian tubes to the uterus. The uterine lining becomes thick as a preparation of the uterus for receiving the fertilised egg (which grows into a baby). This can happen if the egg meets a sperm. If the egg does not get fertilised by sperms, the inner lining of the uterus begins to break away. It is this lining which flows out like menstrual blood. This cycle is repeated every month and has a duration of about 28 days ± 2 days. Average duration of bleeding is 4 to 5 days and estimated blood loss is between 50-80 ml in each cycle.



Menstrual Cycle

4.2 Common Concerns and problems related to menstruation

Irregular periods

It is possible that during adolescence, sometimes a girl may only bleed every few months, or have very little bleeding or too much bleeding. Their cycle usually becomes more regular after about 2-4 years once the hypothalamic pituitary axis becomes mature.

What can you do

- Reassurance to such girls or/and their mothers is sufficient if bleeding is not very heavy.
- If the problem continues or the bleeding is very heavy, she should be referred to a lady doctor for investigations and treatment (Ref. to Algorithm).

Pain with menstrual bleeding:

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

What can you do:

- Reassure the girl that the pain will be relieved spontaneously in a day or two. In case it is unbearable she can take some pain killer
- Counsel her to keep doing her daily work, exercise and walk.

Pre-menstrual Syndrome:

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

- pain in breasts
- a feeling of fullness in the lower abdomen
- constipation
- emotions that are especially strong or hard to control.

What can you do:

- Reassure the girl that these symptoms will go once her periods start.
- Counsel her to continue doing her regular work and exercise.

4.3 Hygiene and cleanliness during menstruation

To maintain menstrual hygiene, girls can use either a clean cotton cloth or sanitary pads with the undergarments to soak menstrual blood. Cotton has a good absorbing capacity. A synthetic cloth should not be used as it may not absorb well and may cause skin reactions.

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

If pads are used, they should be wrapped in a paper bag and disposed. The girl should take a bath every day during menstruation. Lack of menstrual and personal hygiene may cause vaginal discharge, burning during urination and genital itching in girls.

Maintenance of menstrual hygiene is very important for a girl to protect herself from infections. But it is equally important for girls to have a feeling of well-being even during periods and not see them as a monthly punishment or sickness.

4.4 Frequently Asked Questions (FAQs)

- **My periods are not regular. Why?**
Periods in the first few years after menarche may be irregular. This does not indicate any abnormality. She needs to be reassured and told that it will normalise in the course of a few years. Emotional stress because of the menstrual cycles itself or otherwise needs to be addressed. The cycles are more likely to be longer than a month but in a few cases they may even be shorter or have no fixed pattern.
- **What if there is excessive or prolonged bleeding?**
Sometimes adolescent girls may experience heavy bleeding when she needs to use more than 3-4 pads/day, or has passage of clots or it may last for a longer duration than the normal 5-7 days. This is likely to normalise as the cycles become regular and are accompanied by maturation of the egg. Excessive loss of blood may lead to anaemia which can be prevented or treated by dietary counselling and iron supplementation. Treating worm infestation in case it is a common problem in that area can help in preventing aggravation of anaemia. This may need referral for medical checkup by a gynaecologist (Ref. to Algorithm). "I bleed a lot during my periods."
- **Is scanty menstruation a matter of concern?**
The amount of bleeding varies from girl to girl. Even a lesser menstrual flow is normal especially if it is regular in occurrence and is not associated with any other problem. Reassuring the girl about her fertility is important.
- **How do I handle discomfort?**

Young adolescent girls may face a few symptoms during menstruation which make her uncomfortable. The usual complaints are:

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

Weakness, feeling of exhaustion, tiredness and headache may be due to lack of proper nutrition and anemia. Since adolescent girls are growing they need a nourishing diet, especially rich in iron, to make up for blood loss during menstruation. Lack of iron intake/absorption leads to anaemia. For pain during menstruation drugs like mefenemic acid, aspirin or paracetamol can be given 2-3 times a day during periods and the girl can be told the name of the drug so that she can procure it. Itching may be due to lack of cleanliness. Daily bath and maintaining hygiene and use of clean clothes should be encouraged. Explanation that menstruation is a normal physiological process, correction of constipation, advice to carry out physical exercise and reassurance are important aspects of management of menstruation related problems. If the pain interferes with the daily routine of the girl and is not improving with the above mentioned measures she should be referred to a doctor.

- **Why do I feel so low?**
Seven to ten days before menstruation girls may experience irritability and restlessness. Most girls will benefit by reassurance, regular exercise and emotional support. Severe cases may need treatment and should be referred to a doctor.

- Can I become pregnant?

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

In some parts of our country, girls are married before menarche and as soon as they attain menarche, the marriage is consummated and they are expected to bear a child. This may not happen, as the earlier cycles are not producing a mature egg. The family of the married adolescent and she herself will need reassurance and counselling to tackle infertility related social pressures

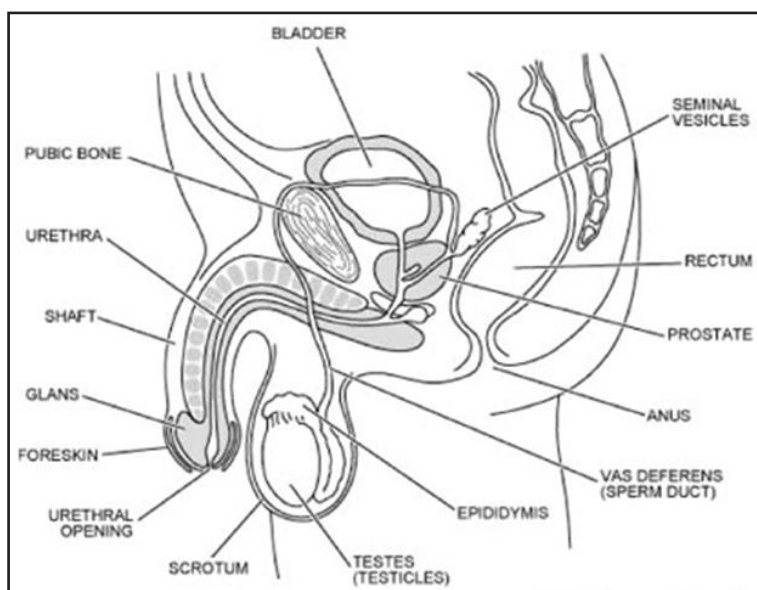
- Is it normal to have discharge from the genital tract?

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

Male Reproductive System

The Male genital tract is designed to

- Produce and store sperms
- Release sperms



- Add regulatory components and fluid to sperm
- Produce testosterone (male sex hormone)

4.5 The sequence of events in Sperm Formation and Ejaculation

Sperm spend their life in the male body in a continuous series of tubes much like the plumbing (water pipes) in a house. Spermatogenesis occurs in the testes after which the full formed sperm leave the seminiferous tubules to enter the epididymis where they remain stored until the appropriate moment. Certain secretions are released in the epididymis that alter the sperm's environment and its surface characteristics, among other things. In preparation for ejaculation, the sperm leaving the epididymis

enter the vasa efferentia. The sperm move along each vasa efferentia and enter the vas deferens. As the sperm move along the vas deferens certain secretions are added to the sperms and to the extracellular fluid (forming semen) that surrounds them. The prostate gland and seminal vesicles add fluid and nutrients at the time of sperm ejaculation providing most of the volume of the ejaculate. This complex of fluid and sperm cells (semen) travels up the urethra to be released externally through the penis.

Glands and Secretions

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

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

Testosterone secreted by testes is responsible for development of male secondary sex characters and desire to have sex and attraction towards opposite sex.

Night Falls or Wet Dreams

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

Counsel about hygiene in boys

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

4.6 Masturbation

Masturbation is stimulation of sexual organs - penis, vagina, breasts to derive sexual pleasure without penetrative sex. Both boys and girls (men and women) can relieve sexual feelings and experience sexual pleasure through masturbation. There are a lot of myths and misconceptions related to masturbation and night fall.

Myths about Masturbation and Nightfall:

1. Myth: Most boys masturbate, but very few girls masturbate.
Fact: This is not true. It is natural for both girls and boys to masturbate.
2. Myth: If an adolescent boy masturbates too much, his adult sex life will be affected.
Fact: False. Masturbation does not affect sex life.
3. Myth: Most people stop masturbating after they get married.
Fact: False. People may or may not continue to masturbate after marriage. It is quite normal. They may feel the need to masturbate when the partner is away or is unwell.

4. Myth: People who masturbate too much are tired and irritable most of the time.
Fact: False. Irritability and tiredness are not increased by masturbation.
5. Myth: Masturbation is considered more acceptable today than it used to be.
Fact: It is true that masturbation is more accepted now than before. Still, it is common for people who masturbate to feel guilty about it. It is unnecessary to feel guilty.
6. Myth: Masturbation can cause pimples, acne, and other skin problems in teens.
Fact: False. It has nothing to do with these changes. Acne and pimples are due to oily skin and go away after a few years spontaneously.
7. Myth: Loss of semen during nightfall leads to weakness of body.
Fact: This is normal among adolescent boys. It does not cause tiredness.
8. Myth: People who masturbate too much when they are young may have mental problems when they get older.
Fact: False. Only if they are not aware that it is normal to masturbate, they will develop guilt and mental problems.
9. Myth: Boys with bad thoughts have nightfall and it is dangerous for their health.
Fact: False. It is normal for boys to have nightfall not only in the night but also sometimes during the day while sleeping. The penis may erect without any sexual urge.
10. Myth: If the penis is small in size, the man is impotent and cannot have sex.
Fact: False. The size of the penis has nothing to do with sexual intercourse. Irrespective of the size if the penis does not erect for any reason at the time of sex then it is difficult to have sexual intercourse.
11. Myth: Masturbation results in curvature of penis.
Fact: False. Penis normally may be little bit curved or stand to one side.

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

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

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

Reassurance and counselling to provide correct and complete information about sexuality and growing up process, dispelling myths and misconceptions related to menstruation, masturbation and night fall are critical for the adolescent. Parents, gatekeepers and other functionaries in the community should be involved to communicate with the adolescents and make them feel comfortable and normal. Involving gatekeepers, teachers, Anganwadi Workers (AWW) and peers for counselling adolescents

Annexure I: Situation Cards

Problem Cards	What is the cause of the problem?	How would you deal with it if such a case comes to you?
Kajal is a 14 year old girl. She is worried since she has not started having her periods.	It is not a problem and most probably she will begin having periods soon.	Reassure her, give iron supplement, if needed. Tell her to report if no periods by age 16.
A 13 year old unmarried girl complains of foul smelling vaginal discharge, accompanied by itching in the genital region. Her periods started six months back and she not sexually active	It is a case of infection of the reproductive tract	Give treatment for RTI, counsel about genital/menstrual hygiene
Saroj is 15 years old and has a lot of thin, white discharge from vagina	It is a case of normal white discharge (no infection)	Reassure her that it is normal at this age and is not an infection/disease.
Fatima is 16 years old and has a lot of bleeding and pain abdomen during periods every month. She feels very weak.	It is a menstrual disorder which is common in girls. Her weakness may be due to anaemia because of excessive loss of blood.	Reassure her that it is not a disease, give symptomatic treatment for bleeding and pain, give iron supplement. Counsel her that if she soaks more than 4-5 pads in a day and her bleeding is on for more than 7 days she needs to consult a lady doctor.
Kamla is 15 years old and started her periods 2 years ago. She has not had her period for the last 2 months. She is not sexually active.	It may just be a case of missed or skipped periods	Counsel that girls of her age do miss their periods. She will have her periods spontaneously.

Self-Assessment Tool (SAT)

1. *What problems are caused by lack of menstrual hygiene?*
 - i. _____
 - ii. _____
 - iii. _____

2. *What should be done to remove socio-cultural taboos related to menstruation?*
 - i. _____
 - ii. _____
 - iii. _____

3. *Do you think masturbation is not a safe way to deal with the sexual urges for adolescent boys and girls?*
 - i. Agree, because _____
 - ii. Disagree, because _____
 - iii. Can't Say, because _____

4. *Adolescents can get the information and health services they need*
 - i. Yes, because _____
 - ii. No, _____
 - iii. Don't know _____
 - iv. Not sure _____

5. *What can be done to make information and health services accessible to adolescents?*
 - i. _____
 - ii. _____
 - iii. _____
 - iv. _____
 - v. _____

Handout X

Pregnancy and Unsafe Abortions in Adolescents

CONTENTS

1. Magnitude of Problems related to Adolescent Pregnancy and childbirth
2. Factors Influencing Adolescent Pregnancy and Childbirth
3. Why are Complications More Common in Pregnancy and Childbirth in Adolescents
4. Problem in antenatal, intranatal and Postnatal periods and new born babies
5. Consequences of pregnancy and childbirth in adolescents
6. Care of adolescents during pregnancy, childbirth and postnatal period
7. Prevention of pregnancy in unmarried adolescents girls
8. Medical Termination of Pregnancy (MTP) Act
9. Nature and Scope of Unsafe Abortions in Adolescents
10. Factors Contributing to abortion related complications in Adolescents
11. Diagnosis and Management of abortion related complications
12. Prevention of unsafe abortion
13. Summary
14. References
15. Annexures

Introduction

Introduce the topic to the participants. In India, where adolescent pregnancies are common, health service providers need to be familiar with the risks and complications that such pregnancies are associated with. This module will introduce Medical Officers to the factors influencing such pregnancies and the critical issues involved.

1. Magnitude of problems related to adolescent pregnancy

- 47% of Indian women are married before they attain 18 years of age (NFHS 3)
- TFR amongst 15-19 years is 14% in urban & 18% in rural of the total fertility (NFHS 3)
- Unmet need of family planning in the 15-19 years age group is 27% (NFHS 3)
- 20% of the pregnant girls below 20 years of age have not had antenatal checkup
- 66.2 % of the pregnant girls below 20 years of age have received iron & folate tablets as part of antenatal care
- For a mother <20 of age, 34% of birth were assisted by doctors, 13% by ANMs and 36% by TBAs.
- More than 60% of mothers below 20 years of age had not received post partum checkup
- Maternal mortality due to teenage pregnancy is 9% (2007-2009)
- Still birth, early neonatal deaths and infant mortality is higher in girls aged <20 years.
- Infant mortality and incidence of low birth weight babies is higher in adolescent mother.

Both adolescent pregnancies and birth rates have declined in India over the last few decades but since many adolescents do not have access to contraceptives, the decline has not matched that in developed countries.

Pregnancy-related complications are the main cause of deaths in 15-19 year old girls and maternal mortality among adolescent girls under 18 years is several times higher than in those aged 18-25 years.

Children born to adolescent mothers also face a higher risk of death, especially during the neonatal and perinatal periods.

An important contributory factor to maternal morbidity and mortality among adolescents is their lack of access to safe abortion services with HIV/AIDS being ever increasing danger that sexually active adolescents face.

2. Factors influencing adolescent pregnancy and childbirth

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

- Declining age of menarche – The age of menarche has declined, especially in urban areas.
- In rural areas, marriage still occurs very early for young girls who are then pushed into early motherhood.
- Early initiation of sexual activity is increasing because of influence of media, cross-cultural influences, decreased supervision by adults (nuclear families, migration), more opportunities etc.

- Ignorance regarding sexuality and reproduction – This predisposes married and unmarried adolescents to pregnancy.
- Sexual coercion and rape – This figures prominently in the lower socio-economic strata. Besides pregnancies it can also cause serious physical and psychological consequences.
- Disruption of education – This influences adolescent childbearing as women with little or no education are more likely to become mothers early.
- Socio-economic factors – These factors force young girls into sexual exploitation and prostitution further compounded by lack of access to contraceptive services and inability to correctly negotiate condom use.
- Lack of access to information – It has a significant bearing on early pregnancy and childbirth. Adventurous nature, poor negotiation skills and sexual coercion predisposes unmarried girls to sexual activity and unwanted pregnancy.
- Adolescent pregnancies tend to be higher in areas with the lower contraceptive prevalence. Contraceptive prevalence has increased mostly among older and married women but not among adolescents.
- Lack of access to services – This leads to unwanted pregnancies and unsafe abortions

2.1 Risks of pregnancy in married and unmarried adolescents

- Pregnancy and childbirth carry more risks in adolescents than in adults because the adolescent girl is not yet mature physically and emotionally for motherhood. The risks are high throughout the antenatal period, labour and the postpartum period.
- Babies born to adolescent mothers have a higher risk of being low birth weight predisposing them to higher morbidity and mortality.
- Risk of poor pregnancy outcome is more common in pregnancy in adolescent than adults.
- The highest maternal mortality is in adolescents aged 15 years and under.
- Pregnancy and the responsibility of child rearing reduce the educational and younger employment opportunities ability of the girl.
- Unwanted pregnancy in unmarried girl may stigmatise her leading to poor self esteem.
- Un-intended pregnancy in both married and unmarried girls may prompt them to resort to illegal and unsafe abortions. This is more pronounced in unmarried girls.

3. Why are complications more common in adolescent pregnancy and childbirth?

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

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

The young girl may not be mentally prepared for motherhood with all its added responsibilities, leading to mental health problems like depression.

- Socio-culturally, pregnancy in unmarried girls bears a terrible stigma with the girl not getting required nutrition, rest, antenatal checkup and emotional support.

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

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

3.2 Problem in antenatal intranatal and post natal periods and newborn

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

Complications of pregnancy and childbirth that occur more commonly in adolescents than adults

1. Ante Partum Haemorrhage
2. Anaemia during antenatal period
3. HIV: Higher incidence of mother to child transmission
4. Hypertensive disorders of pregnancy; preeclampsia
5. Higher severity of malaria
6. Pre-term birth
7. Obstructed labour
8. Low birth weight
9. Perinatal and neonatal mortality
10. Inadequate child care and breastfeeding practices
11. Postpartum depression
12. Too frequent pregnancies
13. Anaemia during postpartum period

4. Problems in the antenatal period

Abortion: Higher incidence of abortion specially in unmarried adolescents

Pregnancy-induced hypertension: Studies report an increased incidence of this condition in young adolescents, when compared with older women.

Anaemia: There is an increased risk of anaemia in adolescents because of nutritional deficiencies, especially of iron and folic acid, malaria and intestinal parasites.

STIs/HIV: Sexually active adolescents are at an increased risk of contracting STIs, including HIV infection, owing to their biological and social vulnerability. There is also an increased risk of parent-to-child transmission of HIV in adolescents, because the HIV infection is more likely to be recent, and therefore associated with higher viral loads. The presence of other STIs (syphilis, gonorrhoea and chlamydia) with local inflammation may increase viral shedding, thereby increasing the risk of transmission during labour.

Higher severity of malaria is often seen in first time pregnant women (which includes many adolescents) and is a common cause of anaemia in them. Increasing the risk of intra-uterine death.

4.1 Problems during labour and delivery

Pre-term birth is common in women under twenty years of age because of immaturity of the reproductive organs and social factors such as poverty, at play.

Obstructed labour in young girls (below 15 years of age) occurs due to the small size of the birth canal leading to cephalopelvic disproportion. Lack of access to medical and surgical care can result in complications like vesico-vaginal and recto-vaginal fistulae and other birth injuries like cervical, vaginal and perineal tears and lacerations.

4.2 Problems in the postpartum period

Anaemia is common and further aggravated by blood loss during delivery thereby also increasing the risk of infection.

Postpartum depression and mental health problems are common due to the reasons described above.

Too frequent pregnancies, can occur in adolescents can occur because of the difficulty in accessing reliable contraception.

4.3 Problems affecting the baby

Low birth weight: There is a higher incidence of low birth weight (weight <2500 grams) among infants of adolescent mothers.

Perinatal and neonatal mortality is higher in infants of adolescent mothers, compared to infants of older mothers.

Inadequate childcare and breastfeeding practices: Young mothers, especially those who are single and poor, may find it hard to provide their children with the adequate care, as reflected in their poor child feeding, including breastfeeding, practices.

5. Consequences of pregnancy and childbirth in adolescent girls:

Married	Unmarried
<i>Immediate</i>	
<ul style="list-style-type: none"> • More likely to seek or receive ANC • May get safe MTP services • Ill health or death due to complications of pregnancy, childbirth and post-partum period, especially birth injuries. • Depression due to stress of child rearing 	<ul style="list-style-type: none"> • Less likely to seek or receive ANC • May resort to illegal and unsafe abortions with associated complications • Ill health or death due to complications of pregnancy, childbirth and post-partum period, especially birth injuries. • Guilt and depression due to social stigma
<i>Long term</i>	
<ul style="list-style-type: none"> • Chronic ill health and depression due to complications during pregnancy, childbirth and post-partum period • Marital discord and divorce due to impaired sexual life resulting from child birth injuries 	<ul style="list-style-type: none"> • Chronic ill health and infertility due to complications during abortion • Interruption of education/career

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

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

6.1 Pre-pregnancy Counselling-

- Contraceptive counseling
- Building up haemoglobin
- Folic acid supplementation
- Detection and treatment of pre-existing medical diseases
- Thalassemia screening
- Rubella vaccination

6.2 Early diagnosis of pregnancy

Health service providers and family members in regular contact with the adolescent, have the shared responsibility of creating an environment in which she feels comfortable to share information about her situation, especially if she is unmarried. She may be unaware of her pregnancy because she may not remember the dates of her last menstrual period, or periods may be irregular.

She may even want to hide her pregnancy or seek ways of terminating it. Being aware of these issues, and being on the lookout for the telltale signs of early pregnancy such as nausea will help ensure an early diagnosis of pregnancy so that care is started early and complications are avoided.

6.3 Antenatal care

At least four antenatal checkups are recommended for all pregnant ladies under RCH Programme. This provision must be especially implemented for teenage pregnancies because they need extra care.

Many complications can be detected and avoided if the adolescent is able to access good antenatal

services. Pregnancy-induced hypertension can be easily detected and be managed on an outpatient basis. In case of more serious complications (such as pre-eclampsia, eclampsia, and abruptio placentae), referral to a hospital is essential. Anaemia and malaria too can be detected and treated during routine antenatal care. Screening for STIs can lead to early treatment, if required. Iron and folic acid supplements will prevent anaemia to a large extent. Most importantly, antenatal visits can help identify those adolescents, who are at risk of preterm labour, though interventions to address this are limited.

Antenatal care also provides a valuable opportunity for providing necessary information and counseling to the adolescents especially unmarried girls support that adolescents need. .

6.4 Counseling during pregnancy

Pregnant woman who reaches a health centre has right to information and counseling. Pregnant Adolescence have special needs, questions and health concerns which must be discussed and an opportunity to raise and discuss these issues.

Their needs must be matched with competent and sensitive counseling. The health services available for routine antenatal care and emergency the danger signs they need to be aware of, etc.

Counseling should also include care of the newborn including exclusive breast feeding and prevention of an early repeat pregnancy.

Since adolescents are more at risk of STIs including HIV/AIDS, voluntary counseling and testing services should be made available to them.

Emphasis should be laid on use of contraception for proper spacing of pregnancies

6.5 Management of labour

Even if the pregnancy in an adolescent is uncomplicated normal and labour starts at term, labour should be supervised and institutional delivery must be encouraged.

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

Awareness about transport facilities /referrals should be there.

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

6.6 Postpartum care

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

Contraception: It is very important that too early, frequent and unplanned pregnancies should not occur for the lack of access to the contraceptive services. The postpartum period presents a good opportunity for taking steps towards pregnancy prevention and promoting poor partum

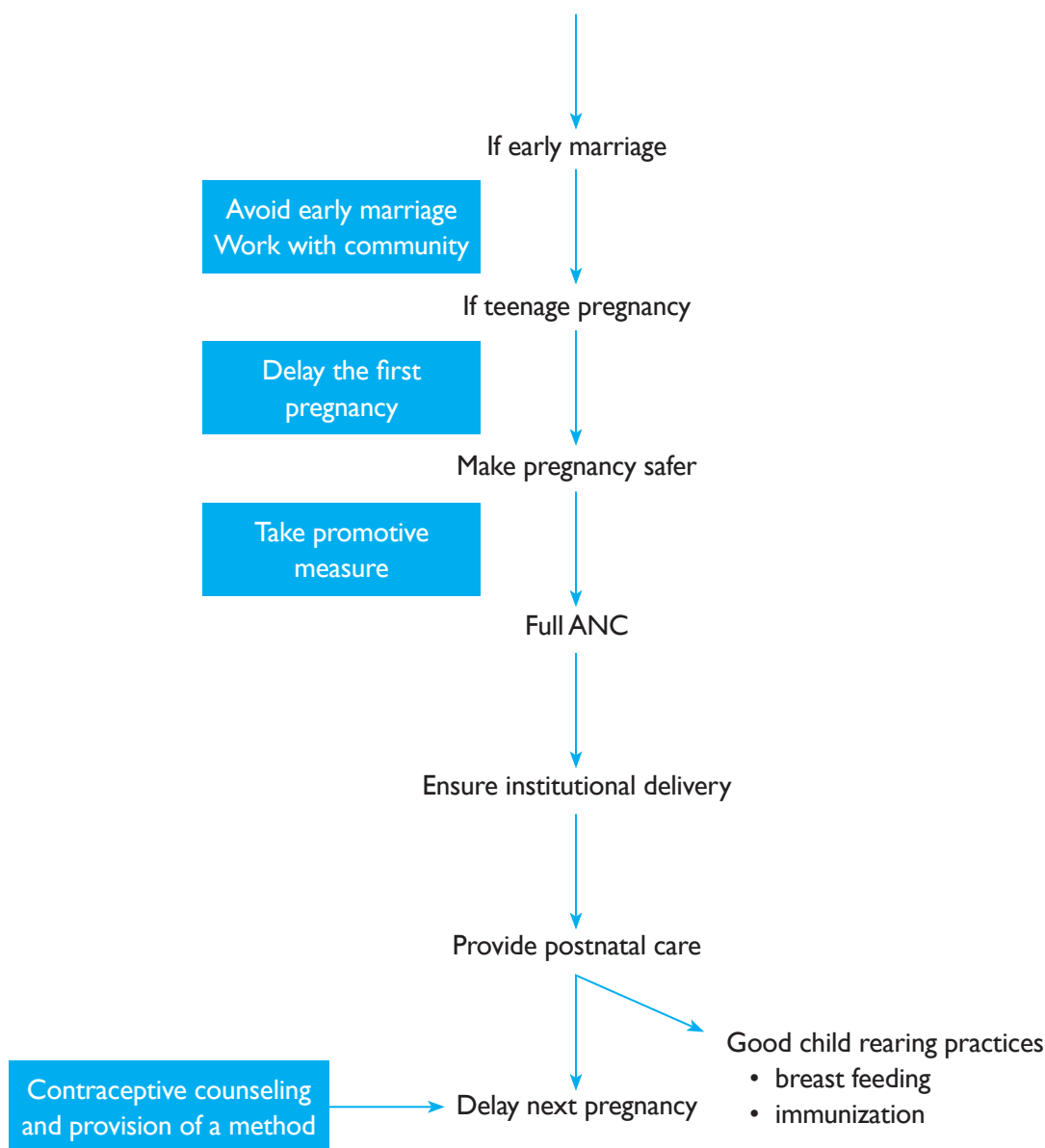
contraception in the form of PPIUCD, condom or other suitable method.

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

Breastfeeding: WHO has made recommendations concerning breast feeding. A young adolescent, especially one who is single - would require extra support in achieving breastfeeding successfully.

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

6.7 Role of the health sector regarding pregnancy in adolescents girls



SUMMARY

1. Adolescent pregnancy is common in India
2. Many factors contribute to adolescent pregnancy
3. Adolescents have higher maternal mortality than adults
4. Their babies also have higher mortality
5. Many of the complications during pregnancy and delivery have worse outcomes in adolescents
6. There are important issues for health-care providers to be aware of in caring for adolescents throughout pregnancy, labour, delivery and the postpartum period
7. Promoting safe pregnancy and childbearing in adolescence requires concerted actions beyond the health sector, like increasing the social and nutritional status of girls and increasing their access to education and job opportunities

7. Prevention of pregnancy in unmarried adolescent girls:

Provide health education

- Information regarding problems of pregnancy in adolescents
- Skills to say 'NO' to sex by creative thinking eg. having periods, ignore; value system of family
- Train boys also to respect the decision of the girl if she says 'NO'
- Inform about contraceptive choices
- Inform about "A B C" strategy ,A-Abstinence, B-Be faithful, C- Condom
- Inform about available services and how to access them
- Inform about dangers of seeking help from unskilled people
- When pregnant discuss about the merits of involving parents/guardians in further management

8. Medical Termination of Pregnancy (MTP) ACT

8.1 Unsafe Abortions in Adolescents

Introduction

Abortion is the termination of pregnancy before the foetus has become capable of sustaining an independent extra-uterine life. In India, termination of pregnancy (spontaneous or induced), before 20 wks is termed as abortion. Abortion can be spontaneous or as a result of outside intervention induced.

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

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

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

8.2 When is MTP permitted?

Since the legalization of abortion in India, deliberate induction of abortion by a registered medical practitioner in the interest of mother's health and life is protected under the MTP act. The following provisions are laid down:

- The continuation of pregnancy would involve serious risk of life or grave injury to the physical and mental health of the pregnant woman.
- There is a substantial risk of the child being born with serious physical and mental abnormalities so as to be handicapped in life.
- When the pregnancy is caused by rape both in cases of major or minor girl and in mentally unbalanced women.
- Pregnancy caused as a result of failure of a contraceptive used in a married couple.

8.3 Who can perform MTP?

- In the revised rules, a registered medical practitioner fulfilling the following criteria is qualified to perform a MTP provided:
 - i. One who has assisted in at least 25 MTPs in an authorized center and having a certificate.
 - ii. One who has got six months house surgeon training in Obstetrics and Gynaecology.
 - iii. One who has got postgraduate diploma or degree in obstetrics and gynecology.
- Termination is permitted up to 20 weeks of pregnancy. In cases of pregnancy exceeding 12 weeks, opinion of two medical practitioners is required.

8.4 Whose consent is required?

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

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

8.5 Where can a MTP be performed?

Termination can only be performed in hospitals, established or maintained by the government or places approved by the government.. These centers could be located in public or private sector.

8.6 The rights of the pregnant woman

- Also, whenever a pregnancy has been terminated, the medical practitioner should record the prescribed information. However, the name and address of the woman, who has requested or obtained a termination of pregnancy, should be kept confidential, unless she herself chooses to disclose that information. The abortion has to be performed confidentially and to be reported to the Director of Health Services of the State in the prescribed form.

8.7 Penalisation

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

9. The Nature and Scope of Unsafe Abortions

In India, though abortion has been legalized since 1971, illegal and unsafe abortions are very common due to various reasons. Safe abortion service should be accessible, acceptable and of quality.

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

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

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

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

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

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

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

9.1 Practice of sex selective abortions is an indicator of gender discrimination and the unequal status of women in society. Overwhelming majority of these abortions are being sought from illegal sources.

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

Reproductive Health communications and education should include specific messages highlighting the importance of girl child, gender equality, the hazards of unsafe abortions and the illegality of pre-selection of sex followed by abortion.

Statutory laws, e.g. the MTP Act (1972) and the PNDT Regulation and Prevention of Misuse Act (1994), need to be strictly enforced. Law-enforcing agencies, in partnership with community-based groups, and social service organisations, should take measures to identify offenders and proceed with a logical follow up in the court of law.

Advocacy initiatives should be aimed to build up alliances among all partners for social mobilization to eliminate this practice and to also facilitate implementation of laws. Professional associations

should be seen as important partners for self-regulation and also bringing peer pressure on those who continue to violate provisions of the Act.

9.2 Factors contributing to unsafe abortions in adolescents

- Fear of social condemnation, especially if unmarried
- Economic factors especially in adolescents both married and unmarried belonging to marginalised section of society and high cost of abortion services in private clinics
- Fear of expulsion from school
- Failed contraception
- Coerced sex (included rape/incest)
- Judgmental and non-friendly attitude of service providers

10. Factors contributing to abortion related complications in adolescents

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

- a. Delay in seeking abortion
- b. Negative attitudes of trained providers
- c. Resorting to untrained providers
- d. Use of dangerous methods
- e. Laws relating to abortion
- f. Service-delivery factors.
- g. Complications following spontaneous abortions
 - a. Delay in seeking abortion is the common cause and most important factor and the commonest cause of complications and death among adolescents. Delay is again due to ignorance (not aware that pregnancy has occurred) or hoping to hide pregnancy till it becomes too late or the costs involved.
 - b. The judgmental and unwelcoming attitude of health providers can also lead to delay in reaching them or force them to seek abortion from untrained providers.
 - c. It is commoner among adolescents to go to untrained and unskilled providers especially when they are unmarried or the pregnancy is unintended and adolescent wants to get rid of it clandestinely (without informing the in-laws). The younger they are, it is more likely that they will be forced to opt for a potentially unsafe abortion conducted in an unhygienic condition by an unskilled provider.
 - d. Use of dangerous methods are also common in adolescents especially unmarried girls who are advised by mothers, untrained birth attendants, quacks, to insert foreign bodies into the cervix un-hygenically or ingest certain potions or drugs.
 - e. There is general lack of awareness among adolescents about the 'Medical Termination of Pregnancy' Services that can be availed of in all District Womens' Hospital and some PHCs. These are however, not used because of the family's need for secrecy and confidentiality and bowing to societal and community demands.
 - f. At present, health facilities do not offer user-friendly abortion services and some are not themselves aware of the rights of clients to these. Most clients feel that privacy and confidentiality is difficult to be maintained in public system.

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

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

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

10.1 Complications due to Unsafe Abortions

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

Complications of abortion in adolescents

Major short-term medical complications:

- Haemorrhage is seen very commonly and is mostly the presenting complaint. It is due to retained products of conception and injuries to the birth canal. It can be fatal. This complication can also result from spontaneous and/or legally induced incomplete abortions.
- Localized or generalized infection.
- Injuries range from genital lacerations to fistulae to perforation of uterus.
- Tetanus can result from the insertion of foreign bodies like sticks, rods or using unsterilized surgical instruments.

Major long-term medical complications are those that happen after a month or more and may leave the girl permanently unable to bear children and carry physical scars for the rest of her life:

- Chronic pelvic infection
- Secondary infertility
- Subsequent spontaneous abortion
- Increased likelihood of ectopic pregnancy
- Increased likelihood of premature labour in subsequent pregnancy

Psychosocial complications:

- Guilt
- Depression

Consequences of unsafe abortions in adolescents

- A. Medical consequences: These include infections which may lead to secondary infertility and reproductive tract injuries:

Medical consequences of unsafe abortion are especially high and more serious for adolescents because of the ways in which abortion is induced and also delay in care-seeking.

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

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

- B. Psychological consequences: These are though not commonly identified or reported, but occur frequently and include depression and withdrawal.

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

- C. Socio-economic consequences: These are very severe when the girl is unmarried and she can be shunned by both her family and the community.

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

The family faces grave economic burden of managing complications of unsafe abortion and is at times, reduced to bankruptcy and ruined.

Medical care costs will severely strain family resources and in the long run, investments made in the girl's education and development are lost.

The MOs should involve community level functionaries and gatekeepers to create awareness in the community regarding facility for Emergency Contraception (EC), early diagnosis of pregnancy, MTP and contraceptive services at PHC level. Stressing that complications and adverse consequences are more in unsafe abortions

11. Diagnosis and Management of abortion related Complications

The diagnosis of post-abortion complications should not differ between adolescents and adult women and history of missed menstrual period(s) followed by an attempt to terminate the pregnancy or spontaneous termination should be sought. The girl is usually brought to the health facility with bleeding from the vagina, purulent discharge from vagina, fever and often in a state of shock.

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

11.1 Compared with adults, adolescents with abortion related complications are more likely to:

- Be unmarried and or from low-socio economic group
- Primigravida

- Have a longer period of gestation at the time of abortion
- Have used dangerous methods to terminate pregnancy or ingested substances that interfere with treatment
- Have been treated by illegal providers
- Visit to the health facility alone or with a friend
- Delay seeking help and therefore have more entrenched complications.

It is important for health-care providers to bear in mind that unwanted pregnancy may not be reported as the real problem, instead some other symptoms may be reported, so should be observe the adolescent's general condition and behaviour should be carefully observed. This will assist in ensuring that the diagnosis of post-abortion complication due to unsafe abortion is not missed. It would be important to engage all the adolescent friendly attributes, employ a gentle, reassuring manner, and to tactfully ask the girl's parents or guardians to wait outside the consulting/ examining room. This will enable the health-care provider to have a private and confidential conversation with the girl.

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

11.2 Principles of management:

- Emergency resuscitation may be necessary as many adolescents presenting 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. 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, intestinal injury, cervical or uterine perforation, evacuation should be carried out as per the standard guidelines for termination of pregnancy.

National guidelines should be adhered to for performing MTP. MTP upto 6-8 weeks of gestation can be performed by trained medical officer at PHC using MVA syringe or medicines. MTP for a pregnancy of more than 8-10 weeks needs to be referred to a CHC.

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

- Management and prevention of further complications such as infection and injury is the need of the hour. Complications are more frequent and more severe in the cases of self-induced abortions or those where foreign bodies have been inserted or the procedure has been done by an untrained person.
- Arrangements for post-abortion care should be thought of since such adolescents usually do not return for follow up. Establishing a good rapport with the patient and attendant/s and providing relevant information will facilitate a repeat visit. The patient must be given information on danger signs to look out for, such as fever and chills, nausea and vomiting, abdominal pain and backache,

tenderness to pressure in the abdomen, heavy bleeding and foul-smelling vaginal discharge. She must also be provided with information on contraception for well-informed decision-making.

- Post abortion contraception counselling is extremely important to encourage the lady and her partner to practice contraception of their choice.

12. Prevention of Unsafe Abortions

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

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

12.1 Improve access to reproductive health information and services

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

12.2 Address laws and policies on access to safe abortion services

Even in our country where abortion is legally available on demand, women (especially adolescents) experience difficulties in exercising their right to obtain these services. The reasons for this include an insensitive environment that cannot ensure confidentiality and non-judgmental behaviour; complicated administrative requirements, etc.

12.3 Train health-care providers in comprehensive abortion care

Health-care providers, both modern and traditional, need to be trained in comprehensive post-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 introduced to the concept of post abortion counselling including contraception. To be able to learn the latter, they need to examine their attitudes and beliefs, in order to prevent their own biases from hindering the provision of care. Clear guidelines need to be issued for the management of post-abortion complications due to unsafe abortion.

Healthcare providers have a very important role to play in the communities they serve in providing safe abortion services to adolescents. First, however, they must overcome the barriers in their own minds about supporting and counselling even the unmarried and girls from marginalized section of society and providing the best technical care they can offer. They must work as 'Change-agents' and involve communities in discussions on unwanted pregnancy, unsafe abortion and its consequences, and the contribution they could make by protecting and safeguarding their adolescents.

12.4 Factors that can help reduce unsafe abortion in adolescents

- Availability and accessibility of contraceptive information and services including Emergency Contraceptives
- Early diagnosis of pregnancy by pregnancy tests so that intervention can be done early

- Availability and accessibility of safe abortion services
- Helpful, friendly and non-judgmental health care providers
- Community norms that permit open and frank discussion with parents and gate keepers about sexuality in adolescents

13. Summary

SUMMARY – Pregnancy in Adolescent girls

- Adolescent pregnancy is common in India.
- Adolescents have a higher risk of poor pregnancy outcomes in the form of illness and death of themselves and their babies, especially in unmarried adolescents.
- Many complications of pregnancy and childbirth have worse outcomes in adolescents than adults.
- Preventive health services should be directed towards:
 - Increasing awareness in the community regarding risks and consequences of adolescent pregnancy and childbirth and unsafe abortions.
 - Making family planning counseling and services easily available to adolescents.
 - Involve other departments to help increase social and nutritional status of girls and increase their access to education/vocational training and job opportunities.
- Curative Health Services include:
 - Providing ANC and promoting institutional delivery and post partum care.
 - Counselling, providing or referring for safe MTP services.
- Despite abortions being legalised in India 4 million women per year still resort to illegal abortions.
- Unsafe abortions are more common in unmarried girls.
- 50% of all maternal deaths in 15-19 year age group are due to illegal abortions.
- Complications due to unsafe abortions are medical and psychological.
- Management of post-abortion complications:
 - Emergency resuscitation and referral to District hospital or appropriate facility with effective treatment even in private sector.
 - Evacuation of uterus in early pregnancy by simple techniques as per Government of India guidelines for MOs at PHCs. Referral to CHC or District hospital if pregnancy 8 weeks or more upto 20 weeks.
 - Management of further complications such as infection and injury.
 - Arrangement of post-abortion care including contraceptive counselling and services.
- Prevention of unsafe abortions:
 - Improve access to reproductive health information and services especially simple and safe MTP services even at the PHC level.
 - Address laws and policies on access to safe abortion services by providing an adolescents sensitive environment.
 - Train health care providers in comprehensive abortion care, and/or counselling for referral to a safe and appropriate facility.
 - Involve inter-sectorial departments and gatekeepers to increase community awareness and reduce stigma associated with pregnancy in unmarried girls.

- Unsafe abortion implies interference of pregnancy by persons without the necessary knowledge and skills, or in conditions that are not conducive to good health. It can be within or outside of the law.
- Adolescents opt for abortions because of socio-cultural and/or socio-economic reasons.
- Adolescents undergoing unsafe abortions tend to be single, pregnant for the first time and usually obtain their abortions later in their pregnancies than adult women.
- They are more likely to have resorted to illegal providers and to have used dangerous methods for inducing abortion.
- They tend to present later, and with more entrenched complications.
- They tend to face more barriers than adults, in accessing and using the health services they need.
- They are less likely to come for post treatment follow-up.
- The management of post-abortion client should include management of complications, post-abortion counselling, addressing contraception and other issues.

References

1. NFHS -3
2. WHO Fourth Edition 2009
3. NRHM guidelines for antenatal care
4. MTP ACT (1971)
5. PC PNDT ACT

15. Annexure I:**Role Play Scenarios****Scenario I**

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

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

How would you handle the situation?

Role Plays**Scenario 2 Unmarried unsafe abortion**

A 17 year old unmarried girl from Rampur walks into your PHC with a friend, looking anxious and disturbed. On examination, you find that she is 7 weeks pregnant. When you ask her what she would like to do with the pregnancy she says that she wants an abortion. You tell her that since she is a minor, she has to tell her family and bring her mother to give her 'consent' for the procedure. She starts crying and saying that her parents would kill her if they came to know that she was pregnant. She begs you to perform the abortion, which you cannot do since there is no adult to give the consent. The friend then intervenes and says that she knows of a local woman in the village who does abortions and that they should go to her instead, since the doctor can't do anything.

What would you, as a Medical Officer, do in this case?

Scenario 3 Unmarried adolescent accompanied by mother to PHC for MTP

Sheela, a 16 year old unmarried girl tells her mother that she has had sex with her boy friend because he was insistent. Now she has not had her periods for the last 2 months. The mother was shocked to hear this and scolded Sheela that she had not done the right thing. She spoke to Sheela's Grandma and got her advice. The Grandma decided to take Sheela to Saroj, the local ANM, for advice. Sheela's mother said that she must inform Sheela's father before going to the ANM. Sheela requests her mother not to tell her father because she fears that her father will beat her. Sheela's mother assures her that her father will not beat her. On hearing the story, Sheela's father was ashamed and angry but accompanied them to the sub-centre. At the sub-centre he requests Saroj to accompany them to the doctor and tells her that nothing should happen to his daughter. Sheela gets proper MTP services at the PHC.

What else will you do to help Sheela for the future?

Annexure 3 Self-Assessment Tool (SAT)**1. What are the most common antenatal complications in adolescents?**

- i. _____

- ii. _____

- iii. _____

- iv. _____

2. In your opinion, what are the most important issues for counseling pregnant adolescents?

- i. _____

- ii. _____

- iii. _____

- iv. _____

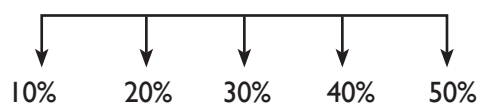
3. What are the critical aspects in caring for the pregnant adolescent in the postpartum period?

- i. _____

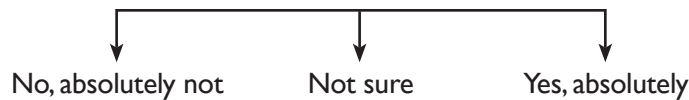
- ii. _____

- iii. _____

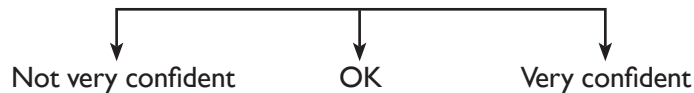
- iv. _____

4. Roughly, what percentage of all maternal deaths are used by unsafe abortion?
(Please mark your estimate with a cross (x) anywhere along the line)

5. **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 cross (x) anywhere along the line)**



6. **How confident do you feel about working with adolescents on the issue of abortion? (Please mark your answer with a cross (x) anywhere along the line)**



7. **A 16 year old girl presents with complications due to unsafe abortion. Which of these best describes how you feel about her situation?**

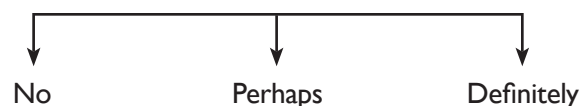
(Please tick () the 3 most appropriate answers)

- i. I feel sorry for her _____ []
- ii. I feel angry with her _____ []
- iii. I feel angry with the man who is responsible _____ []
- iv. I feel we have failed because she resorted to unsafe abortion _____ []
- v. I feel sadness that she didn't use safe abortion _____ []
- vi. I feel pity for the life that has been aborted _____ []
- vii. I feel angry with the person who did the abortion _____ []

8. **As health-care providers, what should we focus on to prevent unsafe abortion among adolescents? (Please tick () the 3 most appropriate answers)**

- i. Improve confidentiality for adolescents seeking abortion _____ []
- ii. Train modern and traditional health-care providers in abortion care _____ []
- iii. Support efforts to provide information about the law to expand access to safe abortion []
- iv. Improve access to safe abortion for adolescents _____ []
- v. Improve provision of contraception to all adolescents _____ []
- vi. Encourage the authorities to stop untrained people carrying out abortions _____ []
- vii. Emphasize abstinence from sex before marriage _____ []
- viii. Encourage adolescents to go through with their pregnancies _____ []

9. **Realistically, is there more you could do with respect to unsafe abortion among adolescents? (Please mark your answer with a cross (x) anywhere along the line)**



Handout XI

Contraception for Adolescents

CONTENTS

1. Why Adolescents need Contraception
2. Barriers to Contraceptives use among adolescents
3. Available contraceptive methods
4. Providing adolescents with contraceptive services
5. Counseling
6. Summary
7. References
8. Annexures

1. Why adolescents need contraception

Contraceptive use among adolescents

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

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

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

2. Barriers to contraceptive use among adolescents

The barriers that adolescents face in accessing contraceptives are:

- The unexpected and unplanned nature of sexual activity
- Lack of information and knowledge about contraceptives and their availability.
- Fear of medical procedures
- Fear of judgemental attitudes of providers
- Inability to pay for services and transport
- 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 general, adolescents lack information about sexuality and specifically about contraception. Health-care providers are unaware and insensitive to the special needs of adolescents. This latter group needs to overcome its own attitudes and moral and tradition-related biases and respond to the special needs of adolescents by designing and reorienting health services to meet those needs.

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

3. Available Contraceptives methods

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

Table 1: Contraceptive Methods

Method	Effectiveness against		Protection against STI/ HIV	Comments and Considerations
	As commonly used	Used correctly and consistently		
Abstinence and non-penetrative sex	Not effective	Very effective	Protective	Most protective method for dual protection but needs to be used correctly and consistently
Male condom	Somewhat effective	Effective	Protective	Provides dual protection when used correctly and consistently.
Female condom	Somewhat effective	Effective	Protective	Provides dual protection when used correctly and consistently.
Spermicides	Somewhat effective	Effective	Somewhat effective	Only provides limited dual protection when used correctly and consistently.
Combined oral pills	Effective	Very Effective	Not protective	Only protective against pregnancy if used correctly and consistently. If at risk of STIs/HIV, recommend switching to condoms or using condoms along with this method.
Fertility awareness based methods effective (Standard Day Method (SDM))	Somewhat effective	Effective	Not protective	Only protective against pregnancy when used correctly and consistently. If at risk of STIs/HIV, recommend switching to condoms or using condoms along with this method.
Lactational amenorrhoea – LAM (During first 6 months postpartum)	Effective	Effective	Not protective	
Withdrawal	Somewhat effective	Effective	Not protective	
<ul style="list-style-type: none"> IUCD (Copper T 380A) CU IUCD 375 	Very effective	Very effective	Not protective	IUCD not first method of choice for nulliparous women. Not recommended for women at risk of STIs/HIV, unless other methods are not available. e
Emergency contraceptive Pills	Effective	Not for regular use	Not protective	Only protective against pregnancy when used correctly and consistently.

3.1 Emergency Contraception

Progestin only OCPs containing the hormone levonorgestrel can be used for emergency contraception. If the correct dose is started within 72 hours after unprotected intercourse, it reduces the chances of pregnancy. Now oral contraceptives are being packaged as emergency contraceptive pills, and levonorgestrel-only tablets are more effective and cause less nausea and vomiting. Emergency contraception has a special role for adolescent girls and women who are subjected to sexual violence, to prevent unwanted pregnancies. There is a need to increase access to ECPs by training

healthcare providers and also by ensuring easy availability of ECPs. All adolescents are eligible for ECP, without restriction on repetitive use.

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

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

4.1 Providing Adolescents with Contraceptive Services

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

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

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

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

5. Counselling

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

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

Counselling should cover responsible sexual behaviour and needs to be directed at both males and females. Male adolescents should be encouraged to share the responsibility for contraception and STI/HIV prevention with their female partners. While adolescents may choose to use any contraceptive method available to them, some may be more appropriate for a variety of social and behavioural reasons. Many of the needs and concerns of adolescents that affect their choice of a contraceptive method are similar to those of adults seeking contraception. For example, using a method that does not require a daily regimen, such as oral contraceptive pills do, may be a more

appropriate choice for an individual.

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

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

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

It is important to remember that even if married, adolescents may have other special information needs. They may be particularly concerned about their return to fertility after discontinuing use of a method. Most women would be under considerable pressure to have children, and thus may want to keep their contraceptive use private from their spouse or in-laws.

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

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

5.1 Sexual coercion

Sexual coercion is the act of forcing or attempting to force someone to engage in any sexual activity against his or her will. The term covers a continuum, ranging from unwanted touching to rape. Typically, sexual coercion is perpetrated by males against females, who are most often adolescent girls and young women.

5.2 Adolescents who are coerced into having sex

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

6. Summary

SUMMARY

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

7. Reference:

"Medical eligibility criteria for Contraceptive use" WHO Fourth Edition 2009

Annexure I: Role-Play Scenarios

Scenario 1

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

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

Scenario 2

Champa, a girl aged 19 and her husband Raghu, aged 21, come to the PHC. They tell you that they have been married for 2 years and that Champa has given birth to a daughter 2 months ago. Champa is breast feeding her and also feels weak. They tell you that they do not wish to have another child for the next 3 years and want to adopt a safe contraceptive method.

- How will you respond to their need?

Annexure 2: Self-Assessment Tool (SAT)

1. Which contraceptive methods should not be used by adolescents?

(Please cross (x) all unsuitable method)

- i. Abstinence _____ []
- ii. Male condom _____ []
- iii. Spermicide _____ []
- iv. Combined oral pill _____ []
- v. Progestin-only injectable _____ []
- vi. Intra-Uterine contraceptive Device (IUCD) _____ []
- vii. Fertility-awareness based methods _____ []
- viii. Lactational amenorrhoea _____ []
- ix. Withdrawal _____ []
- x. Sterilization _____ []
- xi. Emergency Contraceptive Pills (ECP) _____ []

2. Which contraceptive methods are protective against STI/HIV?

(Please write down two examples for each method)

- i. Protective _____
- ii. Not protective _____

3. Which contraceptive methods are available in your PHC?

(Please write down three examples)

- i. _____
- ii. _____
- iii. _____

4. Which contraceptive methods do not require the cooperation of the male?

(Please write down two examples)

- i. _____
- ii. _____

Handout XII

RTIs, STIs and HIV/AIDS in Adolescents

CONTENTS

1. What are Reproductive Tract Infections (RTIs)?
2. What are Sexually Transmitted Infections (STIs)?
3. What are the factors contributing to STIs in adolescents?
4. What are the consequences of RTIs and STIs in adolescents?
5. What are the main factors that hinder a prompt and correct diagnosis and management of STIs in adolescents?
6. HIV/AIDS in Adolescents
7. Annexures

Reproductive Tract Infections (RTIs), or infections of the genital tract can have far reaching effects on reproductive health. Sexually Transmitted Infections (STIs) are one of the most common infections among sexually active adolescents. STIs are an important health problem because they give rise to considerable morbidity. STIs, including HIV, are most common among young people aged 15-24 and more so in young women of that age group. Adolescents today face enhanced vulnerability to HIV/AIDS. The various dimensions of the problems of STIs, RTIs and HIV/AIDS among adolescents have been addressed in this module along with the preventive and management aspects of the problem and how Medical Officers can help adolescents to deal with the problem.

1. What are Reproductive Tract Infections (RTIs)?

RTIs include all infections of the reproductive tract, whether transmitted sexually or not, for example, bacterial vaginosis or candidiasis which are caused by a disturbance in the equilibrium of the vaginal flora or pelvic inflammatory disease caused by iatrogenic infection, e. g. infections introduced to the reproductive tract by improperly managed childbirth or during improper delivery or family planning services, such as IUCD insertion or unsafe abortion or improperly performed medical and surgical procedures etc. These are examples of reproductive tract infections that have not been sexually transmitted. On the other hand, pathogens which are commonly transmitted by sexual contact (Human Immune Deficiency Virus, Hepatitis -B, C, D, etc.) do not always cause an infection of the reproductive tract.

2. 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 also 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 an 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 trichomoniasis, chlamydial infection, gonorrhoea and syphilis. These STIs can be prevented and cured provided that adequate antibiotics are available and standardised treatment protocols are employed. 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 years.

2.1 Symptoms of RTIs/STIs

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

For both adolescent boys and girls	For adolescent girls	For adolescent boys
Genital ulcers (sores)	Vaginal discharge	Discharge from the penis
Burning sensation while passing urine	Pain in lower abdomen	Scrotal swelling and pain
Swelling in the groin	Pain during sexual intercourse	

For both adolescent boys and girls	For adolescent girls	For adolescent boys
Itching in the genital region	Menstrual irregularities	
Perianal soreness or rectal discharge		
Single or multiple papules or warty lesions in genital or perianal area		

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

In today's world, adolescents face heightened risks of exposure to RTI / STIs. In many societies, sexual activity begins during adolescence, either within the context of marriage or before marriage occurs. Sexual relations during adolescence are often unplanned and sporadic or due to pressure, coercion or force. Adolescents start sexual activity before they have:

- Experience and skills in self-protection.
- Adequate information about STIs/RTIs 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 RTI / STIs than adult women because of both biological and social reasons:

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

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

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

3.1 Risk Factors for RTIs/STIs in adolescents

- History of unprotected sexual activity in the recent past
- Partner having sore on the genital region or urethral discharge
- Adolescent girl pregnant or recently delivered (more so, if a home delivery)
- History of recent abortion, spontaneous or induced, especially unsafe abortion

4. What are the consequences of RTIs and STIs among adolescents?

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

Consequences of RTI / 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 by human papilloma virus during adolescence is more likely to result in cancer of the cervix
- Tertiary Syphilis: untreated syphilis can result in heart and brain damage
- Stigma and embarrassment associated with STIs/RTIs can impair psychological development and attitudes towards sexuality later in life
- Urethral stricture
- Death
- Neonatal infections

4.1 Prevention of RTIs/STIs

- Maintaining proper genital hygiene is important. Girls should also maintain good menstrual hygiene
- Practicing responsible sexual behaviour and sex
- Avoiding sexual contact, if either of the partner has an STI
- By not neglecting any unusual discharge and seeking help early
- Ensuring complete treatment of self and sexual partner
- Opting for institutional delivery or home delivery by a trained birth attendant
- Availing safe abortion services
- Awareness generation among adolescents and community
- Improved services: Adolescent-Friendly Reproductive and Sexual Health Services

5. What are the main factors that hinder a prompt and correct diagnosis and management 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 or they do not want to be seen by people they may know or out of fear, of negative reactions from health-care workers.

In many areas, adolescents with RTI/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.

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. RTI/STIs may be asymptomatic, especially in adolescent girls. 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.

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.

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

The syndromic approach can be used for RTI/STI assessment in adolescents because the presentation of symptoms is similar irrespective of age. The approach is especially appropriate where human resources and laboratory facilities are not available for etiological diagnosis. 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 are available for seven syndromes:

Boys	Girls
Urethral discharge	Vaginal discharge
Swollen scrotum	Lower abdominal pain
Inguinal bubo	Inguinal bubo
Genital ulcer disease	Genital ulcer disease

5.1 Key aspects of diagnosis and good management practice

There are certain things that health-care providers need to be aware of and do differently when they are dealing with adolescent patients:

Factors to be considered when treating an adolescent with a RTI/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 with any social implications
- Preventing recurrence of the problem and other STIs
- Tracing and contacting other infected persons

6. HIV/AIDS in Adolescents

HIV stands for:

Human

Immunodeficiency

Virus

AIDS stands for :

- Acquired : Not genetically inherited but get it from some body
- Immuno-deficiency : Inadequacy of the body's main defense mechanism to fight against disease producing organisms
- Syndrome : A group of diseases or symptoms

AIDS results from infection with HIV. HIV gradually destroys the body's capacity to fight off infections by destroying the immune system of the infected person. As a result a routine infection can turn life threatening, as the body is not able to produce antibodies to protect against the infecting organism. The HIV infected person becomes more susceptible to a variety of infections known as opportunistic infections like tuberculosis.

Of the estimated 4 million new HIV infections annually, almost 50% are women and over 40% are young people aged between 15-24 years.

6.1 HIV is transmitted through:

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

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

6.2 A person cannot get HIV by:

- Shaking hands and embracing
- Touching objects in phone booths or public transport
- Shared use of towels, linen, crockery, utensils
- Use of public toilets, swimming pools
- Eating and drinking from the same plate or cup
- Donating blood with new sterile needles
- Mosquito bites
- Caring, hugging, kissing and touching a person with HIV/AIDS

6.3 Risk factors

- Commercial sex work
- Early age at becoming a commercial sex worker
- High numbers of sexual partners
- Unprotected anal sex

- Current or past history of STI
- Early age of sexual debut

6.4 Protective factors that help in avoiding HIV infection are:

- Regular use of condoms
- Reduced number of sexual partners
- Positive relationships with parents, teachers and other adults in the community
- Positive school environments
- Exposure to positive values, rules and expectations

6.5 Biological susceptibility

Biological susceptibility refers to the increased physical risk of acquiring HIV. 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 for the following reasons:

- Immature genital tract in young girls
- Undeveloped genitalia more easily damaged during forced
- STIs, RTIs in sexually active young people
- Female genital mutilation

6.6 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 timing and mode of acquiring infection:

- HIV acquired prior to puberty

Young people who were infected before entering puberty can present with slow skeletal growth and delayed pubertal maturation. This delay in growth and sexual maturation may 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.

6.7 Diagnosing HIV infection

It is not possible to tell whether or not a person has HIV or AIDS by the way he or she looks and acts. Sometimes, it is possible to suspect this infection from the presence of certain symptoms either in isolation or in combination. However, these cannot be relied upon solely for the diagnosis, as they are usually nonspecific and common to other illnesses as well.

6.8 Signs and Symptoms of HIV infection or AIDS:

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

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

Knowing one's HIV status enables an individual to make informed decisions about treatment and care and learn how to avoid passing the infection on to others. Many people infected with HIV have no symptoms and therefore, there is no way of knowing with certainty whether a person is infected except for laboratory test.

ELISA test is the most common screening test used for initial testing. For symptomatic persons, the sample should be positive with 2 different kits and for asymptomatic persons, with three different kits. In case of an equivocal result in asymptomatic person, western blot test is done to confirm the result. Both these tests detect the presence of antibodies against HIV.

Sometimes it is possible to test negative in the very early stages of HIV infection. This period is called the 'window period'. This is because the test is looking for antibodies that have not yet developed. In this case, the test should be repeated after a duration of 3 months. Only a laboratory test can confirm the presence of HIV.

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

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

6.9 HIV prevention in adolescents

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. There is an urgent need for HIV prevention strategies that work for young people. 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. 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.

6.10 Key HIV prevention strategies for young people through health services

Key prevention strategies for young people cannot be the same for all but need to be adapted to the different needs of different groups as for boys and girls, children in and out of school, younger and older adolescents, and married and unmarried young people. These include:

- Information and education on HIV and safe sex
- HIV testing and counseling

- Access to condoms
- Harm reduction for drug injectors
- STI management

6.11 Voluntary Counseling and Testing Center (VCTC) / Integrated Counseling and Testing Center (ICTC)

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

Counseling guidelines clearly state that no HIV testing is to be undertaken without pretest and post test counseling. Therefore, counseling services have to be improved bearing this issue in mind. VCT is the process by which an individual undergoes counseling enabling him or her to make an informed choice about being tested for HIV. This decision must be the choice of the individual and he or she must be assured that the process will be confidential. National guidelines for VCT should be adhered to.

6.12 Benefits of VCTC / ICTC

The potential benefits of VCT are:

- Better ability to cope with HIV related anxiety
- Motivation to initiate or maintain safer sexual practices
- Earlier access to care and treatment
- Prevention of HIV related illness
- Emotional support
- Awareness of safer options for reproduction and infant feeding
- Safer blood donation

6.13 Circumstances in which young people may present for HIV testing and counseling

There are different reasons and situations why a young person may come for testing and counseling:

- **Choice:** the young person makes the decision to come for testing
- **Recommendation:** another person advises, the young person decides
- **Mandatory:** other persons/people make the decision to test the young person

6.14 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) counseling, which is an integral part of all these services.

The aim of services is to help young PLHIV (People living with HIV) to:

- Stay healthy and live positively
- Adhere to care and treatment
- Understand the benefits of disclosing HIV status to family, sexual partner(s), close friends
- Cope with stigma and discrimination towards themselves and their loved ones

(a) Care

Management of HIV is based on medical and psychosocial care in a healthcare setting. The ten principles can be used in managing many diseases, including HIV.

General principles of good chronic care

- Develop a treatment partnership with your patient
- Focus on your patients concerns and priorities.
- Use the 5As –Assess, Advise, Agree, Assist, Arrange
- Support the patients 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

(b) Treatment

Treatment includes antiretroviral therapy (ART), prevention, treatment and care of opportunistic infections and STIs. Treatment also includes management of other chronic conditions (e. g. cancers, depression). 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, and 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 is a lifelong treatment and this creates a challenge for adherence.

(c) Support

Support deals with the emotional, spiritual and material support for young PLHIV, which is often provided by peers, family and community.

- Support may be connected to ART and care
- Support is about assisting young PLHIV to cope with the impact of HIV on their lives on every aspect of life
- Support includes all measures that alleviate the impact of HIV on the young PLHIV, their family and their community.

(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.

An important part of positive prevention is counseling, 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

(e) Counseling

Counseling of young PLHIV concentrates on the emotional, behavioural, and social issues that relate to living with HIV. Counseling often begins with an HIV test result; however, counseling is an essential part of HIV management and care and is much more than explaining to a young PLHIV his/her test result.

7. Annexure I

7.1 Case Studies

Session 3, Activity 2

Case Study 1

A 16-year-old boy is brought to you by his mother. She says that he told her that he had been injured in his groin, playing football with his friends. You notice that the boy is silent and does not interrupt his mother, or add to anything that she says. You tell the mother that you would like to talk to the boy separately. Taking him to another room, you ask the boy what the problem is. The boy is silent. After a few minutes, you gently probe once again. He replies in a low voice and asks you to promise not to repeat anything he says to his mother. . .

- How would you deal with this situation?
- Explain why you have chosen this course of action.

Case Study 2

A 19-year-old boy comes to you with a urethral discharge. He tells you that he has been suffering from this, on and off, for a year. He knows that this is an STI, but does not seem very concerned about it. He says that he has had similar episodes in the past. On enquiry, you learn that the young man is married and has a wife who is 16 years old.

- How would you deal with this situation?
- Explain why you have chosen this course of action.

Case Study 3

A 17-year-old married girl comes to you with her mother. The girl complains of itching and genital discharge for the last 2 months. The girl reveals that her husband works in the city. Her complaint started soon after his last visit to the village a little over two months back.

- How would you deal with the situation?
- Explain why you have chosen this course of action.

Annexure 2:

7.2 Role Play

Session 4, Activity 4

Role Play I

Usha is a 19-year-old girl. She is married and is pregnant for the last 2 months. Her husband is a truck driver in Bombay. He has been sick for the last 3 months complaining of weight loss, loose motions and fever. He has been diagnosed as a HIV '+' case. But he has not disclosed this to his wife and his parents. For the last 2 days he has been having high fever for which he has been brought to a local PHC by his mother and his wife.

- Now as a Medical Officer/ANM how will you deal with this case.

Annexure 3:

7.3 Self-Assessment Tool (SAT)

1. Why are adolescents predisposed to RTIs/STIs?

- i. _____

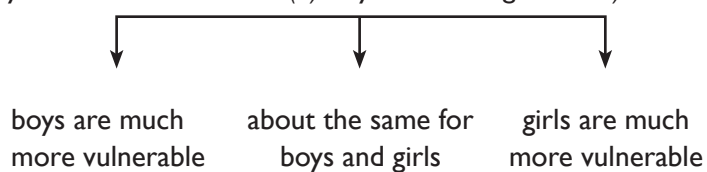
- ii. _____

- iii. _____

- iv. _____

- v. _____

2. Are boys more vulnerable to STIs than girls, in India?
(Please mark your answer with cross (x) anywhere along the line)



3. What factors make adolescents more vulnerable to HIV?

- i. _____

- ii. _____

- iii. _____

- iv. _____

- v. _____

4. *What should Medical Officers do with regard to STI/RTI prevention among adolescents?
(Please tick (✓) three of the most important reasons)*
- i. Stress to all adolescents that they should abstain from sex until marriage []
 - ii. Stress faithfulness to sexually active adolescents []
 - iii. Give condoms and information on how to use them to those who have more than one partner []
 - iv. Make RTI/STI services adolescent-friendly []
 - v. Ensure that all adolescent patients know about RTIs/STIs and all the ways of avoiding them []
 - vi. Make condoms and information on how to use them available to all adolescents []
5. *Factors that hinder adolescents from seeking prompt STI treatment
(Please tick (✓) three of the most important reasons)*
- i. STIs are often asymptomatic []
 - ii. They do not have information about existing services []
 - iii. They do not have money to pay for services []
 - iv. Concerns about confidentiality []
 - v. Fear of stigma and embarrassment []
 - vi. Afraid of being scolded by health-care workers []

Handout XIII

Mental Health of Adolescents

CONTENTS

1. Introduction: The spectrum of mental health
2. Mental health and adolescents
3. Presentation and assessment of adolescent mental illnesses and substance abuse
4. Attitudes towards adolescent mental health and stigma
5. Responding to adolescents with mental illness or substance abuse
6. Promoting mental health in adolescents
7. References
8. Annexure

1. Introduction: The spectrum of mental health

Mental health is defined as: *a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity.* (US Surgeon General Report, Dec 1999)

Mental illness is a spectrum ranging from less serious to more serious conditions. Physical health can affect mental health, and vice versa.

1.1 The spectrum of mental health

The spectrum of mental health ranges from mental wellbeing to diagnosable mental and behavioural disorders that meet specified clinical criteria.

Mental well-being is a state in which the individual can realize his or her potential, cope with the everyday stresses of life, study or work productively, and participate in community life.

The positive dimension of mental health is stressed in the World Health Organization (WHO) constitution, where health is defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. Mental well-being is therefore more than the absence of mental illness and cannot be achieved simply by preventing and treating mental disorders. It is also necessary to promote mental well-being by carrying out activities, providing services and creating environments that promote mental health.

Mental difficulties or problems are ways of thinking, feeling or behaving that impact negatively on an adolescent's quality of life and development. Mental difficulties or problems can be part of normal adolescent development; may be responses to events in the adolescent's life or stressors. Mental difficulties or problems do not meet diagnostic criteria of disorders – they have a different duration, severity and impact.

Mental and behavioural disorders are clinically significant mental health conditions, i.e. those that meet the diagnostic criteria of disorders in the International Classification of Diseases, 10th Edition (ICD-10).

Perceptions of what is “normal” or “abnormal” are determined to a large extent by the social and cultural context. Different ways of thinking and behaving across cultures may influence the way that mental illness manifests and is perceived.

Mental illness encompasses both mental health difficulties or problems, and mental and behavioural disorders. Mental illness is a concept that enables health-care providers to recognize when an individual's thoughts, feelings and behaviours are impacting negatively on their quality of life (e.g. their ability to function normally in their social lives and to study or work) and development.

Mental illness manifests through thoughts, feelings and behaviours of an individual.

- Thinking/thoughts (cognition): e.g. interpreting the words or actions of people as being against oneself.
- Feelings (emotion): e.g. experiencing certain emotions, such as sadness, fear or anger.
- Behaviours (action): e.g. withdrawing from or being aggressive towards others.

2. Mental Health and Adolescents

Adolescence is a time of transition from childhood to adulthood; the period during which a child grows and develops into an adult. The adolescents are also known as teenagers. The majority of adolescents are in good mental health, but the physical, cognitive, emotional, social and sexual changes that occur during adolescence can have impact on their mental well-being.

Mental health is strongly related to other health problems in adolescence, including substance abuse, violence, and sexual and reproductive health.

2.1 Common mental and behavioural disorders seen in adolescents

People who are diagnosed in adulthood with a mental disorder often experience their first episode of the disorder during adolescence. Many of the most serious disorders, such as schizophrenia, bipolar disorder and depression, are identified during the late adolescence or the beginning of adulthood). The pre-existing mental health problems may get worse as the adolescent undergoes this demanding phase of emotional and physical development.

The patterns of mental disorders and their manifestations may be different for boys and girls. These differences relate both to biological differences and to the different roles and expectations of girls and boys, and women and men, in society. Girls are more likely to experience anxiety over body image. Girls may have an added wave of intense and erratic emotions as a result of menstrual hormone fluctuations. Suicide attempts are more common in girls than boys. Boys are more likely to show their feelings in ways that appear to be aggressive. Boys are generally more likely than girls to engage in high-risk behaviours. Generally, completed suicide is more common in boys than girls, partly due to boys' use of more violent methods.

One incident of abnormal behaviour does not signify a mental or behavioural disorder. There is a difference, for example, between a depressed mood and a clinically diagnosed depression. Biological, psychological and social factors contribute to mental and behavioural disorders and to their severity.

The following are the more common mental and behavioural disorders of adolescence:

2.1.1 Anxiety disorders

Anxiety describes unpleasant feelings of apprehension, tension, fear or worry. These feelings can be associated with physical (bodily, somatic) symptoms, such as a fast heart rate, sweating or shaking. This may ordinarily occur before an examination or a competitive sporting activity, for example, but with anxiety disorders the feelings and symptoms are excessive. The feelings and symptoms relate to thoughts in that they may occur in particular situations (e.g. closed spaces) or in response to particular things (e.g. spiders). The individual often understands the irrationality of anxiety but feels unable to control it. Behaviour may be affected, as the individual tries to avoid these situations or things.

Anxiety disorders may be more generalized (not associated with specific situations or things) and may be present all the time. These thoughts, feelings, accompanying behaviours and physical symptoms may impact to varying degrees of severity on the individual's quality of life. In adolescence, there may also be an effect on development.

Obsessive-compulsive disorder (OCD) is an anxiety disorder characterized by intrusive thoughts (obsessions) that produce uneasiness, apprehension, fear, or worry; by repetitive behaviours (compulsions) aimed at reducing the associated anxiety; or by a combination of such obsessions and compulsions. Symptoms of the disorder include excessive washing or cleaning; repeated checking; extreme hoarding; preoccupation with sexual, violent or religious thoughts; relationship-related

obsessions; obsessions of symmetry, aversion to particular numbers; and nervous rituals, such as opening and closing a door a certain number of times before entering or leaving a room. These symptoms can be alienating and time-consuming, and often cause severe emotional distress and academic decline. The sufferers generally recognize their obsessions and compulsions as irrational and may become further distressed by this realization.

2.1.2 Depression

Depression is a common mental disorder during adolescence. It is primarily characterized by sadness (feelings), loss of interest in activities (thoughts, behaviours) and decreased energy (physical symptoms). Other physical symptoms include difficulty concentrating and changes in appetite and sleep. Sometimes, the physical symptoms are more obvious than the feeling of sadness.

Depressed people often have depressive thoughts, which make them feel even worse, such as thinking poorly of themselves (low self-esteem), feeling excessively guilty about things they have done or not done, and having pessimistic thoughts about the future. Two significant associated behaviours are suicide and substance abuse.

Depression is differentiated from normal states of low mood by the extent of its severity and the duration of symptoms, with symptoms usually present for at least 2 weeks without a period of relief.

If depressive episodes alternate with exaggerated elation of mood or irritability, they could be a manifestation of a bipolar disorder.

If the adolescent tells a health care provider that he or she plans to end his or her life, or is threatening serious aggression against someone else, the adolescent should ideally be referred to a psychiatrist. Family and community support is also extremely important.

Suicidal adolescents may not always appear very depressed but may be somewhat “flat” or expressionless; they may even appear relaxed once they have made the decision to end their life. The best way for health-care providers to prevent suicide or attempted suicide is to provide support and help to individuals, enabling them to talk about their feelings and to feel more valued.

It is not uncommon for depression and anxiety to occur together in a mixed anxiety-depressive disorder.

2.1.3 Schizophrenia

Schizophrenia is a mental disorder where there is disturbed thinking and perception and often inappropriate emotions. Disturbed thinking can be recognized in the form of **delusions** – beliefs about people or things that remain fixed, despite evidence to the contrary; these are often bizarre or paranoid (e.g. the individual may believe the parents trying to kill him). Disturbed perception can be recognized in the form of **hallucinations** – sensory perception of something or someone that is not present (e.g. hearing voices that speak about the individual in the third person). Behaviours are also affected and may seem strange to an observer.

Almost half of people with schizophrenia can expect a good recovery. In the remainder, schizophrenia follows a chronic or recurrent course, with limitations to participation in education, work and socialisation. Quality of life can be markedly affected.

2.1.4 Substance use disorders

There are a number of disorders resulting from the abuse of psychoactive substances such as alcohol, opioids (heroin), cannabinoids (marijuana), sedatives and hypnotics, cocaine, other stimulants, hallucinogens, tobacco and volatile solvents. The conditions include acute intoxication, harmful

use, dependence and psychotic disorders. Substance abuse may be associated with all the above mentioned disorders. Additionally, substance abuse is also associated with suicide.

Substances can be legal or illegal and pose both physical and psychosocial consequences. Tobacco and alcohol are the substances used most widely across the globe and pose the most serious public health consequences.

Harmful use is defined as a pattern of substance use that causes damage to physical or mental health. Harmful substance use often causes adverse social consequences (e.g. fights or arguments with others, expulsion from school, loss of job), but the social consequences alone are not sufficient to justify a diagnosis of harmful use.

Dependence is defined as a cluster of behavioural, cognitive (related to thinking or memory), and physiological experiences that may develop after repeated substance use.

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

1. Craving: A strong desire or sense of compulsion to take the substance;
2. Loss of control: Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use;
3. Withdrawal: A physiological withdrawal state when substance use had ceased or been reduced;
4. Tolerance: A need for more of the substance to achieve the same effect;
5. Salience: Progressive neglect of other activities or obligations;
6. Harmful use: 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.

The goals of treatment are to reduce morbidity and mortality due to the use of psychoactive substances and to help them lead a substance-free life. Strategies include:

- Early diagnosis;
- Identification and management of infectious diseases such as HIV, Hepatitis B & C and other medical and social problems;
- Counselling, access to services, and opportunities to achieve social integration and rehabilitation.

2.2 Global impact of mental illnesses during adolescence

Globally, for people of all ages, mental disorders represent 4 of the 10 leading causes of disability. Mental and behavioural disorders are estimated to account for 12% of the global burden of disease. Around 20% of all patients seen by primary healthcare professionals have one or more mental disorders.

Mental illnesses represent a large proportion of the disease burden in young people in all societies. Around 20% of the world's children and adolescents are estimated to have mental health problems or disorders, with similar types of disorders being reported across cultures. About half of all lifelong mental disorders commence before age 14 years and 70% commence by age 24 years. It is estimated that one in every 4 or 5 young people will have at least one mental disorder each year.

Globally, suicide is the third leading cause of death among adolescents. The most common mental disorder associated with suicide is depression.

Most mental health needs in adolescents are unmet, even in high-income countries. Early recognition and treatment of mental disorders in adolescents should be a priority to ensure successful treatment and long-lasting recovery.

2.3 Factors that contribute to adolescent mental health and mental illness

There is no single factor but there is a range of different physical, psychological, social factors and events which contribute in an adolescent developing a mental illness and their consequences being more severe. Similarly, there are multiple factors that can protect the adolescent from mental illnesses and their consequences.

The table below provides good evidence in support of a multifactor basis of mental disorders in young people.

Risk and protective factors for mental health of children and adolescents

	Risk factors	Protective factors	
Biological	Exposure to toxins (e.g. tobacco, alcohol) in pregnancy	Age-appropriate physical development	
	Genetic tendency to psychiatric disorder	Good physical health	
	Head trauma	Good intellectual functioning	
	Hypoxia at birth other birth complications		
	HIV infection		
	Malnutrition		
	Substance abuse		
	Other illness		
Psychological	Learning disorder	Ability to learn from experiences	
	Maladaptive personality trait	Good self-esteem	
	Sexual, physical or emotional abuse; neglect	High level of problem-solving ability	
	Difficult temperament	Social skills	
Social	Family	Inconsistent care giving	Family attachment
		Family conflict	Opportunities for positive involvement in family
		Poor family discipline	Rewards for involvement in family
		Poor family management	
		Death of a family member	
	School	Academic failure	opportunities for involvement in school life
		Failure of school to provide appropriate environment to support attendance and learning	Positive reinforcement from academic achievements
		Inadequate or inappropriate provision of education	Identity with school or need for educational attainment
		Bullying	
	Community	Transition (e.g. urbanization)	Connectedness to community
		Community disorganization	Opportunities for leisure
		Discrimination, marginalization	Positive cultural experiences
		Exposure to violence	Positive role models
			Rewards for community involvement
			Connection with community organizations

Risk and protective factors occur at different levels:

- Individual – biological and psychological;
- Immediate environment – family;
- Wider environment – community and society at large.

The risk factors interact with each other in contributing to risk. For example, maternal exposure to alcohol in pregnancy (an individual factor) may accompany family discord (a factor in the immediate environment) and poor educational opportunities because of social marginalization (a factor in the wider environment). The protective factors at all three levels can substantially reduce the detrimental effects of risk factors. Family attachment and involvement in community activities are two examples of protective factors in the environment that have been shown to act as psychosocial buffers in the face of other risk factors.

Here is an example that considers the risk and protective factors for depression in adolescents:

2.4 Risk and protective factors for depression among adolescents

	Risk factor	Protective factor
Family	Family conflict	Positive relationships; encouragement of self-expression
School	Bullying	Safe environment; supportive staff
Community	Ethnic clashes	Positive relationship with different community members
Beliefs		Having a spiritual belief

Studies of risk and protective factors in different countries from all regions of the world found that the following four factors are significant in determining which adolescents may have depression.

1. Adolescents in families where there is conflict are more likely to experience depression (risk factor). Adolescents who have a positive relationship with their parents, and whose parents encourage their self-expression, are less likely to experience depression (protective factors).
2. Adolescents who attend a school that they like (safe, supportive environment and staff) and are motivated to do well are less likely to experience depression (protective factor).
3. Adolescents who have a positive relationship with members of their community are less likely to experience depression (protective factor).
4. Adolescents who have spiritual beliefs are less likely to experience depression (protective factor).

Developmental tasks of adolescence

During adolescence there are developmental tasks that are necessary for an adolescent to complete in order to reach adulthood. A developmental task represents a culture's definition of "normal" development at different stages. As with all aspects of development, there is a wide range of what is considered "normal", both individually and within different societies.

By completing developmental tasks, the adolescent is able to move towards developing and functioning as an adult. Social and psychological development is essential for successfully accomplishing many of the tasks. Mental illness can delay or prevent the completion of developmental tasks. If left untreated, mental health difficulties and mental and behavioural disorders can hinder psychological or social development in adolescents.

Several different models represent the developmental tasks of adolescence. Perkins' 2007 model identifies eight developmental tasks that enable adolescents to create their identity:

1. Achieving new, more mature relations with others;
2. Achieving a masculine or feminine social role;
3. Accepting one's physique;
4. Achieving emotional independence from or interdependence with parents and other adults;
5. Preparing for marriage and family life;
6. Preparing for an economic career;
7. Acquiring a set of values and an ethical system;
8. Desiring and achieving socially responsible behaviour.

Consequences of adolescent mental illness

Consequences of adolescent mental illness include:

- Suffering (e.g. personal distress, family distress);
- Functional impairment (e.g. inability to study, work, raise a family or be independent);
- Exposure to stigma and discrimination (e.g. isolation, missed opportunities, abuse from others);
- Increased risk-taking behaviour (e.g. unprotected sex, excessive alcohol use);
- Premature death (e.g. violence, suicide, overdose of drugs).

Some people think that a diagnosis of a mental health problem or a mental disorder implies that the person is doomed to have the problem for the rest of their life. Mental health problems, like physical illnesses, can be short-lived as well. A person diagnosed with mental health problems will not necessarily have the problem for the rest of his or her life.

3. Presentation and assessment of adolescent mental illnesses and substance abuse

Mental illness presenting through thoughts, feelings and behaviours

As discussed before, mental illnesses are expressed in thoughts, feelings and behaviours. Here are some examples of how we get information to assess an adolescent's mental health when they come to the clinic:

- What the adolescent says about his or her thoughts and feelings;
- What the adolescent says he or she does (self-reported behaviour);
- Observing how the adolescent looks (self care) and speech (tone of voice);
- What other people (e.g. parents, teachers, other adults, siblings, peers) say the adolescent does or says about his or her thoughts and feelings;
- Observing the adolescent's interactions with other people – behaviour;
- General physical examination;
- Medical records.

Some adolescents may come to the clinic and say they are having problems with certain thoughts, feelings or behaviours, e.g. “I am frightened/sad/worried” or “I am thinking strange thoughts/I have trouble concentrating/I want to die”. In other cases, however, other people may raise with you the possibility that the adolescent is experiencing problems and symptoms.

In addition to mental illness being evident through a person’s thoughts, feelings and behaviours, mental illness may also manifest as physical (bodily or somatic) symptoms.

3.1 Mental illness presenting as physical symptoms

Mental health problems may manifest as physical symptoms or illnesses that cannot be explained in medical terms and may take the adolescent to different health-care providers or even faith healers, looking for help.

- Symptoms include ill-defined physical symptoms or unexplained illness, e.g.:
- Sleep problems or unexplained tiredness;
- Anxiety and palpitations;
- Dizziness, trembling and sweating;
- Generalized aches and pains (including of the head, chest and abdomen);
- Poor appetite or loss of weight.

3.2 Other presentations that might indicate underlying adolescent mental illness

There are also other presentations that should alert the health-care provider to possible mental health problems or a need for a mental health assessment, e.g.:

- Social withdrawal or reduced participation (in school, work or social activities);
- Declining academic performance;
- Signs of excessive and frequent alcohol or psychoactive substance use;
- Self-report or report by others of frequently engaging in high-risk behaviour (e.g. reckless driving, playing with firearms).

Changes in mood and behaviour can provide important indicators of an adolescent’s mental wellbeing, but these observations alone cannot be conclusive of mental illness – they can only indicate the need to carry out a full assessment.

It is important for health-care providers to be aware of these presentations, as they may point to underlying mental health problems.

The HEADS framework or approach can be used to assist the health-care provider in obtaining an adolescent’s psychosocial history. The HEADS approach can help the health-care providers assess whether an adolescent is mentally well or ill and, if they are ill, to assess the severity of the illness.

The letters of HEADS remind the health-care provider of the issues that need to be discussed with the adolescent:

HEADS framework

- H** Home
- E** Education/employment; Eating; Exercise
- A** Activities
- D** Drugs;
- S** Sexuality; Safety; Suicide and depression.

Mental illness can present in a variety of ways, depending on the individual and the external pressures they are experiencing. Changes in mood and behaviours can provide important indicators of an adolescent's mental well-being, but these observations alone are not conclusive of mental illness. Rather, they indicate the need to carry out a full assessment of the individual, beginning with a psychosocial history.

It is necessary to discuss the HEADS approach in more depth, considering possible warning signs that might point towards adolescent mental illness.

3.3.1 Home

The home environment is an essential part of the adolescent's life and hence a good area to begin the interview. This will help the health-care provider understand the family situation, e.g. whether the adolescent is living with parents (one or both) or a guardian.

The discussion can begin with an open-ended question, e.g. "Who lives with you at home?" Some assessment of the nature of the adolescent's relationships is also important, e.g. "Is there someone you can trust to talk to about things that worry you?" or "Are you frightened of someone in the family?"

Warning signs include the following:

- Adolescent has no support at home or anywhere else.

3.3.2 Education/employment

The educational or work environment and the peer group in this setting are important factors in determining the mental health and well-being of adolescents and in influencing their behaviour. If the adolescent is a student, the health-care provider should ask questions to help them understand the student's school performance, attitude to school, involvement in school activities and relationship with teachers. If the adolescent is working, the questions can focus on their work situation.

Questions to begin the discussion could include "How is school this year compared with last year?", "What do you do on a typical school or work day?", "Are you working outside your home?", "How are things for you at school or work?" or "What do you do at work?"

Warning signs include the following:

- Adolescent is having trouble at school or work, e.g. problems with school or work, bullying, or problems with teachers or bosses.
- Adolescent frequently misses school or work.

3.3.3 Eating

The health-care provider should enquire about the adolescent's body image and eating habits. An open-ended question could be "What do you think about your weight?" This opening can lead to questions on the adolescent's eating habits, e.g. "On a normal day, how many meals do you have and what do you eat at each meal?" or "What do you eat between meals?"

Warning signs include the following:

- Adolescent is overweight and has poor eating habits.
- Adolescent believes he or she is overweight, when it is evident that this is not the case.
- Adolescent is absorbed or obsessive about food, exercise, body weight or shape.
- Adolescent is underweight, and from the discussion it appears that financial constraints are contributing to this.

3.3.4 Exercise

The health-care provider should ask the adolescent about their regular exercise routine. An open-ended question could be "What exercise do you enjoy?" This opening can then lead to questions on the frequency and effort level of the exercise. (Exercise includes activities aimed at improving strength or stamina such as weight training and aerobics, recreational activities such as cricket, and physical work done without the explicit aim of exercising.)

Warning signs include the following:

- Adolescent participates in no or very little physical activity.
- Adolescent is overweight and unfit (e.g. breathless, tires easily walking upstairs).
- Adolescent is absorbed or obsessive about exercise and body weight.
- Adolescent is undernourished or engages in excessive physical labour.

3.3.5 Activities

Asking the adolescent about what they enjoy doing for fun can give a picture of their behaviour (e.g. "Hanging out with my friends", "Cooking at home with my mother"). Asking about friends and parents and what they do together for fun can lead to further information about their life.

Warning signs include the following:

- Adolescent has no friends and spends most of the time alone.
- Adolescent spends most of the time with people who are 4–5 years older, who affect his behaviours negatively.

3.3.6 Drugs

The health-care provider should routinely ask all adolescents some general questions about substance use. This is an opportunity for discussions that can prevent adolescents from beginning to use substances or assist adolescents to reduce or stop substance use.

A closed question such as "Have you ever smoked cigarettes?" can begin the assessment. If the answer is yes, you can ask "Are you currently smoking?"

Enquire about use of other legal or illegal substances, e.g. “Do you have friends that use [substance name]?” or “Have you ever tried [substance name]?”

Warning signs include the following:

- Adolescent regularly uses legal or illegal substances.
- Adolescent has tried illegal substances or has friends who do so.
- Substance use is having a negative impact on adolescent’s health or ability to function.
- Other people have expressed concern about adolescent’s substance use.

3.3.7 Sexuality

This part of the interview requires care, as the information being obtained is sensitive. Discussions on sexuality need to take account of the social and cultural context of the adolescent. 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 adolescents of your age. Are there any questions that you would like to ask me, or any questions about changes that you may have noticed?”

When appropriate, the following questions can be asked: “Have you ever had sex?”, “What were the circumstances in which you had sex – did you want to have sex, or were you forced to do so?” and “Are you sexually active now?”

Warning signs include the following:

- Adolescent is being or has been pressured to have sex.
- Adolescent seems at risk for early sexual activity.
- Adolescent has had unsafe sex or has had a number of sexual partners.
- Adolescent seems upset or worried about his or her sexual orientation.

3.3.8 Safety

The health-care provider should ask about safety issues at home, work and school, including questions regarding bullying and violence. Discussion on issues of safety can begin with a question such as “Are there any situations in your everyday life in which you feel afraid or unsafe?”

Then you can ask “Do you feel safe at home/in your place of study or work/in your neighbourhood?” If not, ask “What makes you feel unsafe?”

Warning signs include the following:

- Adolescent is experiencing bullying, violence, sexual harassment or abuse.
- Adolescent is withdrawn and unable to talk of experiences, or examination reveals signs of violence.

3.3.9 Suicide and depression

Asking the adolescent about their mood and signs and symptoms of depression is important. Questions may include “Do you ever feel sad?”, “What situations have caused that feeling?”, “What makes the feeling worse or better?” or “Do you feel able to cope with your situation?”

Signs of irritability and sleep disturbances may be the presenting symptoms of depression in adolescents.

When asking about suicide, the questions should be asked in an accepting manner, placing no blame on the person who may have thought about it. The 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?”

If the adolescent has contemplated suicide, it is important to ask whether he or she would ever act on these thoughts. Some adolescents may identify protective factors such as concern for loved ones for not acting on their thoughts. Others may see little reason to not act on their thoughts. For the latter who are at higher risk, it is important to ensure support is made available with referral to a psychiatrist.

Warning signs include the following:

- Adolescent is sad or anxious or feels hopeless most of the time.
- Adolescent talks about hurting or killing himself, or has tried to hurt or kill himself.
- Adolescent frequently uses alcohol or drugs to escape negative feelings.
- Adolescent has poor self-esteem and no sense of self-worth.

4. Attitudes towards adolescent mental health and stigma

4.1 Beliefs, attitudes and values

Beliefs are statements about an issue that an individual holds to be true.

4.1.1 Attitudes are general opinions or viewpoints about particular issues. The attitude a person has towards an issue is the general opinion they uphold or the stance or direction they take towards that issue. A person’s attitude towards a particular issue is rooted in their beliefs and feelings about that issue.

4.1.2 Attitudes and beliefs can be seen as positive or negative, according to how they link to our emotions and behaviours. For example, I may hold both positive and negative beliefs about the influence of television. On the one hand, I may believe that viewing television stops families from talking to each other (negative), contributes to inactivity and obesity (negative) and leads to children reading fewer books (negative). On the other hand, I may also believe there are some interesting documentaries on television (positive) and that watching television is a good way to wind down at the end of the day (positive). I may hold some of these beliefs more strongly than others. I may also have strong feelings on some of the issues, such as the importance of family members communicating with each other. Stemming from these different beliefs and feelings, my overall attitude towards television may be negative. My attitude impacts on my behaviour in that I avoid watching television and sometimes catch myself telling other people not to watch television.

4.1.3 Values are a set of guiding principles that derive from and contribute to forming our beliefs. These values are embedded in the contexts in which we find ourselves – religious, professional, cultural or otherwise. The values that we hold influence how we view and respond to different events in our life.

We can see an example of differing values in the debate over abortion. One side values the sanctity of life over individual choice, believes that life starts at conception and hence opposes abortion. The other side values individual choice and believes that women who do not feel ready to bring a child

into the world have a right to seek an abortion; they may also believe that in some circumstances women will seek abortions in any case and that it is better that abortions are performed safely and legally. Each side's views are grounded in their own values, which in turn are shaped by the wider context of their lives.

Our beliefs, attitudes and values are formed over time by our experiences and hence by the circumstances into which we are born and live and by the people and situations we encounter. The beliefs, attitudes and values that we hold can influence the way we interact with other people and our ability to provide professional and non-judgemental care and support.

Through examining our own beliefs, attitudes and values towards mental health, we can better understand those that are prevalent in our communities and consider how they have formed. In this way we are better placed to challenge the stigma and discrimination that people with mental health problems are frequently subject to in society and health-care settings.

Promotion of adolescent mental health starts by ensuring it is possible for young people with mental health difficulties to receive help without fear of shame and stigma.

Consider how opinions come from events in our lives. For example, if someone in our neighbourhood is seen as “dangerous” and “someone to avoid”, this can encourage the belief that mental illness is a threat to one's personal safety, a perception that one could hold for many years. (In fact, people with mental illness are more likely to be victims than perpetrators of violence.)

We may all have opinions that are not evidence-based and involve generalizations about people or groups. Challenging these opinions can have enormous influence on our attitudes and values surrounding issues.

4.2 The stigma of mental illness

Stigma is a mark of shame, disgrace or disapproval that results in an individual being shunned or rejected by others. In most societies, mental and behavioural disorders are associated with stigma, and this stigma tends to increase as behaviours become increasingly different from the “norm”.

The stigma of mental illness is often based on people's lack of knowledge about the causes and availability of effective treatment of mental illness. In many societies there are myths and beliefs that increase the stigma and fear of mental illness. For instance, mental illness might be believed to be associated with evil spirits and magic.

Stigma can prevent people from acknowledging their own mental health problems and from disclosing them to others. Many people do not seek help when they need it for fear of being labelled as “mentally ill”.

There is widespread lack of knowledge about mental health disorders, and there is inadequate protection and support for people experiencing stigma. This protection and support should include the right to study or work, the right to privacy, the right to decent housing, the right to a decent standard of care, and all the other rights enshrined in the Universal Declaration of Human Rights and the Convention on the Rights of Persons with Disabilities.

Mental illness and the associated stigma can cause a great deal of suffering for the adolescent and their family and friends. They can result in:

- Rejection by friends, fellow students, co-workers, relatives and neighbours, leading to aggravated feelings of rejection, loneliness and depression;

- Rejection of the young person, which can affect his or her family or caregivers and lead to their isolation or humiliation;
- Denial of equal participation in family life, schooling, social and professional networks, and employment;
- Educated ability to access the services, treatment and support required in health-care settings and the community.

Health-care providers should be aware that adolescents with mental illness are more vulnerable to being abused and badly treated.

Reducing the stigma of mental illness for adolescents

The stigma of mental illness can be reduced by actions at the community and wider societal level. At the community level, there is a need to:

- Talk openly about mental illness and the role of the community in promoting mental health and supporting adolescents with mental illness;
- Provide accurate information on the causes, prevalence, course and effects of mental illness;
- Challenge the negative stereotypes and misconceptions surrounding mental illness, and challenge and correct myths and misinformation on the causes and treatment of mental illness, including among health workers;
- Provide support and treatment services that enable young people with mental illness to participate fully in all aspects of community life.

At the societal level, there is a need to:

- Ensure that those in charge of law and policy reform understand the issues surrounding adolescent mental health, and that they work towards the provision of mental health services in the community;
- Create demand and support for new or revised legislation and its enforcement to protect the rights of people with mental illness, enable access to health and social services, and reduce discrimination in schools and the workplace.

Myths, misconceptions and negative stereotypes about mental illness are a major cause of the stigma associated with mental illness. Therefore, reducing the stigma of mental illness involves talking openly and accurately about the causes, effects and effective treatment of mental illness. One example of this is to make people aware that most adolescent mental health problems are not permanent and can be treated successfully with bio-psychosocial interventions.

5. Responding to adolescents with mental illnesses or substance abuse

Adolescents with mental health problems need to be identified in their communities and referred to primary-level health facilities where they should get the care and support they need. Adolescents requiring specialized care need to be referred to referral-level health facilities.

5.1 Responding to adolescents with mental health problems at the family and community level

Family members, teachers, youth workers, social workers and other non-health workers could help identify (in their homes, schools and elsewhere in their communities) adolescents experiencing

mental health problems. To do this, they need to know the warning signs. They also need to know that it is important to look out for these warning signs.

They could also help adolescents experiencing mental health problems by giving them a patient hearing, empathizing and offering advice and support to adolescents to cope with the challenges they are facing and to deal with them effectively. If the symptoms persist or if the adolescent's ability to function is affected, he or she should be referred to a primary-level health-care facility. Family and community members can make it easier for adolescents to seek help by normalizing and legitimizing care-seeking for mental health problems.

5.2 Responding to adolescents with mental health problems at the primary level

Health-care providers at the primary level need to be able to provide the following services:

- **Recognize mental health difficulties and disorders:** Health-care providers need to be able to recognize the warning signs that an adolescent may be experiencing mental health problems or substance abuse.
- **Deliver simple therapies and treatments:** Health-care providers need to be able to deliver simple psychological therapies and treatments to help the mental health of adolescents.
- **Refer adolescents who need specialized care:** Health-care providers who have not been trained to treat mental disorders should at least be minimally trained to recognize mental health disorders and adolescents in danger of self-harm or suicide, and to refer them appropriately.

At the referral level, a multidisciplinary team should deal with the biopsychosocial and rehabilitation needs of adolescents with serious mental health problems. One key emergency service that should begin is care and support for adolescents who harm themselves or are at risk of doing so.

Adolescents may come to the health centre with a parent or other adult. Health-care providers need to consider how they will communicate with accompanying adults in a manner that is respectful to the rights of the adolescent and also sensitive to the needs of the parents or accompanying adults who are coping with a son, daughter or ward who is psychologically troubled or behaving in a manner they find troubling. This is a challenge when working with all adolescents, but especially when working with younger adolescents who are more dependent on their parents.

It is important to be aware of general principles in dealing with such situations. It is also important to be aware of laws and policies on dealing with such matters. Each case needs to be managed based on local realities, finding the right balance between ethical (i.e. to do what is in the adolescent's best interests) and legal and practical imperatives.

- **Demonstrate respect and empathy for the parent through your words and actions.** Show you respect their views and perspectives on their son or daughter through your words and actions. Reassure the parent that you believe parents have an important role to play in supporting their children.
- **Explain to the parent your guiding principles** (i.e. respect for the evolving capacity of the adolescent) and your working methods (e.g. you may need to speak to their son or daughter in private). Maintain confidentiality and do not share information with the parent, without the adolescent's consent, on anything that the adolescent has confided in you.
- **Try to identify the nature of the relationship between the parent and the adolescent.** Try to understand whether one or both parents may have contributed to the problem, and whether one or both parents could potentially contribute to the solution. Parents may be a part of the problem as well as a part of the solution in many cases. Do not underestimate the influence that parents can have, even on older adolescents who seem independent.

- Provide the parent with the information and advice they need to support their son or daughter, but do this only when you have the permission or support of the adolescent.
- Do not make decisions or agreements with parents on issues concerning their son or daughter “over the head” of the adolescent.

The management of mental health problems in adolescents includes a combination of psychosocial and biomedical interventions. Certain interventions or combinations of interventions work better than others for particular conditions. Beyond that, the management strategy will depend on factors such as the nature of the problem, the competencies of health-care providers, the availability of medication, and so on.

Psychological interventions include:

- undirected approaches, such as those providing help within a counselling framework to help patients explore, discover and clarify ways of dealing with problems or concerns;
- directed approaches that aim to change a pattern of behaviour or things, e.g. cognitive–behavioural therapy (CBT).

Biomedical interventions consist of treatment with the following groups of medications:

- Antidepressants: Examples include fluoxetine (but not other selective serotonin reuptake inhibitors) and amitriptyline (and other tricyclic antidepressants).
- Anxiolytics or minor tranquillizers: These can help to reduce anxiety symptoms but do not help with depression. They are also used as sleeping pills. These medications should be used with caution and only for short periods of time, since they can cause dependence. Examples include benzodiazepines, of which the best known is clonazepam.
- Neuroleptics or major tranquillizers: These are used to treat schizophrenia and some other mental disorders. Oral risperidone or olanzapine should be offered routinely to a person with a psychotic disorder.

Pharmacological agents:

	Starting dose	Maximum doses*	Common side effects	Management of side effects
Fluoxetine	10 mg / day (after break-fast)	20 mg /day	paradoxical worsening of anxiety, insomnia, gastrointestinal disturbances, head-ache, sexual dysfunctions	Add clonazepam for paradoxical worsening of anxiety and insomnia Add proton pump inhibitors for gastrointestinal disturbances
Amitriptyline	25 mg / day	75 mg /day	anti-cholinergic side effects (blurring of vision, urinary hesitancy), orthostatic hypotension	Change to SSRIs
Risperidone	2 mg /day	4 mg /day	extra-pyramidal side-effects (acute dystonic reactions, tremors, and parkinsonism)	Add trihexyphenidyl 2 mg /day for extra-pyramidal side-effects
Olanzapine	5 mg /day	20 mg /day	extra-pyramidal side-effects, weight gain, sialorrhoea, seizures	
Clonazepam	0.25 mg/d	1 mg /day	sedation, dependence potential	

** In the hands of primary health care providers these dosages are likely to be effective and safe.*

Health-care providers who are not trained in providing CBT can provide basic psychosocial support through approaches such as the following:

- Advise the adolescent on ways to prevent anxiety or sadness dominating their thoughts and feelings:
- Spend time with someone you trust and like.
- Do things that are pleasurable (e.g. go for a walk, go to the cinema, read a book) to help push away the feeling of sadness.
- Advise the adolescent on ways to cope with everyday problems:
- Talk to a trusted adult or peer: When we are anxious, our thoughts and feelings get mixed up and it is not easy to think through things clearly; it may be helpful to spend some time chatting with somebody you trust.
- Think positively: We can get into the habit of seeing and thinking things negatively; this is not helpful because it can trigger more anxiety. Try to catch yourself thinking negatively and make yourself think positively. For example, if you have not received an expected phone call, try not to immediately assume the person has not called because they are injured; instead, think of other explanations that are not negative (e.g. they are busy, they have forgotten to call, they cannot access a phone).
- Using a problem-solving approach: When faced with a problem, list all the possible ways in which the problem could be solved and then look at the strengths and weaknesses of each possible solution.

This method can help you choose the right approach for you and is likely to overcome the problem.

- Advise the adolescent on how to relax when feeling overcome with anxiety:
- Find a quiet place where you can be alone for a few minutes.
- Sit down and try to clear your mind of thoughts and feelings that upset you.
- Make a conscious effort to relax your muscles. Do this in the following sequence so you feel your whole body beginning to relax progressively: Begin with the muscles in your hands, and then work through your forearms, arms, shoulders, head, forehead, face, chest, abdomen, back, thighs, legs and feet.
- Take slow, deep breaths. Breathe in through your nose and fill your lungs with air. Breathe in to a slow count of three. When you have completed the in-breath, you will feel your lungs pushing out your ribcage and abdomen. Now breathe out slowly and deliberately to a slow count of six.

5.3 A model of brief intervention in substance abuse

5.3.1 Assessing the readiness to change: The model for stages of behavioural change developed by Prochaska and DiClemente (1986) can be utilized in understanding how people change their behaviour, and in assessing the individual's readiness to change a particular behaviour.

The model includes the following stages of change:

Precontemplation: when one is not really thinking about changing.

Contemplation: when a person is thinking about reducing or stopping substance (drug) use.

Determination/Preparation: when the person has resolved the ambivalence and is ready to participate in action-oriented intervention.

Action: when one takes overt behavioural steps towards changing (reducing/stopping) the drug use behaviour; for example, coming to therapist for counselling sessions, completing home assignments, and reducing/stopping substance use. In this stage help them to identify situations and states likely to trigger/precipitate relapse, and discussing with the patient their plan for action to reduce/stop substance use.

Maintenance: After the period of intensive therapy in the action stage is over, some milder amount of action is continuously required to maintain the changed behaviour; otherwise there is a risk of relapse.

Either Termination or relapse: Successful observance of maintenance phase leads to recovery when the actions can be terminated. Failure of maintenance phase leads to relapse. The health care provider should bear in mind that relapses are common and should not get disheartened from the same and should be prepared to deal with relapses and encourage the adolescent to prevent and effectively deal with the same.

The components of the intervention could be understood through the acronyms FRAMES and DARES (motivational interviewing).

FRAMES:

F: Feedback: Following an appropriate assessment, feedback is provided to the subject on his/her pattern/level of substance use, existing or potential harmful effects, awareness of these issues along with certain laboratory parameters (e.g. Blood test for liver enzymes for alcohol users), keeping in mind his/her motivation to change. Feedback may also include a comparison between the patient's substance use patterns/problems and the prevailing patterns and problems experienced by other similar people in the population.

R: Responsibility: An emphasis is laid upon the person that to think and decide about the need for change in substance use is solely the individual's personal responsibility.

A: Advice: The therapist gives a clear advice to the person regarding the harms associated with continued substance use to make changes in substance use in the direction of a specified goal e.g., 'moderation' or 'quitting'.

M: Menu: The subject is provided information regarding an array of options or a menu of the various alternative ways/strategies to reduce/stop substance use. Providing choices reinforces the sense of personal control and responsibility for making the change and can thereby help in strengthening the motivation to change. For example, keeping a diary for substance use (mentioning details viz., where, when, amount, with whom, why); helping patients to prepare substance use guidelines for themselves; identifying relapse precipitants-high risk situations and strategies to avoid them; providing information on self help resources and written information, reading pamphlets; attending counselling session(s) and follow up; identifying healthy enjoyable activities and life style changes that could replace drug use viz., hobbies, exercises, sports, spending time with family and visiting sober friends; providing information on specialized treatment centres or professionals; putting aside the money they would usually spend on drug use for something which is constructive, healthy and satisfying.

E: Empathy: The therapeutic style of warm, reflective listening and an understanding approach is an important component of effective brief intervention. The therapist communicates respect to the adolescent, encourages exploration, reinforces the adaptive statements made by the adolescent and avoids confrontation to prevent resistance.

S: Self-efficacy: The therapist endeavours to boost the adolescent's sense of self-efficacy or optimism or perceived control and confidence. This is in absolute contrast to the philosophy

of 'powerlessness' promoted by fellowship groups like Alcoholics Anonymous. It is considered particularly helpful to elicit self efficacy statements from patients as they are likely to believe what they hear themselves say.

When a therapist imparts brief intervention to a given adolescent, all the above mentioned elements need not be compulsorily present. Any one or more of these may need to be employed depending on the client's needs as well as the therapist's skills.

5.3.2 Motivational Interviewing (Miller and Rollnick, 1991): is an interaction focused at helping the client to explore and resolve the ambivalence about one's substance use and thereby move through the stages of change. There are five principles which guide the practice of motivational interviewing (acronym DARES). These include:

D: Develop discrepancy: Throwing light on the discrepancy between where your client is currently and where he/she aspires to be.

A: Avoid argumentation: Avoid argumentation with the client because arguments lead to resistance.

R: Roll with resistance: The client is encouraged to think of the problem differently. He/she is never forced to make a decision.

E: Express empathy: To feel with your client and to communicate that you understand and care.

S: Support Self-efficacy.

5.4 Interventions to Reduce Relapse

5.4.1 A. Identifying and Handling High Risk Situations

One can ask for the description of past relapses and the situations where the adolescent feels the risk of restarting the substance is very high. It is like preparing a soldier before going to the battlefield. The better the preparation, lesser is the chance of relapse. High risk situations may vary from person to person. Situations which trigger feeling of loneliness and isolation may be high-risk for one person whereas attending a party, social pressure or need to be seen as confident by friends may be high risk for another. These situations can trigger craving for the substance in an individual. Making the client aware of those situations which trigger craving is very important to prevent relapse.

A. Common high risk situations

- The sight of a bar, especially the one the person used to frequent before
- Meeting friends with whom one was using drugs, passing by usual hangouts
- Peer pressure
- Parties
- Saturday nights/ weekends
- Some environmental cues like eating non-vegetarian food
- Being home alone
- Family conflicts
- Study/Job stress, other stresses, fatigue
- Having a lot of unscheduled time
- Negative emotions like frustration, sadness, depression
- Positive emotions such as happiness, excitement, a feeling of accomplishment (desire to celebrate)

B. Handling Craving

The deification of triggers or precipitants is the most important step in dealing with relapse. Described below are a few common ways effective in handling craving.

Postponement (Urge Surfing): Craving is like a wave and episodes of craving are time-limited. Rather than increasing steadily until they become unbearable, they usually peak after a few minutes, and then die down like a wave. The waves of craving become less frequent and less intense as one learns how to cope with them and with progress of time.

At the time of intense craving the recovering individual can call a sober or abstinent friend and tell them he/she feels like taking a drink/using a drug, and needs help not to do so. Similarly, recall negative consequences of returning to substance use - losing one's job, broken family relationships, etc.

One advice that works very well in clinical situations is that of **HALT**. If one avoids these situations, the likelihood of craving decreases.

H = **Hunger**

A = **Anger**

L = **Loneliness**

T = **Tiredness**

Try the 4 Ds for postponement:

Delay

Distract

Drink water

Deep breathing

C. Drink Refusal Skills and Assertiveness

One of the common situations of relapse is peer pressure during different occasions and situations. One should be aware of pressure tactics, usually from friends.

Beware of Pressure Tactics

Pleading: *"Please give me company just for a few minutes."*

Reassuring: *"It's ok, I'll talk to your parents so they won't be angry with you."*

Anger: *"Look, I'm drinking, but nothing has happened to me." "So you mean to say I'm bad and you are a reformed person." "So you want to avoid me."*

Challenging: *"Don't you want to enjoy the life?" "Don't you have the right to spend your dad's money the way you want to?"*

Threatening: *"So you don't want our friendship." "We will expel you from our group if you don't drink with us anymore."*

Refusal skills are a specific set of skills which are related to dealing with social pressure. Hence it needs a strong body language and confident tone of voice from the person while refusing to drink/ use a drug. In this situation one has to respond rapidly as the delay is likely to increase the urge. Many patients feel uncomfortable or guilty about saying "no" and think they need to make excuses for not

using. Saying things like “*maybe later,*” “*we shall see,*” just makes it likely that they will be pressured again to use. This allows for possibility of future offers. So “No” can be followed by changing the subject, suggesting alternative activities, and clearly requesting that the individual not offer alcohol or other drug again in the future. For e.g. “*Listen, I’ve decided to stop and I’d like you not to ask me to use with you anymore. If you can’t do that, I think you should stop coming over to my house.*”

Some Common Drink Refusal Statements

“No thanks, I have stopped drinking.”

“Let us have tea or coffee instead.”

“I am taking medicine and I can’t drink on it.”

“I have an important engagement.”

“I have to get up early.”

“I have a headache.”

“I was just leaving.”

One of other ways to learn and master it is through role play. Individual role play between substance user and health care provider is one of the best ways to enhance drink refusal skills. In role play, the adolescent and therapist enact potential relapse situations, and the adolescent rehearses what he/she will say in such situations.

Another important component is learning to be “Assertive.” Assertiveness is the ability to insist and stand up for one’s own rights, without hurting others or violating their rights. People with substance use are seen to be unassertive and thereby frequently land up in a situation where they either flee from the situation or more often find it impossible to refuse the offer. Sometimes it is useful if the person is constantly pressured to leave the place by saying politely, “*I can see that you won’t take no for an answer, so I am leaving.*” This will show the friend that the recovering person is determined to stay abstinent.

D. Dealing with faulty cognitions like overconfidence, helplessness, etc.

A person’s faulty thought very often becomes a problem for him/her and leads to a relapse. A simple example is: “*I can stay away from alcohol. Nothing can tempt me.*” The consequence is - going to parties where alcohol may be available, telling myself “*I will go, but I’ll not drink.*” The person needs to recognize that this thought is a red flag or a dangerous thought and consciously needs to tackle it. One of the ways to challenge it is as follows:

Challenging Thoughts (overconfidence as in the above situation)

“What proof do I have that nothing can tempt me?”

“What happened before?”

“Every time in the past when I did something like this, I ended up drinking continuously. So what’s the point in entertaining such thoughts again?”

Similarly another example very often one comes across is that:

“My life has no meaning; it is so bad that I need a break.”

Recognize it's a Red-flag Thought

Challenge these thoughts:

"Even if my life is bad, will reusing drugs really give me the break I need?"

"Or will my life become more 'bad' than before?"

"What happened before when I was using drugs?"

"Even if I succeed in forgetting my troubles for a while, how long can I forget? For a few hours, until the effect lasts."

"And after that? Should I go on using the drug to forget everything?"

"What useful purpose does that serve, except to ruin my health and family, and put me in an even worse position than I was before?"

"Think of other ways in which I can take a break: go home immediately, share with my family, just relax by reading a book, or resting for a while?"

Similarly there are other thinking errors like catastrophizing [e.g. *"After all these months of abstinence, I used the drug again, so there's no use. I cannot recover again"*], jumping to the conclusion that *"I am a useless person because of my alcohol use"* etc.

E. Handling Negative Mood States

Negative mood states like anger, anxiety, fear, depression, guilt, getting upset or bored easily, irritability, tiredness, restlessness, etc. are associated with relapse. A few ways to handle this are:

- The first step is to be aware of one's self-defeating thoughts and depressed mood.
- Realizing the adverse consequences of these negative thoughts.
- Creating opposite (positive) thoughts, challenge negative thoughts.
- Ignoring negative thoughts, not responding to them.
- Accepting oneself as one really is, with strengths as well as limitations.
- Having realistic self-expectations.

F. Assess for co-existing Psychiatric Disorders

Very often the person needs to be assessed for an independent psychiatric disorder. These can have an influence on a person's judgment, motivation and functioning with regard to substance use. Common co morbid disorders are Depression, Anxiety disorders and Schizophrenia. It is important to get these details and treat these conditions effectively. That in turn will help immensely for controlling substance problems. These conditions mostly need pharmacotherapy and one should refer them to a specialist, if required.

G. Having a Balanced Life Style

In addition to identifying and managing high-risk relapse factors, recovering individuals often need to make more global changes to restore or achieve a balance in their lifestyle. Developing a healthy lifestyle decreases the level of stress. The client's lifestyle can be assessed by asking about his/her daily activities, how he/she spends time, sources of stress, balance between pleasure and external demands, time spent in exercise/relaxation patterns, interpersonal activities and religious beliefs.

H. Involving Family

Family plays an important role in preventing as well as helping the person remain alcohol/drug free. A few important tips that one needs to tell the family members include:

Realize that alcohol/ drug dependence is a disease, and not a moral weakness or a lack of willpower.

Do not argue, quarrel, justify his/her use of substance, or take up the responsibility of covering up for the consequences of substance use.

Do not suspect. For example, don't start questioning whether he has had a drink/used drugs or not, especially when he comes home. Do not make phone calls to his friends, or colleagues to check if he is drinking/using a drug.

Pay extra attention to his needs – nutrition, medications, health.

Do not discuss his previous drinking/drug use problems with others.

I. Arranging Follow ups

Relapse prevention as described at the beginning is a process and is ongoing. The importance of this is more obvious while the patient comes for follow up. One needs to check how he/she is handling the urges or any physical/emotional disturbance following stoppage of substance. The ways in which the recovering adolescent is managing time, study, family relationships etc need to be discussed. Similarly any high risk situation he/she has faced recently and how have they coped also need to be addressed. The health care worker can ask appropriate questions to understand both recovery and relapse.

One can discuss what the person can do between now and the next session, so that relapses do not recur.

“What did you do on the days you did not drink /use substance that kept you from lapsing?”

“Which of the coping skills you have been practicing might be especially useful?”

5.5 Pharmacotherapy for substance abuse

Pharmacotherapy for substance abuse mainly consists of two categories:

1. Medications used in detoxification or management of withdrawal symptoms
2. Medications for relapse prevention: anti-craving agents and deterring agents

Benzodiazepines (diazepam, lorazepam, etc) are the mainstay of treatment for **alcohol** withdrawal symptoms. Alcohol withdrawal symptoms are of mild to moderate intensity in a majority of cases and characterized by insomnia, tremors, sweating and inner restlessness. In very few cases, it may be severe to the extent of producing a seizure (withdrawal seizures or rum fits) or altered sensorium (delirium tremens). The withdrawal symptoms usually start 12 to 48 hours of the last alcohol drink.

The dose of a benzodiazepine is adjusted according to severity of withdrawal symptoms. Diazepam or lorazepam are to be used in divided doses every 6-8 hours interval. Lorazepam is safe even in liver disease. Along with this, intramuscular injection of thiamine 100 mg/day for five days should be given followed by oral vitamin B complex for two weeks. The most of the cases can be managed on an out-door basis.

Opioid withdrawal is characterized by lacrimation, body aches, dilated pupils, diarrhoea, sleeplessness and pilo-erection. The commonly used agent for management of withdrawal symptoms of opioids is

buprenorphine.

Nicotine withdrawal does not have any specific symptoms other than irritability, restlessness and persistent desire to take nicotine. Nicotine replacement therapy in the form of nicotine gums (2 mg) is commonly used to handle withdrawal symptoms and at the same time decrease craving.

The basic principle of **benzodiazepine** dependence is substituting the current drug with a longer acting benzodiazepine and slow tapering at the rate of 5 – 10% every week. This helps in smoother withdrawal and minimizes any untoward complications like withdrawal seizures.

No specific pharmacological treatment is available for **cannabis** and **solvents** and needs to be handled symptomatically.

The need of anti-craving agents and deterring agents should be determined by a specialist only. However primary health care providers can safely practice nicotine replacement therapy.

6. Promoting mental health in adolescents

Many sectors have complementary contributions to make to crafting an effective overall response to promoting mental health in adolescents, preventing problems from arising, and responding to mental health problems promptly, effectively and sensitively. For this to happen, ministries of health need to:

- Engage and support other sectors – in particular, the education, social welfare, media, employment, youth and sports sectors – to make important contributions;
- Ensure their actions are evidence-based, are carried out well, reach all adolescents (especially those who are most vulnerable), and are carried out collaboratively with other sectors.

Here are some illustrative examples:

Setting	Sector	Actions
Home	Social welfare services	Educating parents to help them understand the emotional needs of adolescents and how to respond to these needs Nature of mental health problems that might occur; how to respond to them, and when and how to seek help Supporting vulnerable adolescents and their families
School	School Staff	Building individual assets such as self-esteem and life skills Discussing sexual health, injuries, violence and substance use; promoting healthy attitudes and behaviours Making school a safe (i.e. free from physical and emotional violence) and supportive (i.e. where students and staff feel valued and supported) environment Training teachers to detect adolescents who might need help, provide them with counselling support, and refer those who need medical help to health facilities Working with social health services to identify and provide support to adolescents living in difficult circumstances

Setting	Sector	Actions
Community	Community leaders and members	Engaging and sensitizing community leaders and members to create a caring and supportive environment for adolescents with or at risk of mental health problems, and their families Engaging and sensitizing community members to intervene when there is violence in homes and elsewhere in the community Training selected community members to detect and refer to health services adolescents who might need help
Media and Communication technologies	Media personnel	Disseminating information on factors contributing to mental health problems in adolescents, on effective ways to prevent mental health problems and respond to them when they occur, and on substance use and mental health problems Preventing glamorization of suicide

6.1 Life Skills

The term “life skills” refers to a generic set of skills that can be learnt at any stage in life for the promotion of psychosocial competence among young people and that can be applied to many areas of life. The table below gives some examples of life skills.

Communication and interpersonal skills	Decision-making and critical thinking skills	Coping and self- management skills
Interpersonal communication skills: Verbal/non-verbal communication Active listening Expressing feelings, giving feedback (without blaming), receiving feedback	Decision-making and information-gathering skills: Evaluating future consequences of actions or self and others Determining alternative solutions to problems Analysis skills regarding influence of values and attitudes about self and others on motivation	Skills for increasing personal confidence and abilities to assume control, take responsibility, make a difference or bring about change: Building self-esteem and confidence Creating self-awareness skills, e.g. awareness of rights, influences, values, attitudes, strengths, weaknesses Setting goals Self-evaluation, self-assessment, self-monitoring
Negotiation/refusal skills: Negotiation and conflict management Assertiveness Refusal Empathy building Ability to listen, understand another's needs and circumstances, and express that understanding	Critical thinking skills: Analysing peer and media influences Analysing attitudes, values, social norms, beliefs, and factors affecting them Identifying relevant information and sources of information	Skills for managing feelings: Managing anger Dealing with grief and anxiety Coping with loss, abuse and trauma
Cooperation and teamwork: Expressing respect for others' contributions and different styles Assessing own abilities and contributing to the group		Skills for managing stress: Time management Positive thinking Relaxation techniques

Communication and interpersonal skills	Decision-making and critical thinking skills	Coping and self- management skills
Advocacy skills: Influencing skills, persuasion Networking, motivation		

Source: *Skills for health: Skills-based health education including life skills - an important component of a child-friendly/ health-promoting school*. Geneva, World Health Organization, 2003.

7. References

NIMHANS manual “Psychosocial Interventions for Persons with Substance Abuse: Theory and Practice”

8. Annexure

Acts and Programmes related to Adolescent Mental Health

- Mental Health Act (MHA), 1987
- Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985 (Amendment in 1988)
- The Persons With Disabilities Act (PWD ACT), 1995
- Cigarettes (Regulation of Production, Supply and Distribution) Act, 1975
- Delhi Prohibition of Smoking and Non-Smokers Health Protection Act, 1996
- Child Labor (Prohibition and Regulation) Act, 1986
- National Trust Act, 1999 for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities.
- Domestic Violence Act, 2005.
- Protection of Children from Sexual Offences (POCSO) Act, 2012.

8.1 Mental Health Act (MHA), 1987

Aims:

- The mentally ill persons are to receive the best possible treatment and care for the mentally ill persons in the least restrictive environment
- Any interference with or restriction of their human rights, dignity and self-respect is to be kept to a minimum.

The Mental Health Act regulates psychiatric hospitals and nursing homes. According to the act separate hospitals are needed for children and adolescents and addiction and related behavioral disorders.

8.2 Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985 (Amendment in 1988)

Aims:

- To consolidate and amend the law relating to narcotic drugs and psychotropic substances
- To make stringent provisions for control and regulation of operations relating to narcotic drugs and psychotropic substances
- To arrange for identification, treatment, education, after-care, rehabilitation and social reintegration of addicts

Various offences are defined and punishment is prescribed for illegal possession according to the quantity of substance, e.g. small quantity, quantity lesser than commercial quantity but greater than small quantity, and commercial quantity. Any addict convicted under NDPS Act, instead of being sentenced, with his consent, released for undergoing medical treatment for detoxification or de-addiction from a recognized hospital or institution.

8.3 The Persons with Disabilities (*Equal Opportunities, Protection of Rights and Full Participation*) Act, 1995 (PWD Act, 1995)

Disability certificate is issued by a psychiatrist using Indian Disability Evaluation & Assessment Scale (IDEAS). Items assessed in IDEAS:

- Self Care
- Interpersonal Activities (Social Relationships)
- Communication & Understanding
- Work

8.4 National Mental Health Programme

The Government of India has launched the National Mental Health Programme (NMHP) in 1982, with the following objectives:

1. To ensure the availability and accessibility of minimum mental healthcare for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population;
2. To encourage the application of mental health knowledge in general healthcare and in social development; and
3. To promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

NMHP has the following components/schemes:

1. District Mental Health Programme (DMHP) with the following components:
 - Early detection & treatment.
 - Training: imparting short term training to general physicians for diagnosis and treatment of common mental illnesses with limited number of drugs under guidance of specialist.
 - IEC: Public awareness generation.
 - Monitoring: the purpose is for simple Record Keeping.
2. Manpower Development Schemes - Centres of Excellence and Setting up/ Strengthening PG Training Departments of Mental Health Specialities
3. Modernization of State Run Mental Hospitals
4. Up gradation of Psychiatric Wings of Medical Colleges/General Hospitals
5. IEC
6. Training & Research
7. Monitoring & Evaluation
8. Training & Research
9. Monitoring & Evaluation

Channels of Mental Health Care delivery to the Adolescents is

- Teachers
- Parents
- Counselors
- General Practitioners
- School /College Mental Health Programs
- NGOs

Handout XIV

Gender and adolescent health services

CONTENTS

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5. How does health system reinforce conventional gender norms and roles?
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7. References

1. Introduction

In our country as in many others, gender norms, roles and relations influence adolescents' lives including their health. Adolescent girls face many more disadvantages than boys. In early childhood, girls are given less health care and food than boys, and many are denied of opportunities to get basic education. They are typically excluded from decisions relating to their lives, including their own health care. Many girls are not permitted to attend a health facility unescorted. Most lack access to and control over economic resources. Several experience violence and harassment in various forms. All these disadvantages compromise adolescent girls' ability to adopt health promoting behaviours and timely care seeking.

While adolescent boys are not subject to the stringent behavioural restrictions imposed on adolescent girls, gender norms may inhibit them from seeking health information and services, and discussing their health problems. Social pressure to have sex at an early age, as well as a sense of entitlement to sex in and outside of marriage, often under risky conditions, may put adolescent boys and their partners at risk of STIs/HIV. In other words, gender affects the health status of adolescent boys as well.

Putting a gender lens to adolescent health services is, therefore, critical. It can enable health care providers better understand how health problems affect adolescent girls and boys differently. It can help them deliver services in ways that can contribute to effective use of health information and services by adolescents. Ultimately, it can lead to improve health outcomes among adolescents.

2. Gender and sex

The term 'gender' means different things to different people. Many people use the terms 'gender' and 'sex' interchangeably. Some people confuse the word 'gender' with women and girls. Others consider it to be related with just gender-based violence.

Gender refers to socially or culturally defined ideas about female roles, attributes, and behaviours, and male roles, attributes, and behaviours (Population Council, 2009). It determines the roles, power and resources for females and males in any society.

Gender, in fact, refers to girls as well as to boys, women as well as to men.

Gender is not the same as sex. Sex refers to the difference in biological characteristics of males and females, determined by a person's genes. In other words, most people are born female or male but learn to be girls and boys who grow into women and men. This learnt behaviour makes up gender identity and determines gender roles. For example, the fact that only males produce sperm and only females produce eggs and can become pregnant refers to sex. However, the fact that most women spend more time than men caring for children refers to gender.

3. Gender norms, roles and relations

Gender norms, roles and relations constitute the main components of the concept of gender. Examining these components helps better understand the socialisation processes that influence the lives of girls and boys, and women and men.

Gender norms refer to the widely held **expectations or beliefs** within a community about how people should act or think as females or males (WHO, 2011a; Population Council, 2009). Gender norms also refer to views on how strictly or consistently people should comply with one gender role or another. For example, prevalent norms expect boys to be brave and assertive and may discourage them from crying or from expressing feelings of vulnerability. On the other hand, these norms expect

girls to be docile and may discourage them from asserting themselves. Gender norms are widely reproduced in schools, workplaces, families, and health facilities (Population Council, 2001; Wingood and DiClemente, 2000). These norms vary from one culture or to another and change over time.

Gender roles refer to the **roles** assigned to females and males by the society or family in which they live. Such roles include, for example, how they should behave or what jobs they should have (WHO, 2011a; Population Council, 2009). They refer to what girls and boys, and women and men can and should do and what they are responsible for in households, communities and the workplaces. For example, boys and men are typically expected to be bread-winners, while girls and women are expected to be caregivers. Gender roles are learned. They are not innate or “natural.” In fact, almost everything that males can do, females can also do. And almost everything that females can do, males can also do. Like gender norms, broader sociocultural, economic and political factors shape gender roles. Like gender norms, gender roles change over time.

Gender relations are about the **social relations** between and among women and men. In other words, they set out how women and men should interact with each other – and among themselves (WHO, 2011a). Gender norms and roles contribute to establishing gender relations. They can determine hierarchies between groups of women or men based on gender norms and roles.

4. Why does gender matter in adolescent friendly health services?

Does gender really matter in adolescent health? Isn't questioning gender norms and roles against our culture? Isn't paying attention to gender issues the responsibility of others rather than the responsibility of health care providers? Aren't we doing enough by providing services to both girls and boys? Aren't there more pressing priorities than paying attention to gender issues? These kinds of misconceptions and expressions of resistance are commonplace among many health care providers. The fact is that if health care providers lack the skills to pay attention to gender issues while delivering health information and services to adolescents, the adolescent health programme will continue to fall short of serving the health needs of adolescents meaningfully and holistically.

Here are some reasons why gender matters in adolescent health services.

A. Gender place adolescent girls and boys at different levels of health risks

Unequal gender norms and roles pose different types of health risks to adolescent girls and boys. In fact, for girls, discriminations based on gender norms and roles start at the foetal stage itself. Sex-selective abortion is an important example of the discrimination that females face at the foetal stage itself. In India, at each parity, a much higher percentage of pregnant women with no living son than daughter had an ultrasound test (IIPS and Macro International, 2007).

Discrimination that females experience are carried forward through infancy, childhood, adolescence and thereafter. For example, although mortality in the neonatal period is lower for females than for males, females have 36% higher mortality than males in the post-neonatal period and 61% higher mortality at ages 1-4 years. Female children are less likely than male children to be fully vaccinated (42% versus 45%; IIPS and Macro International, 2007).

As female children grew into adolescent girls, they face discrimination in terms of food distribution. And because of this gender discrimination and because of biological differences, adolescent girls are more anaemic than boys.

Girls also face pressure to get married. In India, one in three girls aged 15-19 were already married (IIPS and Macro International, 1997). Research in India and elsewhere has extensively documented that marriage before age 18 is associated with adverse health consequences - unintended pregnancy,

pregnancy-related complications, preterm delivery, delivery of low birth weight babies, fetal mortality and violence within marriage (Raj et al., 2010a; 2010b; Santhya, 2011).

Once married, girls face pressure to prove their fertility; one in six girls aged 15-19 have already begun childbearing in India (IIPS and Macro International, 2007). They are also expected to bear violence perpetrated by their husband and other family members silently (described in detail in the section below). They are pressured to engage in sex even if they suspect their husband has engaged in extra-marital relations or has an infection. They are discouraged from negotiating use of contraceptive methods, including condoms.

Gender affects adolescent boys, married and unmarried, as well. For example, they experience pressure to have sex at an early age and feel entitled to engage in pre-marital, marital and extra-marital sex, even under risky conditions, thereby putting them and their partners at risk of STIs/HIV (Jejeebhoy and Sebastian, 2004; Population Council, 2004; Santhya and Jejeebhoy, 2007). They feel pressured to engage in substance misuse, which is globally established as one of the factors underlying the risk of non-communicable diseases in adult years (WHO, 2011b).

B. Gender-based violence leads to several adverse health outcomes

Violence against girls and women is yet another reason why gender matters in adolescent health services (See Box 1)

Box 1: Violence against girls in India

1 in 5 girls aged 15-19 who experienced sex before marriage were forced to engage in sex

1 in 3 married girls aged 15-19 had ever experienced emotional, physical or sexual violence perpetrated by their husband

1 in 5 15-19 year-old girls had ever experienced physical violence since age 15, perpetrated by a family member or an acquaintance

2 in 5 women who were commercially sexually exploited were minor girls

Sources: IIPS and Macro International 2007; Government of India, 2008; IIPS and Population Council 2010

Violence against girls may be of an emotional nature and may include teasing, spreading rumours, commenting on body, insulting, humiliating in front of others, intimidating on purpose, threatening to harm etc. Violence against girls may be of a physical nature as well and may include slapping, beating, burning or even murder. Violence against girls may be of a sexual nature too. Girls may be subjected to sexual violence by different means, including emotional manipulation, deception, verbal insistence, economic inducements or physical force or threats. Sexual violence can occur in many different contexts, but often in settings or situation normally considered safe, such as at one's home or the home of friends or relatives, at school, at work, at public spaces, within romantic relationship or within marriage.

Violence against girls reflects and reinforces gender norms. For example, girls are typically brought up to accept that violence is justified if provoked, that 'mild' violence is acceptable, that 'occasional' violence is acceptable (Jejeebhoy et al., 2013). Boys are socialised to believe that males are superior to females and that violence is an appropriate way of responding to any perceived disobedience by girls.

Violence against girls has serious health consequences. Evidence from India shows that violence against girls is associated with a range of health consequences for the girl as well as the children she bears. For example, compared to young women who had not experienced physical or sexual violence within marriage, those who had experienced it were 1.5 times more likely to have an induced

abortion (Jejeebhoy et al., 2010a). They are twice as likely to experience symptoms of gynaecological morbidity (see Box 5 in the handout for more details about the consequences of gender based violence).

While adolescent boys are more likely than adolescent girls to commit violence, they are also likely to be victims of violence at times. In India, for example, almost half of boys aged 15-19 report that a parent had ever beaten them since the age of 12 (IIPS and Population Council, 2010).

C. Gender affects adolescent girls' and boys' access to health information differently

Most adolescents in our country lack basic knowledge of sexual and reproductive matters. At the same time, we see wide differences in the awareness levels of adolescent girls and boys (Parasuraman et al., 2009). For example, 49% of girls and 39% of boys aged 15-19 in our country had heard about fertile period during the woman's menstrual cycle. Similarly, 65% of girls and 91% of boys had heard of condoms. Likewise, 19% of girls and 35% of boys had displayed comprehensive knowledge about HIV/AIDS. Can these differences in awareness levels be explained by biological differences between females and males? Not really! These differences in fact reflect differential access to health information for adolescent girls and boys (see Box 6 in the handout for more details).

First, the prevailing gender norms that display a higher preference for sons than daughters and gender roles that expect boys and men to be bread-winners place higher value on education for boys than girls. This results in reduced opportunities for girls to complete secondary education (class 10) compared to boys. Second, although many boys do household chores, girls tend to be given more domestic responsibilities and have less free time than their brothers, including for accessing information broadcast through the mass media. Third, health information imparted through frontline health workers is more likely to reach girls than boys. Finally, many parents think that discussing sexual and reproductive matters with their adolescent children goes against cultural norms and children, and girls, in particular, should not know about sexual and reproductive matters until marriage.

D. Gender affects adolescent girls' and boys' access to health services differently

It is widely established that many adolescents do not seek proper care for health problems, particularly for sexual and reproductive health problems. Few sexually experienced, unmarried adolescents had used condoms consistently in pre-marital relationships (3% and 8% of adolescent girls and boys, respectively) (IIPS and Population Council, 2010). Just 13% of married adolescent girls currently use a contraceptive method and 27% had an unmet need for contraception (IIPS and Macro International, 2007). Adolescents are often likely to seek abortions from unqualified or untrained providers, to have delayed abortions and to have undergone second trimester abortions (Ganatra and Hirve, 2002; Jejeebhoy et al., 2010b). For symptoms of genital infection too, there is evidence that care-seeking is limited (IIPS and Population Council, 2010).

Does gender contribute to this limited health care seeking among adolescents? Yes, it does! Gendered norms, roles and relations affect care seeking among girls and boys differently. For example, adolescent girls lack the agency, that is, decision-making capacity, freedom of movement, and access to and control over financial resources, to seek health care services (see Box 2). Evidence exists that shows that lack of agency is associated with limited health care seeking and poor health outcomes (Jejeebhoy and Santhya, 2013; Kishore and Gupta, 2009; Prakasamma, 2009).

Box 2: Adolescent girls' agency in health matters

3 in 5 married girls do not usually participate in decisions related to own health care

3 in 4 married girls are not permitted to attend a health facility unescorted

2 in 3 married girls do not have any money that they can decide how to use

Source: IIPS and Macro International, 2007

In contrast, expectations that boys and men are self-reliant, sexually experienced and more knowledgeable than girls and women, may inhibit them from seeking treatment, information about sex and protection against infections, and from discussing sexual health problems (Blanc, 2001). Moreover, many may consider taking care of sexual and reproductive matters, including contraception, safe motherhood practices and STI/HIV prevention, as a woman's business (see Box 3)

Box 3: Adolescent boys' engagement in SRH

1 in 4 adolescent boys used a contraceptive method at last sex

1 in 5 adolescent boys believe that contraception is a woman's business and a man should not have to worry about it

1 in 3 adolescent boys were present when their wife sought antenatal check-ups

Source: IIPS and Macro International, 2007

5. How does health system reinforce conventional gender norms and roles?

Do health care providers like medical officers reinforce conventional gender norms and roles? Yes, some medical officers do so sometimes! They do so through the words they use! They do so through their gestures! They do so through their actions! It may not always be intentional – it results from normalized beliefs and practices.

Some medical officers may convey to adolescent girls (and to boys), especially if they are unmarried, that they have done something wrong when they seek sexual and reproductive health services, particularly contraceptive services. Some may insist on getting the consent of the husband before providing services to married girls. Young men who try to support their wives by accompanying them to a health facility may not always be welcomed by the medical officers.

6. What health care providers can do to mainstream gender in adolescent friendly health services?

There are a lot that medical officers can do to mainstream gender in adolescent health services.

Often, many of us think that gender norms and roles do not affect our lives but only the lives of the patients we serve. The reality is that gender plays a part in our own lives. The first and right step toward mainstreaming gender in adolescent health services is to **acknowledge that gender matters in everyone's life**.

Medical officers can take many affirmative actions to mainstream gender in adolescent health services as well. For example, they can:

Conduct a gender analysis

Conduct a gender analysis of issues affecting uptake of adolescent health services. For example, explore the following:

- Which groups – boys or girls, younger or older adolescents, married or unmarried – are seeking services, and why?
- Are information and services provided tailored to the needs of different categories of adolescents?
- Where services are provided, are they physically accessible to adolescent girls and boys?
- Are there concerns about privacy, the attitudes of health staff or language barriers?

Communicate with empathy and respect

Communication – both verbal and non-verbal – can often reinforce stereotyped norms and roles. Therefore, it is important that medical officers develop and demonstrate skills in listening, respecting the adolescent clients' feelings, showing empathy and respect to them in both verbal and non-verbal ways and not conveying judgemental attitudes and personal biases to clients. They also need to ensure confidentiality in interpersonal communication (e.g. by using a separate space, or by waiting until only provider and client are in a room before sensitive issues are raised).

Bring services as close to the adolescents as possible

- Strengthen outreach services to reach adolescent girls who may be inhibited to visit the health facilities
- Identify the most appropriate hours and locations for the provision of services to adolescent girls and boys
- Conduct an audit of the quality of services provided from a gender perspective at regular intervals

Build the capacity of staff to provide services in gendersensitive ways

The health care staff may not be aware of how the gender norms, roles and relationships affect adolescent girls' and boys' access to health information and services differently. Even when they may be aware of these associations, they may not be willing or able to provide services in gender sensitive ways for various reasons.

- Through in-service training, generate awareness of staff about how gender affects the health of adolescent girls and boys, help them to examine their values and beliefs and assist them to develop solutions to respond to gender inequalities
- Emphasize that addressing gender inequalities lie primarily in listening, being empathetic and non-judgemental, providing accurate information, providing options, assisting clients in appraising their situations and making plans, and providing appropriate referrals to other resources or care when necessary
- Follow up training on gender with regular support and supervision

7. References

- Blanc, A.K. 2001. The effect of power in sexual relationships on sexual and reproductive health: An examination of evidence, in *Studies in Family Planning*, 32 (3): 189-213.
- Bruce, J. 2011. *Violence against adolescent girls: A fundamental challenge to meaningful equality*. New York: Population Council and UN Adolescents Girls Task Force.
- Ganatra, B. and S. Hirve. 2002. 'Induced Abortions Among Adolescent Women in Rural Maharashtra', *Reproductive Health Matters*, 10(19): 76-85.
- Government of India (Ministry of Women and Child Welfare, New Delhi). 2008. *India Country Report: To Prevent and Combat Trafficking and Commercial Sexual Exploitation of Children and Women*. Prepared for the World Congress III against Sexual Exploitation of Children and Adolescents, Rio de Janeiro, Brazil, November 2008
- Jejeebhoy, S. J. and M. P. Sebastian. 2004. 'Young People's Sexual And Reproductive Health', in *Looking Back, Looking Forward: A Profile of Sexual and Reproductive Health in India*, ed. S. J. Jejeebhoy. New Delhi: Rawat Publications.
- Jejeebhoy, S.J., K. G. Santhya and R. Acharya. 2010a. *Health and Social Consequences of Marital Violence: A Synthesis of Evidence from India*. New Delhi: Population Council.
- Population Council. 2009. *It's All One Curriculum*. New York: Population Council.
- United Nations Children's Fund (UNICEF). 2012. *Progress for Children: a report card on adolescents*. New York: UNICEF.
- World Health Organization. 2013. *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. Geneva: World Health Organization.

8. Annexure I: Self-assessment check

1. What is the difference between gender and sex?

2. Why does gender matter in adolescent health?

3. What can be done to provide services that are gender sensitive?

Handout XV

Concluding Module

CONTENTS

1. Strategy for Addressing Adolescent Friendly Health Services
2. Providing AFHS through the Public Health System
3. Making a Plan of Action
4. Close of the Orientation Programme

1. Introduction

This Handout is the concluding Handout in the Programme. It asks the participants to reflect on the ways they aim to improve by consolidating areas of strength and addressing areas of weakness in them or their services and draft the outline of a plan of action for implementation, which will help to improve their work for and with adolescents when they return to their respective health facilities.

National Adolescent Health strategy

This strategy is a paradigm shift as it realigns existing approaches to focus on community based health promotion and prevention; and strengthening of clinic based preventive, diagnostic and curative services across the levels of care in adolescent friendly manner.

The new strategy envisions that all adolescents in India are able to realize their full potential by making informed and responsible decisions related to their health and well-being.

2. Providing AFHS through the Public Health System

Strategy for providing AFHS – Rashtriya Kishor Swasthaya Karyakaram

The goal of adolescents making informed decisions for health and well-being will be achieved through the following as shown in the (fig 1):

- Health Promotion for Healthy Community
- Strengthened Clinical Services
- Community-based Approach
- Strategic Partnership
- Incorporate adolescent issues in all RCH training programmes and all RCH materials developed for communication and behaviour change
- Strengthening of AFHC with provision of counselors
- Community based platforms- Peer Educator and Adolescent Health Day
- Inter and intra – ministerial convergence
- Comprehensive behavior change communication

	Service Package	DH	CHC	PHC	Outreach
Information	IEC and IPC for Nutrition, SRH, Mental Health, GBV, NCD, Substance misuse	√	√	√	√
Commodities	IFA/ Albendazole tablets	√	√	√	√
	Sanitary napkin	√	√	√	√
	Contraceptives (condoms, OCP, ECP)	√	√	√	√
	Other medicines (e.g. Paracetamol, anti-spa-smotic and first aid)	√	√	√	√
	Pregnancy testing kits	√	√	√	√
Services	BMI screening	√	√	√	√
	Hb testing	√	√	√	√
	RTI/STI management	√	√	√	√
	ANC for pregnant adolescents	√	√	√	√
	Counseling on Nutrition, puberty related concerns, Pre-marital Counseling, Sexual Problems, Contraceptive, Abortion, RTI/STI, Substance abuse, Learning problems, Stress, Depression, Suicidal Tendency, Violence, Sexual Abuse, Other Mental Health Issues, health lifestyle, risky behaviour	√	√	√	√
	Management of Menstrual problems	√	√	√	
	Management of Iron deficiency Anaemia	√	√	√	
	Screening for diabetes and hypertension	√	√	√	
	Management of common adolescent health problems	√	√	√	
	HIV testing and counselling	√	√		
	Management of physical violence and sexual abuse	√	√		
	Linkages with de-addiction centres and referrals	√	√		
	Treatment by specialists	√	√		
	Referral	√	√	√	√

3. Making a Plan of Action: Improvements one can make at the workplace:

3.1 Purpose

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

- The proposed changes one intends to make;
- The importance of the proposed changes;
- How to assess whether or not one is successful in making these changes;
- The personal and professional challenges and or problems one may face in making these changes;
- The ways in which these challenges and or problems may be addressed assistance required

3.2 General instructions

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

Specific Instructions for Making a Plan of Action

- Column 1
Changes you personally plan to make in your everyday work with or for adolescents. Stress that each change could relate to something they learned during any of the modules they have worked through. Explain each remaining column in turn.
- Column 2
Why is this change important: who or what will benefit and in what way? Explain that the first task is to concentrate on the first two columns only.
- Column 3
How will you measure the extent of success of this change?
- Column 4
Are there any personal or professional challenges and/or problems you anticipate in carrying out the changes?
- Column 5
What assistance are you likely to need and who could provide you with this assistance?

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

SAMPLE PLAN OF ACTION – Example							
Column 1	Column 2			Column 3		Column 4	Column 5
The changes I plan to make in my every day work with or for adolescents	Why is this change important?			Measuring the extent of success of this change		Challenges and/or problems anticipate in working with adolescents	Assistance
	Who/What will benefit?	Why?	How to measure?	When to measure?	Assistance required		
Contact the local schools to provide information on the new adolescents-friendly health services being provided by our clinic	Students in local schools. Friends of students and family members of school staff who are not in local schools.	They will find it easier to obtain the services they need.	A steady increase in the number of students who come to the clinic to obtain services.	Six months after making contact with the schools.	Lack of interest from the school principal. Resistance from the teachers.	Support from the block education authority. A meeting to convince them of the value of this work.	The MO of the PHC could request this. Village Leaders parents and influential people.
Attitude of staff to be improved towards adolescents and their services	Adolescents	Adolescent will feel comfortable	Increase in number of clients	Six months after initiating the programme	They may not change	Repeated meetings of workshops	Request your superior to also meet with them and encourage
Privacy	Adolescents	Adolescent will feel comfortable	Increase in number of clients	Six months after initiating the programme	Lack of separate time/separate space	Change in time, curtain	From HQ, from community donation
confidentiality	Adolescents	Adolescent will feel comfortable	Increase in number of clients	Six months after initiating the programme	Unaware client	Awareness generation posters for information	From Headquarters for posters

